

CHAPTER 3

Overview of the “Helping the Noncompliant Child” (HNC) Parent Training Program

In this chapter, we first present some of the necessary requirements for effective parent training, including characteristics of the training setting, who should attend sessions, the parenting skills that are taught, and the methods for teaching those skills. We then present overviews of the parent training program, the use of behavioral criteria to determine success in learning each parenting skill and the structure of sessions, and note the availability of additional training materials for the parent training program. Finally, we describe ethical considerations in the use of parent training to treat child noncompliance, engagement of families in the intervention, and therapist characteristics.

As noted in Chapter 1, we hypothesize that the child’s noncompliant, inappropriate behavior is shaped and maintained through maladaptive patterns of family interaction, which reinforce coercive behaviors. As a logical outgrowth of this formulation, our intervention strategy involves teaching parents to change their behavior toward their child so as to incorporate more appropriate styles of family interaction. In the initial part of this chapter, we delineate some of the basic requirements for our parenting program to be effective.

THE TRAINING SETTING

Parent training can occur either in the home or in a clinic setting. There are advantages and disadvantages to each approach. Intervention in the home prevents the need for generalization from the clinic to the home to occur. However, home-based intervention requires substantially more time and expense on the part of the therapist (e.g., travel time and gas expenses). It is also the case that third-party payers typically will not pay for services provided outside of a clinic. As noted earlier, our program is based on a clinic training model, as this appears to be more efficient and therefore most likely to be

employed by most mental health professionals. We have also spent substantial time and effort in our research endeavors to examine and facilitate generalization from the clinic to the natural environment (see Chapter 10).

Intervention is initiated and carried out with individual families rather than in groups in a clinic playroom similar to the one used for clinic observations. However, our parent training program has been adapted for use in a group format by several clinical researchers (e.g., Baum, Reyna McGlone, & Ollendick, 1986; Breiner & Forehand, 1982; Long & Forehand, 2000b; McMahon, Slough, & the Conduct Problems Prevention Research Group, 1996; Pisterman et al., 1989).

There are a few fundamental considerations in setting up the clinic playroom in which the parent training program will be conducted. The room should have a chair for each person (i.e., the therapist, parent[s], and child), various sets of age-appropriate toys, and an additional chair that serves as the TO chair. Because children with conduct problems often engage in destructive behavior, we recommend that the furniture be basic, functional, and durable, and that the room be furnished as minimally as possible. If possible, the light switch should either be out of the child's reach or taped or locked in the "on" position.

Toys should be conducive to joint play and facilitative of imaginative play (Cavell, 2000). Examples of such toys are building materials (e.g., Legos, building blocks, Lincoln Logs), crayons or markers with paper and coloring books, a dollhouse with furniture and people, cars and trucks, and farm or zoo animals. Toys that should be avoided include board games, aggression-facilitating toys (e.g., guns), and messy toys (e.g., bubbles, paints) (Hembree-Kigin & McNeil, 1995).

The placement of furniture and toys is also important. Toys should be placed in that part of the room farthest from the door, with chairs for the therapist and parent(s) placed between the toys and the door (see Figure 3.1). This layout (1) provides separate areas for discussion among adults and for toy play and (2) prevents the child from having easy access to the playroom door should the child decide to leave during the session!

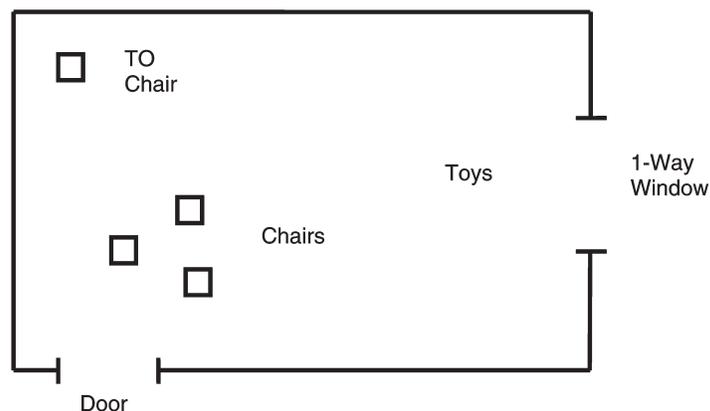


FIGURE 3.1. Example of playroom layout.

