King's Research Portal

Document Version
Publisher's PDF, also known as Version of record

Link to publication record in King's Research Portal

Practitioner Review: When parent training doesn't work: theory-driven clinical strategies

Stephen Scott[1,2] and Mark R Dadds[1,2,3]

[1]King's College London, Institute of Psychiatry, England; [2]National Academy for Parenting Practitioners, England;
[3]University of New South Wales, Australia

Improving the parent–child relationship by using strategies based on social learning theory has become the cornerstone for the treatment of conduct problems in children. Over the past 40 years, interventions have expanded greatly from small, experimental procedures to substantial, systematic programmes that provide clear guidelines in detailed manuals on how practitioners should implement the standardised treatments. They are now widely disseminated and there is a great deal of empirical support that they are very effective for the majority of cases. However, evaluations of even the best of these evidence-based programmes show that a quarter to a third of families and their children do not benefit. What does the practitioner then do, when a standard social learning approach, diligently applied, doesn't work? We argue that under these circumstances, some of the major theories of child development, family functioning and individual psychology can help the skilled practitioner think his or her way through complex clinical situations. This paper describes a set of practical strategies that can then be flexibly applied, based on a systematic theoretical analysis. We hold that social learning theory remains the core of effective parent training interventions, but that ideas from attachment theory, structural family systems theory, cognitive-attribution theory, and shared empowerment/motivational interviewing can each, according to the nature of the difficulty, greatly enrich the practitioner's ability to help bring about change in families who are stuck. We summarise each of these models and present practical examples of when and how they may help the clinician plan treatment. **Keywords:** Conduct disorder, antisocial behaviour, treatment, parent training, parent–child relationship.

Parent training programmes are very successful for treating oppositional defiant and conduct disorders. There are a number of good general articles reviewing their content and effectiveness (e.g., Kazdin, 2005; Reyno & McGrath, 2006); the one by Scott (2008) covers both attachment and social learning approaches. This paper aims to complement those reviews with a practical guide derived from our clinical experience, including the programme of Dadds and Hawes (2006). Specifically, we present useful strategies derived from a range of theoretical standpoints. They are designed to stop things going wrong in treatment, and to get them back on track when they do. One of the joys of doing therapeutic work, but also one of the complexities, is that there are many useful theoretical approaches from which to choose. The baseline from which we begin is social learning theory (SLT), which focuses on the impact of external contingencies on the individual's behaviour. This has been the dominant theory explaining antisocial behaviour in the past 30 or 40 years and has led to extremely successful interventions set out in detailed manuals so that practitioners can deliver them reliably. Controlled trials show that when practitioners are well trained and supervised, SLT-based programmes can be made to work for the majority of fairly severe cases under routine 'real-life' clinical conditions (e.g., see Scott, Spender, Doolan, Jacobs, & Aspland, 2001).

However, even under optimal conditions, there are always cases when the family doesn't change. In the trial cited above, a quarter of cases made no progress. What does the clinician do then? Give up and label the family as 'resistant' or 'not ready for therapy'? We believe that here a skilled practitioner deploys different strategies according to the demands of the situation, drawing upon previous training and personal experience of what has worked. This is sometimes called 'an eclectic approach'. However, as it is individual and unspecified, it may be good, bad or indifferent, and is hard to codify so it can be replicated by others. We therefore wish to set out a more systematic approach. It requires the practitioner to have a firm grounding in four theoretical approaches as well as SLT, and to swing them in and out of action systematically according to what is happening with the family. It gives the clinician a greater range of options than found in any manual based on one theoretical approach.

Certainly, the best existing manuals do include some procedures for maximising family engagement, minimising resistance, and problem-solving when things don't go according to plan. But manuals can only suggest so much, and beyond a certain point the practitioner needs to be able to think things through creatively and flexibly from first principles. We agree with Kurt Lewin's axiom, that nothing is quite as practical as a good theory. The expert clinician, rather than having to rely on a limited number of fixed, specific techniques, can think things

through at the level of the underlying theory and then come up with a wider range of skilful, creative solutions. And practitioner skill is known to improve child outcomes, over and above simple fidelity to the model – more skilled practitioners get better results, and vice versa less skilled ones sometimes have no effect and can even do harm (Scott, Carby, & Rendu, under review).

In this paper we present four theories that we have found particularly useful for guiding interventions with difficult and complex families when the standard manualised SLT treatments don't work. We assume that a thorough assessment will have been carried out, looking at the child's problems, what is going on in the family, and whether there are particular conditions or disorders that need attention (for an account of assessment see Scott, 2005). The additional theories we find useful are attachment theory, structural-systems theory, cognitive attribution theory, and shared empowerment/motivational interviewing. We are not presenting these as alternatives to SLT, which provides a superb base for assessing and conceptualising problematic parent–child interactions that promote children's antisocial behaviour. However, any theory has its limitations, and a small set of complementary theoretical tools can afford the practitioner greater scope to be flexible and effective.

Social learning theory

Social learning theory evolved from general learning theory and in particular operant behaviourism (Scott & Yule, 2008). The fundamental tenet is that moment-to-moment exchanges are crucial: if a child receives an immediate reward for their behaviour, such as getting parental attention or approval, then they are more likely to do the behaviour again, whereas if they are ignored or punished then they are less likely to do it. This approach revolutionised work with disruptive children in the late 1960s and remains the main evidence-based approach.

