Introduction

Purposes of the Program

This manual is designed to serve several purposes. First, it sets forth detailed instructions for conducting clinical evaluations of children with oppositional or behavior problems, and includes a set of interview forms and behavior rating scales that clinicians can use for their assessments. These may be photocopied for personal use, with some limitations (see the copyright page for details). Some forms are also designed to be used for the periodic evaluation of the parent's and child's responses to the treatment program throughout training and shortly after its completion (posttreatment evaluation). Second, and more to the point, the manual specifies the step-by-step procedures to follow in conducting a highly effective, empirically validated program for the clinical training of parents in the management of defiant child behavior. Careful attention was paid to preparing the format for the presentation of each step of the program so that the manual is of utmost practical use in conducting the training program. Third, this manual provides a set of parent handouts to be used during the course of teaching the program. These handouts include forms to be completed by the parent as well as instructions for their use with each session of the program. Specifically designed to be easy to read and brief in content, the handouts are intended to be used only in conjunction with training by a skilled child/family therapist, and not as stand-alone tools.

This manual and the program it describes are not intended for use by individuals who have not had education and training in the knowledge and skills necessary to provide mental health services to defiant children and their families. It is intended for use by clinical psychologists, psychiatrists, social workers, child and family therapists, and others trained at the graduate level in the provision of professional services to families. Professionals using this program should have graduate training in child development,

child psychopathology, social learning and behavior modification techniques, and other clinical interventions with families as may be required. In short, this program is not a substitute for either general clinical training or the careful exercise of clinical judgment and ethics in dealing with defiant children and their families. The utmost care is always required in tailoring these methods to the individual characteristics of a particular child and his or her family.

This manual is also not intended to be a review of the scientific literature on parent training programs or research on oppositionality in children. Satisfactory reviews of those literatures as well as other, similar approaches to parent training have been published in numerous forums (use Google Scholar as an Internet search engine and *child oppositionality, child defiance*, and *oppositional defiant disorder* as search terms). The manual instead is intended to be a clinical handbook for conducting only those procedures pertinent to this particular sequence of child behavior management methods.

Types of Children Appropriate for This Program

As with any clinical procedure, this program was not designed as a blanket method to be applied to all defiant children regardless of their presenting problems or the concerns of their families. It is expressly intended for children who display noncompliant, defiant, oppositional, stubborn, or socially hostile behavior toward their parents alone or in conjunction with other childhood disorders. These children are often referred to as having "externalizing" or "acting out" disorders and may fit the more generic layman's labels of "oppositional," "difficult," "defiant," or "aggressive" or the more specific clinical diagnoses of oppositional defiant disorder (ODD), attention-deficit/hyperactivity disorder (ADHD), conduct disorder (CD), autism spectrum disorders (ASD), or even juvenile-onset bipolar disorder, provided that defiant behavior is a primary problem. The program is also quite applicable to children with mild developmental delay (mental retardation) in which child noncompliance or defiance is a problem for parents. Despite being intended for use with clinically referred populations of children, however, portions of the program also may be quite valuable for use with mild situational behavior problems in otherwise typical children whose families are being seen for more general parent, marital, or family therapy. In particular, children displaying difficult, acting-out, or defiant behaviors as part of adjustment reactions to parental separation or divorce often respond well to the methods in this program. In short, where children exhibit problems with listening to and complying with parental commands or requests or with adhering to household or neighborhood rules, this program will prove quite useful.

The program was designed for children having at least a 2-year language or general cognitive developmental level and a chronological age between 2 and 12 years. Although it is possible to use the program with children as young as 18 months, the success of the program greatly hinges on the child's level of receptive language development, in that the child must have the capacity to comprehend parental commands, directives, or instructions. Children younger than 2 years with delayed language development will

respond less successfully to this program, or their families will require greater training time and practice than families of children without such delays. Also, some parts of the program (except time out) may be used with children 13 years of age or older, depending on their level of social maturity and the severity of their behavior problems. Immature preadolescents with mild to moderate noncompliant behavior can be successfully treated with this program, with appropriate modifications accounting for their greater level of mental development and their desire to be autonomous and to participate in the family's decision-making process concerning their behavior. For children older than 13 years, however, I recommend our program Defiant Teens (Barkley, Edwards, & Robin, 1999) as a behavioral family therapy program or the similar program of Forgatch and Patterson (1990). Those programs concentrate more heavily on teaching family problem-solving, communication, and conflict-resolution skills to both the parents and the adolescent than does the present parent training program.