In an ideal situation, the playroom is equipped with a one-way window and a radio signaling device such as the “bug-in-the-ear” (a hearing-aid-like device converted to a radio receiver that the parent wears in his or her ear), giving the therapist the ability to unobtrusively talk to the parent from behind the window while the parent interacts with the child. However, these accoutrements are *not* necessary for the successful implementation of the program.

Sessions are optimally scheduled twice each week, with a session length of 75–90 minutes. We have found the more traditional format of weekly 50-minute sessions to be less successful. A 50-minute session usually does not permit adequate time for homework review, observation of parent–child interaction, and the extensive teaching and practice procedures employed in the program. In addition, weekly sessions increase the likelihood of an unacceptable level of performance decay. If parents are having difficulty implementing a procedure at home, they usually either stop using the skill or, worse, become proficient at using it incorrectly. By attending two sessions each week, parents receive a more constant level of feedback and training. When practical considerations (e.g., distance, insurance reimbursement, scheduling) prevent twice-weekly sessions, we strongly recommend that phone contact occur midway between the weekly sessions.

WHO SHOULD ATTEND SESSIONS

When two parents reside in the home, we encourage both to attend sessions. Two parents consistently implementing the program will be more effective than only one parent! In our clinical experience, both parents attend in about 50% of the cases. Not surprisingly, when only one parent is involved in treatment, it is usually the mother.

When only one parent attends sessions, we encourage that parent to share handouts with the second parent. The two parents also are encouraged to practice the skills together so that they both are using the skills.

In some cases, an extended family member (e.g., the child’s grandmother) may be a coparent. In these cases, we encourage the involvement of that person. We have found particularly high levels of coparenting by extended family members in ethnic minority groups (e.g., African American) (Forehand & Kotchick, 1996; Kotchick et al., in press).

PARENTING SKILLS

Which skills can parents most effectively use to modify child noncompliance and other inappropriate behavior? As noted in Chapter 2, parent training interventions have tended to employ a number of similar teaching procedures and parenting skills (Dumas, 1989; Kazdin, 1995; Miller & Prinz, 1990). For young (3- to 8-year-old) children presenting with noncompliance, our research and clinical experience support the teaching of five core skills: giving attends, giving rewards, use of active ignoring, issuing clear instructions, and implementing time outs. These parenting techniques are described in

detail in subsequent chapters, and Chapter 10 presents the data from studies examining these skills.

Our clinical experience has indicated that these skills should be taught in a specific order. In particular, the attending and rewarding skills from Phase I should be taught prior to teaching clear instructions and TO from Phase II. We strongly believe that these positive attention skills are critical to providing a more positive social context for the child and thus increase the likelihood of cooperative behavior (see Chapter 1). In addition, we have found that parents who are first taught a disciplinary procedure such as TO (which is a type of punishment) may terminate prematurely, as they often will have reduced their children's problem behaviors (albeit temporarily). Unfortunately, these parents have not learned any positive skills for interacting with their children or for maintaining their children's positive behavior. Therefore, for both ethical reasons and overall intervention effectiveness, we believe that, in nearly all cases, it is important to teach punishment procedures to parents later in the intervention process. However, it may sometimes be necessary to introduce nonphysical punishment procedures (e.g., TO) earlier in the program, when the child is extremely out of control (see Chapter 6, p. 128) or when working with physically abusive parents (see Chapter 9, pp. 190–192).