Patterson (1982) showed that two main processes were operating in such families. First, parents model antisocial and aggressive behaviour so the child learns it too. Second, family process involves 'reinforcement traps'. For example, a parent makes an intrusive request of a child, the child protests with aversive behaviour, and the parent then backs off. Here the child is learning that if they get nasty, it is effective in avoiding having to do something unpleasant. Consequently, the child is more likely to do it again. As the parent then gets more and more aggressive and through this gets the child to obey, they too are learning that aggression works. In another reinforcement trap, the more a child engages in undesirable behaviours, the less he or she will get reinforced for positive behaviours (Snyder & Stoolmiller, 2002). A range of efficacious behavioural

interventions has flowed from this model, such as Parent–Child Interaction Therapy (Brinkmeyer & Eyberg, 2003), Parent Management Training from Oregon (Forgatch & DeGarmo, 1999), Triple P (Sanders, 2008), Helping the Noncompliant Child (McMahon & Forehand, 2003), and The Incredible Years (Webster-Stratton & Reid, 2003). The application of operant principles to parent–child therapies is one of the most potent innovations of the mental health sciences; meta-analyses of scores of trials give large effect sizes (e.g., Lundahl, Risser, & Lovejoy, 2006; National Institute for Clinical Excellence, 2006; Reyno & McGrath, 2006).

For the practitioner, SLT offers clear principles for directly changing parenting behaviour that fosters and maintains child problems. It offers an explicit methodology that parents can implement relatively quickly – often they can be practising it within 15 minutes of the first treatment session. The two elements of increasing warmth and rewards for positive behaviour, and setting clear limits and consequences for antisocial behaviour, can been given in either order or simultaneously, according to clinical need. Usually, it is desirable to promote positive behaviour first so the overall relationship improves before punishments are given, but sometimes where the child is aggressive and disruptive, procedures such as time out need to be applied immediately to gain control of the situation (Eisenstadt, Eyberg, McNeil, Newcomb, & Funderburk, 1993).

What is not covered by SLT, and when is this important?

First, SLT defines rewards and punishers empirically. That is, a parental behaviour is seen as a 'reward' if it strengthens the child behaviour it follows, and a 'punisher' if it weakens behaviour. But existing manuals seldom build in genuine assessments of which parent behaviours are rewarding and punishing; rather, it is assumed that attention is rewarding, 'time out' is punishing and so on. SLT is silent on the issue of how and why attention, especially from someone with whom the child is in a close relationship, is rewarding. Attachment theory may help here, especially when attention fails to be rewarding.

Second, SLT developed by focusing on externally observable behaviour, ignoring the 'black box' of the inner world. But a common clinical scenario is where parents cannot change because although they are clear how they should behave, they have strong beliefs that prevent them doing so ('he's horrible and ruins my life by winding me up, why should I be nice to him?' 'he's so delicate and precious, it will harm him if I upset him by being firm'). Most skilled clinicians know that addressing these thoughts and feelings is crucial to treatment success and routinely work with them, but existing manuals do not emphasise how. So what model can be used to think

about these cognitive-emotional processes in a systematic way? We argue that attribution theory, largely developed with social and health psychology (e.g., Abramson, Seligman, & Teasdale, 1978; Dix, Ruble, Grusec, & Nixon, 1986), provides a set of organising principles for working with parental beliefs about their children and other family members in ways that can overcome blocks to change.

Third, its very strength in analysing moment-to-moment proximal interactions between parents and children can come at the expense of attention focused on the larger system. SLT traditionally focuses on parent–child contingencies, but much evidence is available to show that these are themselves dependent on broader networks in which they occur, starting with the relationship between the parents themselves, and moving through the wider family, school and social network. It is helpful to hold in mind that healthy families show boundaries and hierarchies in how they are organised internally and in relation to their social context, and to work with these. Sometimes parent training doesn't work because although one parent 'gets it' and puts the principles into practice, wider issues in the system prevent progress, such as an undermining partner at home or bullying at school.

Fourth, SLT has had little to say about the families who simply don't engage and won't turn up. Yet antisocial children often have families who have not had good experiences of authority and are suspicious of outside agencies, have had many painful and disruptive life events, lead rather chaotic lives, and are wary of attempts to help which anyway haven't worked in the past. These families have high non-attendance and drop-out rates from treatment despite their children having the most severe problems (Kazdin, 2005), so that even well-run services often end up reaching only a small proportion of the overall target population. The skilled clinician therefore needs to have a systematic approach to fostering engagement and minimising drop-out. We argue here that two related ideas, shared empowerment and motivational interviewing, can help by tapping into and maximising the aspirations and passions of these families. We will now describe in greater detail how each of these theoretical approaches can help the delivery of parenting programmes.

Attachment theory

Bowlby (1982) and subsequent attachment theorists (Grossmann, Grossmann, & Waters, 2005) developed a model of parent–child relationships from a broad theoretical base that included ethology. It focuses on the nature, significance and function of a child's tie to his/her parent. Although based on observations of children who experienced severely compromised caregiving, it has been widely applied as a model for normal and abnormal development. However, 'parent–child attachment' is not synonymous with 'parent–child relationship'. Attachment focuses more precisely on how the parent protects the child against harm and provides a sense of emotional security, providing a 'secure base' for exploration. Early attachment experiences do not shape subsequent development in a fixed, deterministic manner (Bowlby, 1988), so that insecure attachment is not synonymous with disturbance, nor is secure attachment a guarantee against disturbance.