The present program has been successfully employed with single-parent as well as two-parent families and those of low income or educational levels, although again the constraints noted previously apply here as well. Even where the child in an abusive family is not defiant, this program can serve to provide parents with more humane and effective methods of dealing with the everyday management of such a child.

Whereas the program can certainly stand alone, and often does, as the primary form of intervention provided to parents of defiant children, it can also serve as an adjunct to other forms of therapy being provided to troubled parents or families who also happen to have oppositional children. Many therapists have found behavioral parent training programs like this one to be highly useful as an adjunct to marital counseling, when disagreements over child management are an issue in the marriage (see Sanders, 1996, for a discussion), or to psychotherapy with anxious, depressed, or otherwise maladjusted adults who are also having problems managing the behavior of their children.

Goals of This Program

The present program has a limited number of goals but is effective at accomplishing them with most families. These are as follows:

1. To improve parental management skills and competence in dealing with child oppositional behavior.
2. To increase parental knowledge of the sources of childhood defiant behavior and the principles and the extent to which social learning within the family may contribute to such behavior.
3. To improve child compliance with commands, directives, and rules given by the parents and so reduce the extent of parent–child conflicts.
4. More generally, to reduce parenting stress and, it is hoped, thereby increase family harmony through the improvement of child behavior management skills by

parents, such as the use of positive attention and other consequences with their children; the provision of clear guidance, rules, and instruction to the children; the application of swift, fair, and just discipline for inappropriate child behavior; and general reliance on principle-guided parenting behavior.

Outcomes Expected from This Program

The procedures described here and incorporated into many behavioral parent training programs have a substantial amount of research supporting their efficacy when used with parents seeking treatment for disruptive child behavior, whether for this specific program (Anastopoulos, Shelton, DuPaul, & Guevremont, 1993; Chacko et al., 2009; Chronis, Chacko, Fabiano, Wymbs, & Pelham, 2004; Curtis, 2010; Danforth, Harvey, Ulaszek, & McKee, 2006; Gerdes, Haack, & Schneider, 2012; van den Hoofdakker et al., 2007; Pisterman et al., 1989; Rejani, Oommen, Srinath, & Kapur, 2012; Thomas & Zimmer-Gembeck, 2007) or for other highly similar behavioral training programs for parents (Atkeson & Forehand, 1978; Chacko et al., 2008; Eyberg, Nelson, & Boggs, 2008; Furlong et al., 2012; Kaminski, Valle, Filene, & Boyle, 2008; McCart, Priester, Davies, & Azen, 2006; McMahon & Forehand, 2005; Ogden & Hagen, 2008; Sanders, 1996; Thompson et al., 2009; Wagner & McNeil, 2008; Webster-Stratton, 1982, 1984; Webster-Stratton & Spitzer, 1996). A minor variation of this parent training program served as the parent training intervention in the landmark Multimodal Treatment Study of ADHD (MTA; MTA Cooperative Group, 1999), which was one component of the effective psychosocial treatment arm of that study. It was also used effectively in a more recent multimodal treatment study of ADHD children in India having a similar psychosocial component as the original MTA study (Rejani et al., 2012). However, in cases in which parents did not seek treatment but whose children were identified through screening at kindergarten for high-risk cases or through in-home visits by health care professionals, there may be low rates of attendance or compliance and little if any benefit from enrollment in programs such as this one (Barkley et al., 2000; Seeley et al., 2009; Thompson et al., 2009).

Each procedure incorporated into this program is also separately supported by published studies demonstrating significant improvements in child behavior as a function of these or highly similar behavior management methods being adopted by parents, including (1) *improving parental selective-attending skills* (Eyberg & Robinson, 1982; McMahon & Forehand, 2005; Kaminski et al., 2008; Kelley, Embry, & Baer, 1979; Patterson, 1982; Pollard, Ward, & Barkley, 1983; Pisterman et al., 1989; Roberts, 1985; Webster-Stratton, 1984; Webster-Stratton, Hollinsworth, & Kolpacoff, 1989); (2) *improving parental deliverance of commands* (Blum, Williams, Friman, & Christophersen, 1995; McMahon & Forehand, 2005; Gerdes et al., 2010; Green, Forehand, & McMahon, 1979; Patterson, 1982; Roberts, McMahon, Forehand, & Humphreys, 1978; Williams & Forehand, 1984); (3) *improving children's solitary play behavior* (Anastopoulos et al., 1993; Pollard et al., 1983; Wahler & Fox, 1980); (4) *parental use of time out* (Anastopoulos et al., 1993; Bean & Roberts, 1981; Curtis, 2010; Danforth et al., 2006; Day & Roberts, 1982; Eyberg &