METHOD OF TEACHING

An extensive body of research indicates that modeling and role playing are the most effective teaching procedures in parent training (see O'Dell, 1985, for a review). These findings support our model for training parenting skills. Although we employ other teaching methods, such as instructing parents in what to do and giving them handouts describing the skill, we particularly emphasize modeling and role playing. In addition, parents are given homework assignments to employ the skill at home with their child. In this gradual shaping procedure, parents are told, are shown, practice, and generalize to the home each new skill. Parents also must meet specific performance criteria for a parenting skill before proceeding to the next skill (see below). This active approach to teaching parenting skills may be especially effective with disadvantaged parents (e.g., low SES, single parents) (Knapp & Deluty, 1989).

Similarly, our research (e.g., Davies, McMahon, Flessati, & Tiedemann, 1984) indicates the importance of actively including the child in the learning process. The child is present in the clinic playroom throughout the session; more importantly, the therapist and parent explain, model, and role play the parenting skills with the child before they are implemented "for real." This parent training program is one of the only ones of its type to involve the child as an active participant to this extent.

The sequence of instructional procedures that we follow for teaching the parenting skills is presented in Table 3.1.

An additional part of the teaching procedures consists of the therapist, in interactions with the parent, shaping how the parent should interact with his or her child. For example, in providing feedback to the parent during the instructional sequence just de-

TABLE 3.1. Sequence of Instructional Procedures for Teaching Each Parenting Skill

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- Didactic instruction and discussion
 - Therapist demonstrates skill through modeling and role playing
 - Parent practices skill with therapist
 - Child is taught skill
 - Therapist and parent explain and model skill for child
 - Child repeats skill verbally
 - Parent and child role play skill
 - Parent practices skill with child (therapist provides ongoing cues and feedback)
 - Parent practices skill with child (no ongoing therapist feedback)
 - Parent is given handout describing the skill
 - Homework assignment (parent records on data sheet)
-

scribed, the therapist can (1) provide positive reinforcement for appropriate parenting behavior (“Nice job of attending there!”), (2) provide corrective feedback (“Remember—no questions”), (3) prompt the parent as to what to say/do next (“Say, ‘You’re pushing the car up the tower’ ”), and (4) model a desired behavior (“You’re pushing the car up the tower”). At other times, the therapist may ignore off-task comments by a parent. If such skills are good procedures to use with children, then they are also appropriate for the therapist to use with the parent!

OVERVIEW OF SKILLS TAUGHT IN THE PARENT TRAINING PROGRAM

The program consists of two phases: Differential Attention (Phase I) and Compliance Training (Phase II). In each phase a series of parenting skills is taught in a sequential manner. A synopsis of the skills that are taught in the parent training program is presented in Table 3.2.

During the Differential Attention phase of the intervention (Phase I), the parent learns to increase the frequency and range of social attention to the child and reduce the frequency of competing verbal behavior. A major goal is to break out of the coercive cycle of interaction by establishing a positive, mutually reinforcing relationship between the parent and child. In the context of the Child’s Game, the parent is taught to increase the frequency and range of positive attention to the child; to eliminate verbal behaviors—commands, questions, and criticisms (Forehand & Scarborough, 1975; Johnson & Lobitz, 1974)—that are associated with inappropriate child behavior; and to ignore minor inappropriate behaviors. First, the parent is taught to attend to and describe the child’s appropriate behavior. Moreover, the parent is required to eliminate all commands, questions, and criticisms directed to the child during the clinic training session. The second segment of Phase I consists of teaching the parent to use verbal (e.g., praise) and physical (e.g., hugs) attention contingent upon compliance and other appropriate behaviors (rewards). In particular, the parent is taught to use praise statements in which