Attachment-based interventions have been developed for a range of clinical problems (Cicchetti, Rogosch, & Toth, 2006; Hoffman, Marvin, Cooper, & Powell, 2006; Dozier, Lindhiem, & Ackerman, 2005). For children, the theory differs from SLT in that interactions with parents are not just a matter of rewards and punishments making certain behaviours more or less likely. Rather it acknowledges the emotional importance of having a trustable, secure figure who can be relied upon to be responsive to his/her needs, especially around times of distress. If a child does not receive this, then various more-or-less maladaptive behaviour patterns towards the mother, father and others may ensue at times of stress, including avoidance, anxious-ambivalent preoccupation, and disorganised, disturbed behaviour. Adults who developed these patterns in childhood may in turn have corresponding difficulties in being emotionally securely available as parents, instead being dismissive, preoccupied, or unpredictably alternating between warm and frightening behaviour.

There have been several trials for attachment-based interventions, mostly with infants. The meta-analysis by Bakermans-Kranenburg, van Ijzendoorn, and Juffer (2003) found 81 studies. Overall, the interventions modestly improved parental sensitivity and attachment security. Importantly, they worked for the more severe cases with disorganised, disturbed attachment patterns. These studies provide evidence of the theory's utility, especially with infants, but we are not advocating commencing with attachment-based therapies for older children with conduct problems. Rather we argue that there are aspects of attachment ideas that can add value to social-learning-based treatments (e.g., Shaw, Bell, & Gilliom, 2000; Lyons-Ruth, 1996). Vice versa, largely forgotten animal learning experiments helped elucidate the role that conflicting parental signals may play in generating attachment difficulties. Alternate pleasant (comfort and food) and noxious stimuli (puffs of hot air) were delivered to infant monkeys by their (mechanical) mother monkeys. This produced 'approach-avoidance' conflicts in the infants, so that aversive stimuli from the mother resulted in increased clinging rather than avoidance, a pattern closely related to anxious/ambivalent attachment (Harlow & Harlow, 1962; Dadds, 2002).

This process happens with humans as well, and clinging behaviour by a young child can be exhausting for parents. While it may elicit comforting

behaviours in mothers, it can also produce negative reactions that unfortunately often increase further aversive clinging behaviour from the child. Such a vicious circle is very similar to that described by Patterson's coercion theory. In extreme cases, the parent and child become trapped in a cycle of proximity seeking and rejection, with the child developing increasingly aversive set of (mis)behaviours to attract the attention of the caregiver. Dadds (2002) describes this cycle as eliciting aversive discipline interchanges that become increasingly frequent and attachment 'rich'. That is, they contain all sorts of interchanges relevant to basic attachment drives in the child, and naturally, the child will continue to escalate. In this model, the child is misbehaving not for any old attention per se, but for all the attachment-rich dynamics the discipline interchanges bring. Positive interchanges between the parent and child become increasingly scarce, and any calm interchanges concern immediate practical issues and are 'attachment neutral' – they rarely speak of love and passion and nurturance.

An approach derived from attachment theory can help here. Many families trained in traditional SLT approaches can correctly use rewarding strategies for positive child behaviour and a time-out procedure for misbehaviour. However, the treatment sometimes does not work because the reward strategies (e.g., descriptive praise, behaviour charts) are still 'attachment neutral' and the new discipline procedure is still 'attachment rich' (Dadds & Hawes, 2006) because the parent gets trapped into being negative which then still triggers disturbed attachment-seeking behaviour. Parents who go down this path often seek multiple referrals, complaining that parent training programmes (by which they mean rewards and time out) don't work for their child.

In these cases, careful interviewing or observation will often reveal that the use of rewards is materialistic and boring and contains little in the way of all the things that make people love and want to spend time with each other. Time out, on the other hand, remains subtly infused with attachment-rich behaviours (e.g., hostility, rejection, ambivalence) that are highly salient and threatening to the child. Successful use of the SLT contingencies will only occur when the reward side of the ledger includes higher investments of emotion, touching, time together, and expressions of love and commitment (e.g., 'where is my special boy? Come and spend some time with me!'), than the discipline procedures. It can be very challenging to parents to implement this type of 'balance sheet'. For example, a child that cooperates with a request to pass a pen is not likely to receive the same depth of highly emotional parenting engagement as the child who says 'get f***ed' in response to the same request. The former is likely to motivate parents to use some modest praise and rewards at best, whereas the child's abusive response is likely to elicit the most extreme of parents' feelings about the child. Attachment ideas alert us that what we really want parents to do with a conduct problem child in response to the most menial act of cooperation is react with love, appreciation, emotion, and even a need for proximity, and not let any of the attachment-rich processes be affected by the abuse. Likewise, when responding to misbehaviour they should maintain a firm positive attachment while calmly removing the child to time out.