Robinson, 1982; McMahon & Forehand, 2005; Kaminski et al., 2008; Patterson, 1982; Pisterman et al., 1989; Roberts, Hatzenbuehler, & Bean, 1981; Roberts et al., 1978; Strayhorn & Weidman, 1989; Wahler & Fox, 1980; Webster-Stratton et al., 1989); (5) *response cost as disciplinary methods* (Anastopoulos et al., 1993; Little & Kelley, 1989); (6) *parental planning and activity scheduling as problem prevention measures*, particularly before entering public places (Anastopoulos et al., 1993; Curtis, 2010; Gerdes et al., 2012; Pisterman et al., 1989; Sanders & Christensen, 1984; Sanders & Dadds, 1982; Sanders & Glynn, 1981); (7) *parental practice of new skills* (Kaminski et al., 2008); (8) *overall consistency in child management* (Kaminski et al., 2008); and (9) *daily behavior report cards for school behavior monitoring and home-based consequences* (Barth, 1979; Dougherty & Dougherty, 1977; Fabiano et al., 2010; Jurbergs, Palcic, & Kelley, 2008, 2010; Lahey et al., 1977; Schumaker, Hovell, & Sherman, 1977).

However, the degree of success is greatly affected by the extent, nature, and severity of the child's psychopathology and that of the parents, among other factors (see Predictors of Success and Failure section). With children whose major problem is noncompliance or oppositional behavior and whose families are not seriously dysfunctional, this program usually results in significant reductions of oppositionality and in some cases bringing the child's behavior and compliance within the range considered normal for children of that age group. In my experience, children with more serious forms of developmental psychopathology, such as ADHD, ODD, CD, or ASD, or juvenile bipolar disorder that are chronic in nature may be improved in their compliance under this program. Nevertheless, after treatment, many may continue to be rated as more deviant in inattentive and impulsive behavior than normal children on child behavior rating scales, particularly if the children had significant degrees of symptoms of ADHD or CD before treatment (Anastopoulos et al., 1993; Chacko et al., 2009; Drugli, Larsson, Fossum, & Morch, 2010; Johnston, 1992). With such children, the attitude taken is one of training parents to "cope" with the child's problems rather than "cure" them; yet the program can minimize the extent of parent–child conflict and the degree to which child noncompliance contributes to the child's various problems and the distress within the family.

Children older than 12 years or those who are seriously aggressive and assaultive with others should not be considered candidates for this program. They often do not respond, or their reaction to the procedures results in an escalation of family conflicts. In rare instances, there may be an increase in the adolescent's already destructive, verbally aggressive, or even physically assaultive behavior, creating even more distress for the family than existed prior to treatment (Barkley, Guevremont, Anastopoulos, & Fletcher, 1992). Older children have had more years of effectively utilizing coercive behavior (especially that involving physical as well as verbal resistance), are more severe in the degree of defiant and conduct problems, may have more frank psychiatric disturbance, and may come from more disrupted or impaired families (Dishion & Patterson, 1992; Patterson, Reid, & Dishion, 1992). For all of these reasons, then, older children may benefit less from parent training programs, although benefits may still accrue to some older children and their families (Barkley et al., 1999; Barkley, Edwards, Laneri, Fletcher, & Metevia, 2001; Barkley, Guevremont, et al., 1992; Dishion & Patterson, 1992; McCart et

al., 2006). Older adolescents may be more responsive to cognitive-behavioral therapies of which they are the direct focus of treatment (McCart et al., 2006). Severely aggressive and defiant older children and adolescents may be better treated with multiple and more intensive in-clinic therapies (Patterson, Dishion, & Chamberlain, 1993), with in-home multisystemic forms of therapy (Mann, Borduin, Henggeler, & Blaske, 1990) or within treatment foster care, day hospital programs, residential treatment facilities, or inpatient child psychiatry units, at the conclusion of which parents can be trained in this program to prepare them for the children's return to the home.