TABLE 3.2. Outline of Skills Taught in the Parent Training Program

<u>Phase I (Differential Attention)</u>	
<i>Attends</i>	
<ul style="list-style-type: none"> • Attend to and describe child’s appropriate behavior • Verbally follow, do not direct, child’s activity • Do not ask questions, give commands, or teach 	
<i>Rewards</i>	
<ul style="list-style-type: none"> • Give positive physical attention (e.g., hugs) • Give nonspecific verbal praise • Give verbal praise, labeling the desirable behavior 	
<i>Ignoring</i>	
<ul style="list-style-type: none"> • No eye contact or nonverbal cues • No verbal contact • No physical contact 	
<u>Phase II (Compliance Training)</u>	
<i>Clear Instructions Sequence</i>	
<ul style="list-style-type: none"> • Clear Instructions <ul style="list-style-type: none"> • Reduce unclear instructions (such as chain, vague, question, etc.) • Employ clear instructions (get child’s attention, state instruction clearly, wait 5 seconds) • Consequences for Compliance and Noncompliance <ul style="list-style-type: none"> • Positive attention for compliance to the clear instruction (Path A) or to the warning (Path B) • Warning or Time-out sequence for noncompliance (Path C) 	
<i>Standing Rules</i>	
<ul style="list-style-type: none"> • (“If . . . then” statement, continuously in effect, immediate time out) 	
<i>Situations Outside the Home</i>	
<pre> graph LR A[Clear Instruction] --> B(()) B --> C[Compliance (Path A)] C --> D[Positive Attention (Reward/Attend)] B --> E[Noncompliance (Paths B, C)] E --> F[Warning] F --> G[Compliance (Path B)] G --> H[Positive Attention (Reward/Attend)] F --> I[Noncompliance (Path C)] I --> J[Time Out] J --> A </pre>	

the child’s desirable behavior is labeled (e.g., “You are a good boy for picking up the blocks”). Throughout Phase I, the therapist emphasizes the use of contingent attention to increase child behaviors that the parent considers desirable. The parent is also taught to actively ignore minor inappropriate behaviors. At home, the parent is required to structure daily 10- to 15-minute Child’s Game sessions to practice the skills that were learned in the clinic. Near the end of Phase I, with the aid of the therapist, the parent formulates a list of child behaviors that he or she wishes to increase. The contingent use of attends and rewards to increase these behaviors is also discussed. The parent develops programs for use outside of the clinic to increase at least three child behaviors using the new skills.

In Phase II of the parent training program (Compliance Training), the primary

parenting skills are taught in the context of the clear instructions sequence (see Table 3.2). The clear instructions sequence consists of three paths. The therapist first teaches the parent to use appropriate commands (clear instructions)¹ to increase the likelihood of child compliance. In the context of the Parent's Game, the therapist teaches the parent to give direct, concise instructions one at a time and to allow the child sufficient time to comply. If the child initiates compliance within 5 seconds of the clear instruction, the parent is taught to reward and attend to the child within 5 seconds of the compliance initiation (Path A). If the child does not initiate compliance, the parent learns to implement a brief TO procedure involving the following event sequence. The parent gives a warning that labels the TO consequence for continued noncompliance (e.g., "If you do not pick up the toys, you will have to sit in the chair"). If the child initiates compliance within 5 seconds, the therapist instructs the parent to provide positive attention (i.e., rewards and attends) for the child's compliance (Path B). If compliance does not occur within 5 seconds following the warning, the parent learns to implement a brief TO procedure that involves placing the child on a chair facing a wall (Path C). The child must remain in the chair for 3 minutes and be quiet and still for the last 15 seconds. Following TO, the parent returns the child to the uncompleted task and gives the clear instruction that originally elicited noncompliance. Compliance is followed by contingent attention from the parent. In practice with the child during the Parent's Game in the clinic, the parent is instructed to give a series of clear instructions and to provide appropriate consequences for compliance and noncompliance (i.e., the clear instructions sequence). In the home, the parent practices the use of clear instructions, positive consequences for compliance, and, finally, the use of the TO procedure for noncompliance.

When the parent is using the clear instructions sequence successfully in the home, the parent is taught to use standing rules as an occasional supplement to the clear instructions sequence. Standing rules are "if . . . then" statements ("If you hit your brother, then you must go to TO") that, once stated and explained to the child, are permanently in effect. Finally, the therapist instructs the parent in ways to implement the various Phase I and Phase II skills in settings outside the home, such as when visiting others or at the grocery store.