Systems theory

By systems theory, we are referring to therapies that draw on systemic, cybernetic, narrative, or constructivist/constructionist theories. In the child mental health context, the term is used in two senses. Firstly, to refer to all the wider systems that can impinge on a child, including for example the school and neighbourhood. Secondly, to refer to the family, which has led to an array of interventions loosely called Family Therapy. Gurman, Kniskern, and Pinsof (1986) state that 'Family therapy may be defined as any psychotherapeutic endeavour that explicitly focuses on altering the interactions between or among family members and seeks to improve the functioning of the family as a unit, or its subsystems, and/or the functioning of the individual members of the family'. There has been a host of different therapies developed under the general banner of systems/family therapy (Cottrell & Boston 2002). Two particular manualised distillations of systems/family approaches have proven notably successful for conduct problems and delinquency: Functional Family Therapy (Alexander, Pugh, Parsons, & Sexton, 2000) and Multisystemic Therapy (Schoenwald & Henggeler, 2005). These are reviewed in more detail in Bailey and Scott (2008); here we wish to show how systemic thinking, especially structural family therapy, can help the parent training practitioner with difficult families.

In structural family therapy the underpinning theory is that problems result from inappropriate family structure and organisation (Minuchin, 1974). The therapist is concerned with the boundaries between the parental subsystem, the child subsystem and the extended family, and sees the family in terms of spatial relationships, extremes being enmeshed or disengaged. Allowing for variations across cultures, a healthy family generally has a parental subsystem that cooperates in caring for the children, but also has its own time for love and friendship and so on. The child subsystem is clearly separated from the parental subsystem, as are other relatives and friends. The parents act as an executive system and can function effectively to solve family problems.

Families who present with conduct problem children often show distortions to this pattern. Many such parents are beset with their own relationship problems, cannot deal with problems as a team, and

find themselves split and estranged in their attempts to manage the children. While there is little evidence that problematic family structures are a direct cause of child problems, they can certainly maintain them. Green, Loeber, and Lahey (1992) showed that hierarchical structures tend to become disorganised when a family has a problem child. Typically, boundaries between parent, child, and extended family systems become unclear, the parents' relationship becomes conflicted, and the extended family may get caught in the battles during the many failed attempts to manage the problem child.

Several studies have shown that targeting this teamwork aspect of parental relationships can enhance outcomes for the children (e.g., Dadds, Schwartz, & Sanders, 1987). In practice, the process and content of therapy should be set up so that the parental subsystem is strengthened. This can be done implicitly by making time to see both parents together without the children. Then the parental relationship can be targeted more explicitly in the style first advocated by Minuchin, whereby the couple is asked, for example, to have a 'date' and refrain from talking about the children, or make structural changes in terms of who is responsible for various household and childcare tasks.

The child subsystem can be targeted the same way. A common problem is that 'better-behaved' siblings become increasingly close to and protected by a parent, and the problem child therefore becomes more and more resentful of this. There is a subsystem of the parent and the non-problem child from which the problem child feels excluded. Here, use of SLT parent training approaches whereby time out and other contingencies are applied to the problem child alone often fails. Thinking structurally requires strategies whereby the parent subsystem is hierarchically organised separately from the child subsystem. Thus, the parent can be advised to not engage with telltale behaviour (who did what to whom – this is clearly dividing the child system and aligning with one or the other), to minimise punishing one child during fights, but rather to interpret fights as children jointly not getting along, and so apply contingencies to both children, and of course, reward both children when they are not fighting – thus reinforcing the child subsystem.

This type of structural thinking can be applied no matter what structures and systems are encountered, including single parents, parents with step-parent partners, extended families with relatives living in the home, and so on. It is great for openly targeting family processes as they impact on implementation of SLT parent training.

Cognitive factors and attribution theory

Skilled clinicians know that careful consideration of parents' thoughts and feelings are crucial to treat-ment success and routinely work with them in parent training programmes. But little attention has been paid to explicitly presenting models to help us think about these cognitive-emotional processes in a systematic way. Attributional theory, largely developed with social and health psychology (e.g., Abramson et al., 1978; Dix et al., 1986), provides a set of organising principles for working with parents' attributions in ways that overcome blocks to change. The fundamental principle is that we are all driven at times to interpret each other's behaviour along dimensions of stable–transient, internal–external, and global–specific. A substantial literature has shown that people who are in unhappy relationships are prone to attributing each other's negative behaviour to stable, internal, and global factors. Conversely, positive behaviour is assumed to be transient, externally caused, and specific.

A wealth of research has shown that parents of conduct problem children develop problematic attributions about the meaning of the child's behaviour (e.g., Dadds, Mullins, McAllister, & Atkinson, 2003). Common examples include the parent feeling that the child's problem behaviour is intentional and under the child's control, is designed to deliberately upset the parent, is a sign of serious mental problems, is inherited from other (disliked) family members (e.g., an abusive ex-spouse), or is in some way a punishment that the parent deserves. Conversely, when the child does show moments of good behaviour, or even good days, the parent is prone to dismissing these as transient, externally caused, and specific. More generally, parents may have beliefs about models of discipline that are incompatible with the operant techniques typically taught in parent training programmes. All of these cognitions can make it very difficult to calmly parent a child; they are a risk factor for failure to implement traditional parent training programmes (e.g., Wahler & Dumas, 1989; Miller & Prinz, 1990).