Parents with at least a high school education who have minimal degrees of personal or family distress are likely to do quite well in acquiring and utilizing the skills and knowledge taught in this program. These parents are also more likely to report high levels of consumer satisfaction with the training procedures (Calvert & McMahon, 1987; McMahon & Forehand, 1984, 2005; Patterson, 1982; Sanders, 1996; Webster-Stratton & Spitzer, 1996). The methods taught in this program have received high levels of acceptability when reviewed by other adults or by the parents who are the direct recipients of training (Calvert & McMahon, 1987; Kazdin, 1980; McMahon, Tiedemann, Forehand, & Griest, 1984; Sanders, 1996; Webster-Stratton & Spitzer, 1996). Such parents not only report improved child behavior, as noted in all of the reviews referenced above, but also demonstrate changes in directly observed parental and child behavior. Parents trained in child behavior management skills also reported increased knowledge of parenting skills, reduced parenting stress, and an improved sense of self-esteem and parenting competence (Anastopoulos et al., 1993; Curtis, 2010; Danforth et al., 2006; Gerdes et al., 2012; van den Hoofdakker et al., 2007; Pisterman et al., 1989; Spaccarelli, Cotler, & Penman, 1992; Spitzer, Webster-Stratton, & Hollinsworth, 1991); better sibling behavior (Eyberg & Robinson, 1982; Humphreys, Forehand, McMahon, & Roberts, 1978); and in some cases better marital and family functioning (McMahon & Forehand, 2005).

Maintenance of Treatment Gains over Time

A number of studies have examined the extent to which parents and children continue to manifest improved interactions with each other once treatment within a behavioral parent training program such as this one has been terminated. Improvement in child behavior, parent behavior, and parental attitudes toward their children have all been noted to be maintained over periods of 3 months to 5–6 years and even 9 years after treatment termination (Drugli et al., 2010; Dubey, O'Leary, & Kaufman, et al., 1983; Eyberg et al., 2008; McMahon & Forehand, 1994, 2005; Patterson, 1982; Patterson, Chamberlain, & Reid, 1982; Patterson & Fleischman, 1979; Pisterman et al., 1989; Strain, Steele, Ellis, & Timm, 1982; Webster-Stratton, 1982; Webster-Stratton et al., 1989). Yet several studies have noted that parents' use of positive attending skills to prosocial child behavior is less likely to be maintained at follow-up than is the parents' use of other skills taught within the program (Webster-Stratton, 1982; Webster-Stratton et al., 1989). Despite this potential for decline in parental positive attending skills after treatment termination, gains in child behavior found at the end of treatment continue to be maintained across follow-up

periods up to 4.5 years later. This wealth of studies reflecting the maintenance of treatment gains over time is encouraging, but it is not found in all research studies of parent training; a few studies have not found such long-term effects of behavioral parent training (Bernal, Klinnert, & Schultz, 1980; Strayhorn & Weidman, 1991), suggesting that lasting gains are not always the norm for all forms of behavioral parent training.

Generalization of Treatment Gains across Settings

Therapists as well as school staff may be tempted to believe that parental participation in behavioral parent training programs at the offices of mental health professionals or even in the parents' homes will result in improved child behavior at school. Unfortunately, most studies have not found such generalization of treatment gains to school settings to occur unless interventions were delivered specifically in the school setting (Barkley et al., 2000; Horn, Ialongo, Greenberg, Packard, & Smith-Winberry, 1990; Horn, Ialongo, Popovich, & Peradotto, 1987; McMahon & Forehand, 1984; Patterson, 1982), although at least one has done so (Strayhorn & Weidman, 1991). Some studies have found children whose parents received parent training, or at least a subset of such children, to manifest improved school conduct, but just as many children within those studies showed either no change in school behavior or a significant worsening of such behavior associated with parent training (Firestone, Kelly, Goodman, & Davey, 1981; McMahon & Forehand, 1984). None of the studies that failed to find generalization of treatment effects to school settings, however, directly targeted school behavior problems as part of the parent training program. Consequently, therapists using traditional behavioral parent training programs should not encourage either parents or school staff to believe that generalization of gains to child school behavior is likely to occur if no effort is being made as part of the training program to institute changes in the school setting aimed at improving child behavior. This is one of the reasons why, in this edition, I have added a session to help parents assist teachers with improving their children's school conduct and performance through the use of home-based reward programs. Such procedures have been shown to result in improved teacher ratings of school behavior and improved homework performance, as noted previously. Likewise, programs that focus on identifying children through school screenings and then offering parents' behavioral interventions for their children at both home (via parent training) and school (via teacher mediated interventions) are unlikely to find that behavior at home has changed significantly (Barkley et al., 2000; Seeley et al., 2009) in such instances where parents have not sought out the intervention on their own initiative, as noted above.