WHEN TO PROGRESS TO THE NEXT SKILL: BEHAVIORAL CRITERIA

Progression to each new skill in the parent training program is determined by the use of behavioral criteria. The therapist uses the observational data collected during each ses-

¹In the original edition of this manual (Forehand & McMahon, 1981), we referred to clear instructions as "alpha commands." In this edition, we use "commands" and "instructions" to refer to the broad class of directives given by parents to their children. "Clear instructions" refer specifically and only to commands using the criteria specified in the parent training program (see Chapter 7). We continue to use the terms "alpha commands" and "beta commands" in the Behavioral Coding System, which we use in our observations of parent-child interaction (see Chapter 4).

sion to determine if the parent–child pair has attained the behavioral criteria necessary for movement to the next step of the program. The behavioral criteria ensure that the parent has attained an acceptable degree of competence in a particular skill before being taught additional parenting techniques. This is critical, since the parenting skills build on one another. In addition, these criteria allow for the individualization of the program by allocating training time more efficiently. Some parents require more training in some parenting skills than in others. The behavioral criteria allow a flexible approach whereby the therapist can concentrate greater attention on the more serious parenting skill deficiencies. The criteria for each skill are presented in Table 3.3.

STRUCTURE OF SESSIONS

The number of sessions necessary for the completion of each phase of the parent training program depends upon the speed with which the parent demonstrates competence in the skills being taught and the child’s response to this intervention. The number of sessions for each family necessary for the completion of the entire parent training program has ranged between 5 and 14 sessions. The average number has been approximately 8–10 intervention sessions. Each 75- to 90-minute session typically consists of the following activities:

TABLE 3.3. Behavioral Criteria for Successful Skill Acquisition

For the relevant parenting skill, the parent is required to complete at least one 5-minute observation (Child’s Game or Parent’s Game) in which the parent obtains:

Phase I

Attends

- Average of 4 or more attends per minute (i.e., at least 20 attends).
- Average of .4 or fewer commands plus questions per minute (i.e., no more than a total of 2 commands and questions).

Rewards

- Average of 4 or more rewards plus attends per minute (i.e., at least 20 attends plus rewards).
- Of this sum, at least 2 rewards per minute (i.e., at least 10 rewards).

Ignoring

- Successfully ignores 70% of child’s inappropriate behavior.^a

Phase II

Clear Instructions

- Average of 2 or more alpha commands per minute (i.e., at least 10 alpha commands).
- No more than 25% of total commands are beta commands.

Consequences

- 75% child compliance ratio (child compliance/total parental commands plus warnings).
 - 60% rewards plus attends ratio (parental rewards plus attends issued within 5 seconds following child compliance to a parental command or warning).
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^aRecommended.

1. A 5-minute data-gathering period in which the therapist observes the parent and child engaged in either the Child's Game (Phase I) or the Parent's Game (Phase II).
2. Discussion with the parent about the use of the relevant parenting skill(s) (attempts, rewards, ignoring, clear instructions, TO) during the preceding observation period and at home (which skills are discussed depends on the skill(s) taught to that point).
3. The procedure and rationale for the next skill are explained, and the underlying social learning principles on which the skill is based are briefly presented.
4. The therapist demonstrates the skill via modeling and role playing.
5. The parent practices the skill with the therapist, who role plays the child.
6. The child is taught the skill. First, a developmentally appropriate explanation of the skill is given to the child by the parent and therapist. Then the parent and therapist demonstrate the skill to the child. The child repeats the skill verbally and participates in role plays of situations involving the skill.
7. The parent practices with the child in the intervention setting. The therapist observes and coaches, either through the bug-in-the-ear device or by nonverbal prompts and feedback.
8. The parent practices with the child in the intervention setting but without ongoing feedback from the therapist.
9. Depending upon the parent's progress, the therapist may conduct a 5-minute data-gathering period to determine whether the parent meets the behavioral criteria for that particular skill (see Table 3.3).
10. Parents are given handouts specific to each parenting skill for reference in the home setting.
11. Specific homework is assigned to practice the skills on a daily basis at home, both in structured practice sessions with the child and, later, at various times throughout the day (e.g., in Phase I, the parent develops programs to increase at least three behaviors using the new skills). Parent uses data sheets to record practice sessions and use of the new parenting skills in the home.