There is some evidence that addressing attributions helps. One study (Sanders et al., 2004) added attributional retraining and anger management to basic parent training. Parents in the enhanced condition showed a greater reduction in attitudes associated with child abuse, and fewer unrealistic expectations. However, on measures of anger experience or expression, parents in both interventions showed similar reductions. We think that the skilled therapist will take time to ask about parent interpretations. Useful questions include things like: 'How did you feel last time he really tried to hurt you?' 'What was the worst thought you had?' 'In your darkest moments, what do you think is happening with John?'

One approach is simply to get the negative attributions out in the open and keep them there. It can be very useful to finish a discussion of these matters with something like: 'OK, so let's keep an eye on how you are going with these thoughts and feelings.

As we move through the programme, we can review them and see how you are feeling.' Here the hope is that the changes in the parent–child interactions that occur as part of SLT parent training will provide a chance for problematic attributions to be reviewed and hopefully replaced with more constructive alternatives as the parent begins to experience the child as more helpful. However, if fixed attributions continue to block progress, they can be addressed using classical cognitive approaches. For example, often one can get a parent who believes her child is intentionally 'winding her up' to see that this represents his need to have close contact with her, even if he uses aggression to do so: by being close to him at other times, the aggression will often diminish. Or the parent who feels his child is always randomly aggressive can be taken through a detailed daily diary, and episodes of good behaviour can be highlighted, and often an understandable pattern for the aggression found; for example, it may occur when Dad is on the phone or a sister is being cuddled. During this it helps to try to reframe many of the parent's own efforts as heroic and point out when they are successful: helping the parent regain a sense of control often in turn reduces negative attributions about the child.

Shared empowerment and motivational interviewing

It does not matter how effective a therapy is if parents won't engage in the first place, or if those who do start don't then implement the approach proposed. In families with conduct problem children, initial engagement is often hard, and dropout rates of 25–50% are typical (Forehand, Middlebrook, Rogers, & Steffe, 1983; Kazdin, 2005) compared for example to 10–20% in families with anxious children. Under these circumstances, having a rationale on how to manage the process of initial engagement and subsequent involvement of the family is necessary for effective change. SLT can provide a basic starting point by emphasising that the practitioner should make expectations clear and praise the parent when they implement the programme. A collaborative approach whereby one works with parents to define and achieve their goals is helpful from the outset (Webster-Stratton & Herbert, 1994). However, sometimes this doesn't work and indeed seems only to generate resistance and make the parents feel bad. What should the practitioner do next? There is little empirical parent training literature to guide the process; however, Patterson and Chamberlain (1994) showed that parent engagement and cooperation are best enhanced through use of a staged model, in which didactic input is suspended until client trust is built by giving parents adequate time to express their concerns.

We take the view that there are two interlinked theoretical positions worth deploying. First, and right through the therapy process, a *shared empowerment* model that emphasises teamwork, parent empowerment, and support will help engage families and keep them on board (Dadds & Hawes, 2006). This respects parents and maximises their buy-in. Secondly, if things grind to a halt, rather than persisting in trying to coerce the parents to do what we recommend ('you really need to practise the methods at home'), we recommend taking a *motivational interviewing* approach.

Shared empowerment

Several shared empowerment techniques are useful. From the outset, the therapeutic team is seen as comprising complementary 'experts', namely the parents who are experts on the family's needs, aspirations, strengths and weaknesses, and the therapist who is an expert at child mental health and treatment. All information and decisions are made openly by the team, and the scientific and clinical literature on child mental health and treatment is not 'owned' by the practitioner. Instead, the clinician can feed back the results, but say that his or her interpretation is but one available: the findings are seen as an independent 'contributor' to the decision process. 'Resistance' is discussed as a communication by parents that something hasn't been set up properly, and the practitioner takes a 'one-down' stance and apologises for moving ahead without fully understanding what the parents need.

There are a number of risks when trying to engage the family that can be addressed right from the first session. First, it can be hard to do useful therapy and also establish a good working relationship with the parent (parental subsystem) independent of the child or children, all in the first session. We believe it is crucial to interview the parent(s) alone, in order to allow them the space to vent on all relevant issues and set up plans for treatment as an adult team. Observations of the broader system and interaction patterns can follow in subsequent sessions. Second, failure to establish a trusting relationship with *both* parents (if there are two). For example, a mother may describe her problems with her 6-year-old son. When the father is asked for his views, he attacks the mother's handling of the boy, stating he has no problems but that the mother is to blame for her nitpicking parenting style. Often inexperienced therapists instinctively move to protect the mother, subtly advocating for her in an attempt to bring some reason to the father. This often leads the father to feel that the therapist (usually female too) is siding with the mother. He drops out or pulls the family out, or stays but undermines the process. We therefore recommend paying careful attention to making sure that all members of the family feel heard and respected, no matter how outrageous their views, which should be integrated into the larger conceptualisation. It is surprising how extreme views are

retracted and empathy increases all round once a person has felt heard. Third, difficult issues, such as abuse and violence, family members' feelings for each other, parental attributions about the child's behaviour and problems, use of drugs and alcohol, the role of extended family, are either not raised or are done in a way that feels blaming. In a successful first session, these issues will have been raised sensitively but explicitly and incorporated into the joint conceptualisation and treatment plan. Failure to do this risks the therapist marching valiantly into treatment despite the parents not being at all convinced, so they later drop out.