Predictors of Success and Failure

Research with this program suggests that 60–75% or more of families with ADHD and/or clinically serious oppositional children may expect to demonstrate clinically significant improvement or even recovery (normalization) with this program (Anastopoulos et

al., 1993; Pisterman et al., 1989; Quici, Wheeler, & Bolle, 1996) and similar such programs (Bernal et al., 1980; Dishion & Patterson, 1992; Webster-Stratton et al., 1989). The percentage improved is greater among younger (< 6 years) and less clinically severe children (Dishion & Patterson, 1992; Webster-Stratton, 1982). But not all families can be expected to benefit from a behavioral parent training program like this one. Research on similar such programs suggests a number of factors that are related to program ineffectiveness (number of sessions attended, failure to complete training or to return for follow-up, reduced level of improvement in parent and child conflicts). Such factors should be considered by parent trainers as a possible basis on which to triage families into those assigned to group parent training (good likelihood of responding) versus individual training (higher number of risk factors), or even to divide families into those who are to be offered parent training and those who may need other, more parent-focused treatments first (Holden, Lavigne, & Cameron, 1990).

Child Factors

Only a few child characteristics have been identified as related to the effectiveness of parent training programs. As noted, one relatively consistent predictor of diminished effectiveness of parent training is the age of the child. Preschool children (< 6 years) appear to have the highest rates (> 65%) of positive responding to behavioral parent training programs compared with school-age children, who are somewhat less likely to improve (50–64%) (Anastopoulos et al., 1993; Dishion & Patterson, 1992; Strain et al., 1982; Strain, Young, & Horowitz, 1981) or with adolescents who may even be less likely than school-age children to respond (25–35%) (Barkley et al., 2001; Barkley, Guevremont, et al., 1992; McCart et al., 2006). However, this effect of age actually might be an inverted-U-shaped or curvilinear function, in that within the preschool age group, higher parental dropout rates and lesser degrees of responding have been found to be associated with *younger* ages of the children (Holden et al., 1990). Even within the elementary age range, the effect of age on treatment response has been found in one study to be the opposite of that noted previously, with parents of younger children being more likely to discontinue treatment prematurely (Firestone & Witt, 1982). Higher intelligence or mental age in children has also been associated positively with better response to parent training or with parental persistence through a parent training program (Firestone & Witt, 1982).

The severity of the children's behavioral problems and defiance specifically has been noted in some studies as being correlated with more limited treatment efficacy and a greater likelihood of parental premature termination from training (Dumas, 1984; Holden et al., 1990). Higher levels of childhood internalizing symptoms (anxiety, depression, withdrawal) may also predict lesser degrees of effectiveness of such programs (Drugli et al., 2010). However, this relationship of child internalizing and externalizing psychopathology to treatment outcomes might be explained by another one: the relationship of parental stress, marital distress, and parental psychopathology to the severity of the child's problems (Webster-Stratton & Hammond, 1990). That is, the severity of the child's problems here is simply serving as a marker for more important parent factors (see

later discussion) that are the actual reason that parents terminate training prematurely or fail to respond as positively to the training. Other research, however, has shown that children with more severe levels of disruptive behavior may benefit the most from behavioral parent training (Hautmann et al., 2010).

The extent to which the child manifests symptoms of psychopathy may also bode less well for success or improvement in responding to parent training programs such as this one. These symptoms include lack of conscience, empathy, and guilt and are often referred to as a callous–unemotional (CU) constellation or component among children with other disruptive behavior disorders, such as ADHD, ODD, and CD, and can be measured reliably as early as age 3 years (Loeber, Burke, & Pardini, 2009). Research suggests that the presence of CU makes distinct predictions across time beyond just the symptoms of the other disruptive behavior disorders and is frequently associated with a greater likelihood of persistent antisocial behavior (Burke, Waldman, & Lahey, 2010; Loeber et al., 2009; Pardini & Fite, 2010). The few studies examining the relationship of CU traits to outcomes of behavioral interventions have found such children to have higher rates of externalizing behavior even before treatment, to demonstrate them throughout training, and to be less improved by training, if at all (Waschbusch, Carrey, Willoughby, King, & Andrade, 2007). Another study found that a low heart rate in children with conduct problems prior to behavioral parent training was a predictor of decreased effectiveness of the training program (Stadler et al., 2008). A low heart rate may be a marker for low autonomic arousability more generally and has been shown in some studies to be associated with a greater likelihood of CU traits and persistent conduct problems (Stadler et al., 2008), and so in this study may have simply served as an index for higher CU traits in these children prior to training.