TRAINING MATERIALS

In addition to this volume, there are additional materials that therapists may find helpful in learning and implementing this parent training program. A 70-minute videotape (*Parent Training for the Noncompliant Child: A Guide for Training Therapists*; Forehand, Armistead, Neighbors, & Klein, 1994) that demonstrates the intervention procedures and component parenting skills is available for training therapists. It may be obtained from the second author (RLF) at the following address: ChildFocus, 17 Harbor Ridge Road, South Burlington, VT 05403. A supplemental self-guided book for parents that employs similar skills and teaching techniques (*Parenting the Strong-Willed Child*; Forehand & Long, 2002) is available from McGraw-Hill (800-722-4726, ext. 3; <http://books.mcgraw-hill.com>) (see Chapter 10 for a description). A leader's guide for a 6-week

parent class (Long & Forehand, 2000b) based on the Forehand and Long volume is available from Nicholas Long, Department of Pediatrics, UAMS/ACH, 800 Marshall Street, Little Rock, AR 72202.

ETHICAL CONSIDERATIONS

Therapists who plan to use the procedures described in this book should be aware of their ethical obligations when treating child noncompliance. Teaching parents to increase compliance should involve monitoring and training of parents by the therapist with regard to the kinds of commands to be given, the proper use of consequences for compliance and noncompliance, and parental expectations for the level of child compliance (Forehand, 1977). For example, although unlikely, it is conceivable that parents might use the skills taught to them to obtain compliance to deviant or morally undesirable commands. Similarly, regarding the proper use of consequences, parents could effectively reduce noncompliance by leaving a child in TO most of the day. Obviously, this is not an acceptable approach. Regarding parental expectations, parents might expect 100% compliance from their children. The normative developmental data that have been collected (see Chapter 1) make such a goal unrealistic and harmful. Such situations rarely occur; however, the important issue is that therapists should be sensitive to the possibility of their occurrence and incorporate instructional and monitoring procedures into their parent training programs to prevent these situations from happening. Our goal is not to develop quiet, docile children but rather to enhance the pleasure and significance of family interactions for all members of the family (Risley, Clark, & Cataldo, 1976).

ENGAGING FAMILIES IN THE INTERVENTION

For parent training to be successful, families must (1) believe that the intervention is an appropriate and potentially useful one for dealing with their concerns about their child's behavior, (2) become actively involved in the intervention, and (3) complete the program (i.e., not drop out). This process of engagement in parent training has received increased attention in the past several years. Of prime importance has been the development of conceptual frameworks for examining the engagement process in general (e.g., Kazdin, Holland, & Crowley, 1997; Prinz & Miller, 1996; Webster-Stratton & Herbert, 1994) and therapist behavior in particular (e.g., Patterson & Chamberlain, 1994). For example, Prinz and Miller (1996) present four domains that they suggest affect parental engagement in parent training interventions such as ours: (1) parents' personal expectations, attributions, and beliefs (e.g., expectations about the nature of the intervention, attributions about the source of the child's problem and/or about their own self-efficacy); (2) situational demands and constraints (e.g., financial and social stressors, marital and personal adjustment, daily hassles, and competing demands of other activities); (3) intervention characteristics (e.g., group versus individual parent training, home ver-

sus clinic delivery, type of intervention, scheduling of sessions, including the child in the session, homework); and (4) relationships with the therapist. These domains have been shown to be associated with engagement in parent training over and above that provided by the child, parent, and family factors described in Chapter 1 (Kazdin et al., 1997; Prinz & Miller, 1994). Furthermore, the greater the number of barriers experienced by the family, the greater the likelihood of subsequent dropout (Kazdin et al., 1997).