Motivational interviewing

Motivational interviewing can be used alongside SLT parent training when engagement is proving difficult, or when parents actively resist proposed courses of action. Miller and Rollnick (2002) defined it as 'a client centred, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence'. It was first developed with alcohol and substance misusing clients and comes in part from the theory of Carl Rogers insofar as it operates from, and unconditionally accepts, the client's view of the world and their problems. Any discrepancies that are explored concern incongruities among the person's own experiences and values. However, it differs from Rogers' method as it directively elicits and selectively reinforces change talk. It also differs from the 'traditional' authoritative 'expert' model of telling a client what the matter is and what to do about it. It is a method of communication rather than a way to get people to do what they don't want to do. Unlike SLT, it does not attempt to impose change through extrinsic means such as praise and rewards, consequences or sanctions, especially when they are inconsistent with the person's own beliefs. Unless a new course of action is in some way in the person's inherent interest, change will not happen: it arises through its relevance to the person's own values and concerns. Several trials attest to the effectiveness of motivational interviewing not only in helping clients engage with treatment and accepting assessment results, but also in improving outcomes during interventions (Miller & Rollnick, 2002). With conduct problem children, Prinz and Miller (1994) found that adding an initial session with a related approach led to lower dropout rates subsequently, as did Nock and Kazdin (2005) who took a more problem-solving approach to overcome barriers to participation.

Change talk is contrasted with resistance talk, which is seen not as a general attitude, but as only pertaining to certain ideas. The practitioner can of course elicit resistance, typically by arguing for change, assuming the expert role ('my knowledge has the answers'), criticising, shaming or blaming, labelling (trying to shock the client out of the status quo), being in a hurry, or claiming pre-eminence ('praising your child will work if it is done properly'). Instead, the practitioner should ask open questions, including recognising both sides of a question or behaviour ('what do you find helpful about smacking?'), listen reflectively, affirm positive steps taken, and summarise what the person has said (in their own words) before going on to elicit change talk. The latter, from the parent, includes recognising the disadvantages of the status quo, recognising the advantage of change, expressing optimism about change and then expressing intention to change.

When should such an approach be deployed? Typically, when one has little external control of the situation. If the parent and child are engaged in treatment and complying, it may not be necessary. But it is particularly helpful when the practitioner has less control: in initial engagement when the parent (or teacher or child) is doubtful about commencing treatment, or in accepting a view suggested by test results; when a parent is dropping out of treatment because the practitioner is getting increasingly coercive (trying increasingly desperately to get the parent to turn up on time or at all, to discipline the child, and so on).

As an example, take the situation where parents come in each saying they have had a hectic week and were not able to implement the programme, and when they did it didn't really work. At first, all practitioners can try to problem-solve this and offer encouragement for a better outcome next session. If this pattern is repeated, however, it is advisable to sit back and really listen. This discussion may culminate with the practitioner saying 'So it sounds like you have given it your best shot and it is not working for you', or 'I hear you. While this is often an effective treatment, it is not working for you. It is just too hard'. With the parent's views then fully out, the practitioner can prompt where they will go from here. Applied carefully, the use of motivational interviewing techniques in these difficult situations can help parents turn around of their own volition and undertaking, aware that the practitioner is warm, supportive and on their side, but unable to help unless they help themselves.

Conclusion

In concluding, we suggest that the practitioner should hold in mind the same theories for their own relationship with the parents. Thus lots of rewards should be applied to parents' behaviour (SLT); the process should follow *attachment* principles so that the therapist–parent relationship is predictable, reliable and able to be effectively tapered and then terminated without distress; *healthy family structures* should be facilitated and reinforced by addressing which family members attend sessions and when. Family members should be given time

and enabled to talk about their darkest thoughts and feelings (*attributions*) about the child, themselves as parents, and the family in general. The practitioner should offer *shared empowerment* to families and strive to elicit their intrinsic motivation and passion to change.

Whether the approach set out above is actually effective rather than another over-optimistic description of the 'this is how we do it' kind by so-called experts will need careful evaluation. This will require outcome studies (e.g., comparing 'straight' SLT parent training with this multi-model approach), process studies (e.g., videotaping of therapy sessions with independent assessment of when certain situations such as failure to progress, or parent resistance, are present, and whether the clinician adopts this model, and how skilfully, and whether it works) combined with qualitative interviews with parents and practitioners about what they thought was going on. Only this way will further progress be made.

To summarise, we have proposed some practical approaches derived from four different psychological theories that practitioners can use when encountering difficulty working with parents of children with conduct problems. The bedrock of these treatments is nonetheless social learning theory, which provides the theoretical and strategic tools to improve relationships through training parents in a range of techniques for correcting aggression, disobedience and the host of other antisocial behaviours exhibited by uncontrolled and unhappy children. Successfully helping parents to implement these strategies can be a challenging undertaking as it involves parents changing their own behaviour and their family's structure and processes. Experienced practitioners develop a coterie of techniques for aiding this process that they call on when things go wrong and the evidence-based manuals no longer help. We emphasise the theories underpinning any techniques, because the former drive the latter and allow the practitioner to *think* creatively, from first principles, about how to understand family difficulties and then generate practical solutions.