As noted, children with ADHD who are also defiant and whose parents undergo this training program should not be expected to be "recovered" or normalized in all of their behavioral problems as a consequence of this program. Research suggests that child defiant and hostile behavior is likely to improve the most from this program, with ADHD symptoms improving only somewhat or not at all (Anastopoulos et al., 1993; Chronis et al., 2004; Johnston, 1992). Thus, stimulant medication or other pharmacological therapy may need to be added to the treatment package provided to such children in order to address more fully their comorbid ADHD (Firestone et al., 1981). Where stimulant medication is used with children who have ADHD, therapists may find that there is sometimes little additional benefit provided to families by including a parent training program (Abikoff & Hechtman, 1995; Firestone et al., 1981; Horn et al., 1991). Given that stimulant medications have proven to be among the most effective treatments for these children (Connor, 2006), clinicians should discuss this treatment with parents upon making the diagnosis of ADHD. Some parents wish to wait until after training is done, however. Thus, in this edition, I have amended the original parent training program to suggest discussing this issue in the final session of the program for those parents who have elected to wait to begin such treatment. Therapists wishing more information about psychopharmacology for children who have ADHD are referred to my textbook on the subject (Barkley, 2006) or the excellent book for parents on this topic by Wilens (2008).

At least one study has suggested that girls may benefit somewhat less from behavioral parent training programs than boys or at least have a greater likelihood of continuing to have a diagnosis of ODD/CD at 5- to 6-year follow-up (Drugli et al., 2010).

Parent Factors

Parent-related factors may be even more predictive of outcomes in behavioral parent training programs than child factors (Reyno & McGrath, 2006). Parents who are relatively younger than the average of those seeking training, who are less intelligent and/or have less than a high school education, and who have a lower socioeconomic status usually have higher dropout rates (Fernandez & Eyberg, 2009; Reyno & McGrath, 2006) or do not achieve the same degree of success as others (Dumas, 1984; Firestone & Witt, 1982; Holden et al., 1990; Knapp & Deluty, 1989; Reyno & McGrath, 2006; Webster-Stratton & Hammond, 1990). However, the detrimental effects of lower socioeconomic status have not always been noted in studies of behavioral parent training (McMahon & Forehand, 1984; Reyno & McGrath, 2006; Rogers, Forehand, Griest, Wells, & McMahon, 1981). One study also found that ethnicity was related to dropping out of treatment or progressing more slowly through training, with minority groups having more of these difficulties than the majority group (Holden et al., 1990). However, social class was also found to show the same relationship to poor progress through treatment and it, rather than ethnic group, may actually have created this difference among ethnic groups, given the differential representation of such groups across social class. Indeed, later research did not find ethnicity to be a factor in deriving benefits from psychosocial treatment (Jones et al., 2010). As might be expected, the number of required sessions the parents actually attended in the training program has been shown to be related to treatment efficacy (Strain et al., 1981). A lower sense of parenting self-efficacy also has been shown to be a predictor of greater improvement in child behavior in some behavioral parent training programs (Hautmann et al., 2010).

Diminished benefits from parent training and high dropout rates are especially likely for parents (mothers) who are socially isolated from adult peers in their community and encounter aversive interactions with their extended family (Dumas, 1984; Dumas & Wahler, 1983; Salzinger, Kaplan, & Artemyeff, 1983; Wahler, 1980; Wahler & Afton, 1980). Even when such parents demonstrate improved child management and fewer parent–child conflicts, they may have a greater likelihood of relapse after training concludes (Dumas & Wahler, 1983; Wahler, 1980; Wahler & Afton, 1980). Dumas and Wahler (1983) have shown that maternal insularity (isolation) when combined with socioeconomic disadvantage accounted for nearly 50% of the variance in treatment effectiveness, suggesting that these factors may be particularly important during the pretreatment stage when the therapist is assessing the likelihood that a family may respond positively to behavioral parent training. It is possible, however, that by providing greater involvement and training from the therapist, ensuring more time for practice (Knapp & Deluty, 1989), and addressing the mothers' social isolation either before or during training (Dadds & McHugh, 1992; Dumas & Wahler, 1983; Wahler, Cartor, Fleischman, & Lambert, 1993), these families may be able to achieve significant improvements in child management.