Webster-Stratton and her colleagues (e.g., Webster-Stratton & Herbert, 1994) used qualitative research methods to describe the process of intervention from the perspective of the parents. Participants in her parent training program (which, as discussed in Chapter 2, is also derived from the work of Hanf) went through five phases during the course of intervention (Spitzer, Webster-Stratton, & Hollinsworth, 1991). In the first phase (Acknowledging the Family's Problem), parents first had to acknowledge that their child was engaging in behaviors that the parents were unable to control. This was associated with parental anger, fear of losing control, self-blame, and depression. In addition, some parents also expressed concerns about being stigmatized and socially isolated from other parents because of their children's behavior. In the second phase (Alternating Despair and Hope), many parents often experienced immediate relief once they began using the newly acquired parenting skills and experienced some initial success. However, they failed to consider the long-term effort required to sustain these improvements and the "one step forward, two steps back" nature of much child behavior change. In the third phase (Tempering the Dream), apparent setbacks and parental resistance became more common, as progress slowed or regressed. Parents needed to understand that maintenance of improvements in child behavior required a long-term commitment to carrying out the program. In the fourth phase (Making the Shoe Fit), parents were able to adapt the program to fit their own needs. Key components of success in this phase were understanding the parenting techniques and how to implement them in multiple settings and situations above and beyond those directly discussed in the parent training program. In the final phase (Coping Effectively), parents accepted the notion that their children would require intensive efforts over the long term; however, they also were able to develop ways to provide self-reinforcement and support from others in their environment.

THERAPISTS

A single therapist per family is sufficient to conduct the parent training program successfully. However, in settings where therapist training occurs, it can be very helpful to employ two therapists to work with each family. First, it permits trainees to learn from in vivo exposure. As the trainee becomes more experienced and comfortable in the role of cotherapist, he or she can assume a greater proportion of the teaching role. Eventually, this person may function as a primary therapist. A second advantage of employing cotherapists is that it enables the therapists to be more flexible in demonstrating various skills to the parent. In the initial stages of teaching a new skill, one therapist models the

skill while the other therapist role plays the child. This allows the parent to devote full attention to the modeling of the parenting skill. However, utilizing two therapists is obviously an expensive procedure in terms of personnel, and whether it is appropriate in a particular setting will depend upon both resources and training goals.

Therapist Relationship Skills

As noted above, the importance of the therapist establishing a collaborative relationship with the parent during parent training has been emphasized (Kazdin et al., 1997; Prinz & Miller, 1996), and therapist activities in such a relationship have been delineated (Sanders & Dadds, 1993; Webster-Stratton & Herbert, 1994). For example, Webster-Stratton and Herbert have described a number of roles for the therapist in the context of her parent training program (Webster-Stratton, 2000) that are clearly relevant to the program described in this volume. These roles include (1) building a supportive relationship through the use of appropriate self-disclosure, humor, optimism, and serving as an advocate for the parent; (2) empowering parents by reinforcing and validating their insights, modifying powerless thoughts, promoting self-empowerment, and building family and group support systems; (3) active teaching, which includes persuading, explaining, suggesting, adapting the concepts and skills to the parent's situation, giving homework assignments, reviewing and summarizing, ensuring generalization, role play and rehearsal, and evaluating parental satisfaction and progress; (4) interpreting through the use of analogies and metaphors, reframing, and making connections between the parents' childhood experiences and those of the child; (5) leading and challenging by setting limits, pacing the session, and dealing with resistance; and (6) anticipating problems and setbacks, predicting parental resistance to change, and predicting positive change/success.