Correspondence to

Stephen Scott, Box P85, Institute of Psychiatry, King's College London, De Crespigny Park, London SE5 8AF, UK; Email: s.scott@iop.kcl.ac.uk

---

Key points

- Parent training based on social learning theory is the treatment of choice for children with conduct problems; however, it doesn't work in a quarter to a third of cases.
- Under these circumstances, flexibly but systematically applying a limited range of additional theories can help shift families who are difficult to change.
- When parents succeed in being more positive but still get very hostile in disciplinary exchanges, *attachment theory* can help make sense of why the child persists in being aggressive, and can lead to useful intervention strategies.
- When parents know what they should do, but cannot put it into practice due to conflicting or negative beliefs, *cognitive attribution theory* can inform a specific therapeutic approach.
- When one member of the family is interacting better with the child but other members or outside influences are preventing progress, *structural family systems theory* approaches can help.
- When families are reluctant to engage or become increasingly resistant to suggested interventions, a *shared empowerment/motivational interviewing* approach can bring them back on board.

References

Abramson, L.Y., Seligman, M.E.P., & Teasdale, J.D. (1978). Learned helplessness in humans: Critique and reformulation. *Journal of Abnormal Psychology*, *87*, 49–74.

Alexander, J., Pugh, C., Parsons, B., & Sexton, T. (2000). *Blueprints for violence prevention: Functional family therapy*. University of Colorado: Institute of Behavioral Science.

Bailey, S., & Scott, S. (2008). Juvenile delinquency. In M. Rutter, D. Bishop, D. Pine, S. Scott, J. Stevenson, E. Taylor, & A. Thapar (Eds.), *Rutter's child and adolescent psychiatry* (5th edn). Oxford: Blackwell.

Bakermans-Kranenburg, M.J., van Ijzendoorn, M.H., & Juffer, F. (2003). Less is more: Meta-analyses of sensitivity and attachment interventions in early childhood. *Psychological Bulletin*, *129*, 195–215.

Bowlby, J. (1982). *Attachment and loss*. London: Penguin.

Bowlby, J. (1988). *A secure base: Parent–child attachment and healthy human development*. New York: Basic Books.

Brinkmeyer, M.Y., & Eyberg, S.M. (2003). Parent–child interaction therapy for oppositional children. In A.E. Kazdin, & J.R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 204–223). New York: Guilford.

Cicchetti, D., Rogosch, F., & Toth, S.L. (2006). Fostering secure attachment in infants in maltreating families through preventive interventions. *Development and Psychopathology*, *18*, 623–649.

Cottrell, D., & Boston, P. (2002). The effectiveness of systemic family therapy for children and adolescents. *Journal of Child Psychology and Psychiatry*, *43*, 573–586.

Dadds, M.R. (2002). Learning and intimacy in the families of anxious children. In R.J. McMahon, & R.D. Peters (Eds.), *The effects of parental dysfunction on children* (pp. 87–106). New York: Kluwer Academic.

Dadds, M.R., & Hawes, D. (2006). *Behavioral family intervention for child conduct problems: A behavioral-attachment-systems approach.* Brisbane: Australian Academic Press.

Dadds, M.R., Mullins, M.J., McAllister, R.A., & Atkinson, E. (2003). Attributions, affect, and behavior in abuse-risk mothers: A laboratory study. *Child Abuse and Neglect*, *27*, 21–45.

Dadds, M.R., Schwartz, S., & Sanders, M.R. (1987). Marital discord and treatment outcome in behavioral treatment of child conduct disorders. *Journal of Consulting and Clinical Psychology*, *55*, 396–403.

Dix, T., Ruble, D.N., Grusec, J.E., & Nixon, S. (1986). Social cognition in parents. *Child Development*, *57*, 879–894.

Dozier, M., Lindhiem, O., & Ackerman, J.P. (2005). Attachment and biobehavioral catch-up: An intervention targeting empirically identified needs of foster infants. In L.J. Berlin, Y. Ziv, L.M. Amaya-Jackson, & M.T. Greenberg (eds.), *Enhancing early attachment: Theory, research, intervention and policy* (pp. 178–194). New York: Guilford Press.

Eisenstadt, T.H., Eyberg, S., McNeil, C.B., Newcomb, K., & Funderburk, B. (1993). Parent–child interaction therapy with behavior problem children: Relative effectiveness of two stages and overall treatment outcome. *Journal of Clinical Child Psychology*, *22*, 42–51.

Forehand, R., Middlebrook, J., Rogers, T.R., & Steffe, M. (1983). Dropping out of parent training. *Behaviour Research and Therapy*, *21*, 663–668.

Forgatch, M., & DeGarmo, D.S. (1999). Parenting through change: An effective prevention program for single mothers. *Journal of Consulting and Clinical Psychology*, *67*, 711–724.

Green, S.M., Loeber, R., & Lahey, B.B. (1992). Child psychopathology and deviant family hierarchies. *Journal of Child and Family Studies*, *1*, 341–350.

Grossmann, K.E., Grossmann, K., & Waters, E. (2005). *Attachment from infancy to adulthood: The major longitudinal studies.* New York: Guilford Press.

Gurman, A.S., Kniskern, D.P., & Pinsof, W.M. (1986). Research on marital and family therapies. In S.L. Garfield, & A.E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (3rd edn). New York: Wiley.

Harlow, H.F., & Harlow, M. (1962). Social deprivation in monkeys. *Scientific American*, *207*, 136–146.