Parents with higher levels of psychopathology (especially depression, alcohol/drug dependency, adult ADHD) do not seem to do well in parent training programs such as this one (Chronis et al., 2011; Patterson & Chamberlain, 1994; Sonuga-Barke, Daley, & Thompson, 2002). They may start out resistant to training and homework assignments and seem to remain so throughout treatment. Also, parents demonstrating greater negativity and helplessness or poor anger control typically do not respond as positively in such training programs or are more likely to drop out of treatment (Fernandez & Eyberg, 2009; Frankel & Simmons, 1992). Providing training in more effective problem-solving or anger management skills prior to or as an adjunct to parent training in child management may prove useful in enhancing the effectiveness of parent training programs (Chacko et al., 2009; Goldstein, Keller, & Erne, 1985; Pfiffner, Jouriles, Brown, Etscheidt, & Kelly, 1988; Prinz & Miller, 1994; Sanders, 1996; Spaccarelli et al., 1992).

If parent training is to be done with parents of children having ADHD, therapists must consider the fact that ADHD in children is known to have a strong hereditary predisposition (see Barkley, 2006, or Nigg, 2006, for discussion), with an average of 25% or more of parents likely to have the disorder. Up to 65% of children with ADHD may have ODD as a comorbid disorder, and even those who do not are likely to be more difficult to manage than are normal children, making childhood ADHD a common factor among children whose families are being recommended for a behavioral parent training program such as this one. This suggests that not only is there a significant probability that the child who is the focus of the parent training efforts has ADHD, but that one of the child's parents may have ADHD as well. Parental ADHD has been shown in several studies to result in significant detrimental effects on parenting behavior (Chen & Johnston, 2007; Chronis-Tuscano, Raggi, et al., 2008; Griggs & Mikami, 2011), as discussed in detail below, and to be a strong predictor of parenting distress (Theule, Wiener, Rogers, & Marton, 2011). It has also been associated with reduced effectiveness of or parental failure within behavioral parent training programs (Chronis et al., 2004; Chronis-Tuscano et al., 2011; Evans, Vallano, & Pelham, 1994; Sonuga-Barke et al., 2002). This adverse effect of adult ADHD on parent training appears to be mediated by the degree of negative parenting practices used by the adult with ADHD (Chronis-Tuscano et al., 2011). Treatment of parental ADHD with stimulant medication may prove useful in facilitating a positive response of that parent to the parent training course (Chronis-Tuscano, Seymour, et al., 2008; Evans et al., 1994). For these reasons, clinicians need to employ screening methods for the presence of parental ADHD among parents with a child having a known diagnosis of ADHD or parents scheduled to enter parent training programs such as this one. This can be done easily using a rating scale of adult ADHD symptoms, such as the Barkley Adult ADHD Rating Scale–IV (Barkley, 2011). Parents with high scores on such a scale should be referred for a more thorough evaluation to determine the diagnosis of ADHD and to have it treated prior to parental enrollment in a parent training program.

Degree of marital discord is also a predictor of diminished effectiveness within this (Chronis et al., 2004; McMahon & Forehand, 2005) and other (Chronis et al., 2004; Patterson, 1982; Webster-Stratton & Hammond, 1990) parent training programs. Perhaps it is better to provide such parents with marital therapy (Dadds, Schwartz, & Sanders,

1987) or divorce counseling to help resolve their marital problems before parent training in child management is offered or as an adjunct to it. Participation in parent training, while it often improves parenting skills, is unlikely to improve marital difficulties (Anastopoulos et al., 1993).

As might be expected, whether or not the marriage or family was intact (parents married) at the time of training is also a predictor of response to parent training programs. Single-mother families responded less well than two-parent households (Chronis et al., 2004; Drugli et al., 2010; Strain et al., 1981, 1982; Webster-Stratton & Hammond, 1990). But this is not to say that such mothers may not respond at all, as some studies have found immediate treatment related gains for them during training (Chacko et al., 2008, 2009). Yet even when such single mothers responded to programs such as this one, their children's oppositional behavior may not be normalized following treatments and treatment gains are less likely or unlikely to be sustained (Chacko et al., 2009).

Degree of life stress experienced within the past year may also be associated with reduced parent training efficacy (Webster-Stratton & Hammond, 1990). This, of course, could simply be the result of greater stress being associated with the other factors above that have been found to be related to program effectiveness.