Despite the obvious relevance of these clinical skills to the success of family-based interventions, there has been very little empirical research to evaluate these skills. Patterson and his colleagues have an ongoing program of research that has focused on the role of parental resistance in their parent training intervention. Patterson and Chamberlain (1994) presented a conceptualization of parental resistance that includes both within-session (refusal, stated inability to perform) and out-of-session (homework) resistance. Initial resistance is thought to be a function of the parents' history of parent-child interaction, preexisting parental psychopathology, and social disadvantage, as well as therapist behavior (Patterson & Chamberlain, 1988). Patterson and Chamberlain demonstrated that these contextual variables were associated with parental resistance throughout parent training. According to their "struggle hypothesis," parental resistance is expected to increase initially but then eventually decrease as the parent begins to meet with success.

High levels of resistance in the first two sessions of their parent training program were associated with subsequent dropout (Chamberlain, Patterson, Reid, Kavanagh, & Forgatch, 1984). Directive therapist behaviors of "teach" and "confront" increased the likelihood of parental noncooperative behavior within the session, whereas supportive and facilitative therapist behaviors had the opposite effect (Patterson & Forgatch,

1985). This poses an intriguing paradox for therapists: the directive therapist behaviors that seem to be intrinsic to parent training would also be those that predict parent non-compliance during treatment. Patterson and Forgatch (1985) conclude that two sets of therapist skills are required: "standard" parent training skills and relationship characteristics to deal with parental noncompliance. Growth-curve analyses of parental resistance over the course of parent training have shown a pattern of increasing resistance that peaks at about the midpoint, followed by a gradual decrease in resistance (Stoolmiller, Duncan, Bank, & Patterson, 1993). In general, these findings support the struggle hypothesis proposed by Patterson and Chamberlain (1994).

Research with a family-based intervention for adolescents with conduct problems indicated that relationship characteristics such as affect-behavior integration, warmth, and humor accounted for 45% of the variance in predicting treatment outcomes (Alexander, Barton, Schiavo, & Parsons, 1976). Structuring skills such as directiveness and self-confidence accounted for an additional 15% of the variance. Additional research from this group suggests that reframing statements are associated with reductions in family members' defensive statements (Robbins, Alexander, & Turner, 2000) and with more positive within-session attitudes with adolescents (Robbins, Alexander, Newell, & Turner, 1996).

Researchers involved with the Teaching Family Model (Achievement Place) intervention for adolescents with conduct problems have also provided data with respect to the relationship of therapist (in this case, teaching-parent) behavior to intervention outcome (see Braukmann, Ramp, Tigner, & Wolf, 1984, for a review). Use of particular teaching behaviors (description, demonstration, use of rationales, providing opportunities for practicing behaviors, providing positive consequences) is positively correlated with higher levels of youth satisfaction and negatively correlated with self-reports of delinquency. When teaching parents' used relationship-building behaviors, such as joking, showing concern, and enthusiasm, there was an increase in youths' satisfaction with the interactions (Willner et al., 1977).

Although therapist characteristics have not been studied with the HNC parent training program, we believe that those characteristics that have been identified as important in the family intervention programs just reviewed apply to our program as well. That is, successful application of the parent training program with parents of noncompliant children will depend, at least in part, on how the therapist relates to, and interacts with, the parent and child.

FINAL THOUGHTS

The HNC parent training program is highly standardized, with the parent proceeding through a set sequence of parenting skills taught in a particular manner. Despite this standardization, the program is also quite flexible. For example, the behavioral criteria ensure that the parent will attain a certain level of proficiency in one parenting technique before moving to the next skill. In addition, they make it more likely that training time will be allocated most efficiently. Skills that are acquired more rapidly (i.e., the

behavioral criteria are met early on) will consume much less time than those skills with which the parent is having difficulty. It is also important to note that each parent and child “team” presents unique personalities, problems, and strengths. The steps necessary to persuade one parent to try a particular procedure with a child may be quite different from those required to persuade a second parent. Furthermore, some parents present with intense personal problems that may have to receive attention as part of the therapeutic process. Nevertheless, as long as the child’s behavior is the primary difficulty, we have found it to be most effective to continue with the parent training program until it is completed, acknowledging and providing assistance where possible with secondary problems. If necessary, the secondary problems can then be addressed (see Chapter 5).