Hoffman, K.T., Marvin, R.S., Cooper, G., & Powell, B. (2006). Changing toddlers' and preschoolers' attachment classifications: The circle of security intervention. *Journal of Consulting and Clinical Psychology*, *74*, 1017–1026.

Kazdin, A.E. (2005). *Parent management training.* New York: Oxford University Press.

Lundahl, B., Risser, H.J., & Lovejoy, M.C. (2006). A meta-analysis of parent training: Moderators and follow-up effects. *Clinical Psychology Review*, *26*, 86–104.

Lyons-Ruth, K. (1996). Attachment relationships among children with aggressive behavior problems: The role of disorganized early attachment patterns. *Journal of Consulting and Clinical Psychology*, *64*, 64–73.

McMahon, R.J., & Forehand, R.L. (2003). *Helping the noncompliant child family-based treatment for oppositional behavior* (2nd edn). New York: Guilford Press.

Miller, G.E., & Prinz, R.J. (1990). Enhancement of social learning family interventions for child conduct disorder. *Psychological Bulletin*, *108*, 291–307.

Miller, W.R., & Rollnick, S. (2002). *Motivational interviewing.* New York: Guilford Press.

Minuchin, S. (1974). *Families and family therapy.* Cambridge, MA: Harvard University Press.

National Institute for Clinical Excellence. (2006). *Parent-training/education programmes in the management of children with conduct disorders. A Health Technology appraisal.* London: NICE.

Nock, M.K., & Kazdin, A.E. (2005). Randomized controlled trial of a brief intervention for increasing participation in parent management training. *Journal of Consulting and Clinical Psychology*, *73*, 872–879.

Patterson, G.R. (1982). *A social learning approach: 3. Coercive family process.* Eugene, OR: Castalia.

Patterson, G.R., & Chamberlain, P. (1994). A functional analysis of resistance during parent training therapy. *Clinical Psychology and Scientific Practice*, *1*, 53–70.

Prinz, R.J., & Miller, G.E. (1994). Family-based treatment for childhood antisocial behavior: Experimental influences on dropout and engagement. *Journal of Consulting and Clinical Psychology*, *62*, 645–650.

Reyno, S.M., & McGrath, P.J. (2006). Predictors of parent training efficacy for child externalizing behavior problems – a meta-analytic review. *Journal of Child Psychology and Psychiatry*, *47*, 99–111.

Sanders, M.R. (2008). Triple P-Positive Parenting Program as a public health approach to strengthening parenting. *Journal of Family Psychology*, *22*, 506–517.

Sanders, M.R., Pidgeon, A.M., Gravestock, F., Connors, M.D., Brown, S., & Young, R.W. (2004). Does parental attributional retraining and anger management enhance the effects of the Triple P-Positive Parenting Program with parents at risk of child maltreatment? *Behavior Therapy*, *35*, 513–535.

Schoenwald, S.K., & Henggeler, S.W. (2005). Multisystemic therapy for adolescents with serious externalizing problems. In J.L. Lebow (Ed.), *Handbook of clinical family therapy* (pp. 103–127). New York: John Wiley & Sons.

Scott, S. (2005). Conduct disorders. In C. Gillberg, R.C. Harrington, & H-C. Steinhausen (Eds.), *Clinician's deskbook of child and adolescent psychiatry.* Cambridge: Cambridge University Press.

Scott, S. (2008). Parenting programs. In M. Rutter, D. Bishop, D. Pine, S. Scott, J. Stevenson, E. Taylor, & A. Thapar (Eds.), *Rutter's child and adolescent psychiatry* (5th edn). Oxford: Blackwell.

Scott, S., Carby, A., & Rendu, A. (under review). *Impact of therapists' skill on effectiveness of parenting groups for child antisocial behaviour.*

Scott, S., Spender, Q., Doolan, M., Jacobs, B., & Aspland, H. (2001). Multicentre controlled trail of parenting groups for child antisocial behaviour in clinical practice. *British Medical Journal, 323*, 194–197.

Scott, S., & Yule, W. (2008). Behavioral therapies. In M. Rutter, D. Bishop, D. Pine, S. Scott, J. Stevenson, E.

Taylor, & A. Thapar (Eds.), *Rutter's child and adolescent psychiatry* (5th edn). Oxford: Blackwell.

Shaw, D.S., Bell, R.Q., & Gilliom, M. (2000). A truly early starter model of antisocial behavior revisited. *Clinical Child and Family Psychology Review*, *3*, 155–172.

Snyder, J., & Stoolmiller, M. (2002). Reinforcement and coercive mechanisms in the development of antisocial behavior. The family. In J. Reid, G. Patterson, & J. Snyder (Eds.), *Antisocial behavior in children and adolescents: A developmental analysis and model for intervention* (pp. 65–100). Washington, DC: American Psychological Association.

Wahler, R.G., & Dumas, J.E. (1989). Attentional problems in dysfunctional mother–child interactions: An interbehavioral model. *Psychological Bulletin*, *105*, 116–130.

Webster-Stratton, C., & Herbert, M. (1994). Working with parents who have children with conduct disorders: A collaborative process. In C. Webster-Stratton (Ed.), *Troubled families, problem children* (pp. 105–167). Chichester: John Wiley & Sons.

Webster-Stratton, C., & Reid, J.M. (2003). The Incredible Years Series. In A.E. Kazdin, & J.R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 224–240). New York: Guilford Press.