Therapist Factors

Therapist factors clearly may play a role in the success of behavioral parent training programs. Such factors long have been known to be of importance in studies of psychotherapy outcomes with adults (Garfield & Bergen, 1986) and children (Crits-Christoph & Mintz, 1991; Kazdin, 1991). A few studies have examined this issue relative to behavioral parent training, particularly among Patterson's research team at the Oregon Social Learning Center. Trainee-therapists do not appear to be as effective in maintaining parents in parent training programs as are more experienced therapists (Frankel & Simmons, 1992; Thompson et al., 2009). Moreover, among experienced therapists, those who teach and confront parents more are likely to encounter greater parent resistance to training than are those who facilitate and support parents in the process of training (Patterson & Forgatch, 1985). Resistance can occur both in response to the formal training procedures within the session as well as to the homework assignments parents are required to perform (Patterson & Chamberlain, 1994). Patterson and Chamberlain (1994) report that parent trainers working with families of seriously antisocial children can expect to encounter resistance from most families at the start of treatment, which is likely to increase up to the midpoint of treatment. In less serious cases and in families with younger children, this resistance may be worked through and resolved by the time of treatment termination. In more difficult cases, resistance is likely to persist at high levels, foreboding fewer changes in parents' management skills with their children as well as less positive outcomes overall. Such client resistance is likely to provoke the therapist into confronting behaviors, which, as noted above, may increase client resistance. Thus, a "delicate balancing act" must be achieved by the parent training therapist, who is attempting to achieve an optimal level of teaching and confronting of parents' resistance

while providing facilitation and support to motivate the parents to undertake behavioral change (Patterson & Chamberlain, 1994).

Program Factors

Enough studies of behavioral parent training programs such as this one have been conducted that permit the combining of their results into a meta-analysis. This approach provides greater power to test (and detect) treatment effects as well as a means for studying various moderator or mediator factors that may influence the effectiveness of the program. One such analysis was conducted by Kaminski and colleagues (2008) that examined components of these training programs that appeared to contribute to greater improvements (as measured by larger effect sizes). The authors noted that programs that focused on increasing positive interactions between parent and child, increasing emotional communication skills, teaching parents to use time out, the importance of parental consistency, and requiring parents to practice the new skills conveyed in the training sessions were all associated with greater effects than programs not using these methods. The present program incorporates all of these components and thus could be expected to result in greater effectiveness in improving child behavior and adjustment than programs not utilizing these methods.

Organization of the Manual

This training manual has been organized into four parts: Part I provides information on the background of this program, its theoretical and research basis, methods of evaluating oppositional and defiant children both before and after treatment, and various prerequisite information to consider before undertaking this program of therapy. Part II provides detailed instructions on conducting each of the sessions of the program. Clinicians may wish not only to acquaint themselves thoroughly with Part II but also to review the contents of each step periodically while training families. Each step in this section begins with an outline of the material to be taught in that step, such that a clinician experienced in this program need only refer to this outline during a training session with a family. Part III contains assessment materials, which are highly useful during the pre- and posttreatment evaluation of the children and their families. Part IV contains the handouts to be used with each step of the program. (Note that Parts III and IV are included in a Spanish-language supplement available from the publisher; see point 7, below.)

Revisions to the Original Program

Readers already familiar with the original manual for this program (Barkley, 1987) may appreciate knowing about the modifications presented in the second edition (Barkley, 1997) that have carried over into this edition. Most of these changes are listed below:

1. The introductory section (above) of the manual as well as Chapter 1 ("The Rationale for the Program") continue to be more densely referenced with citations of the research literature that support the efficacy of the program and its components. This was done so that therapists wishing to venture into the empirical literature behind the program and its methods could do so more easily. It was also done to buttress many of the assertions set forth in the original manual for which citations had not been provided. Finally, clinicians negotiating with managed care or other insurance companies for approval of these services and remuneration of clinical fees for the training program may need to cite the clinical research literature on the proven effectiveness of behavioral parent training in support of their case for reimbursement from these companies. Providing such research citations to insurers or government agencies underwriting the costs of training can be helpful.
2. The initial assessment materials have been greatly revised and include demographic information, developmental/medical history, and parental and teacher behavior rating forms that should prove highly useful in conducting evaluations of defiant children. The Home and School Situations Questionnaires are, once again, provided here to assist with identifying the precise situations in which disruptive behavior is occurring, in part to aid treatment planning but also to gain an impression of the pervasiveness of the children's behavioral problems.
3. The original Steps 3 (Increasing Compliance) and 4 (Decreasing Disruptiveness) were combined into a single session (Step 3) in the second edition, based on our clinical experience that both can be easily covered within a single training meeting with parents. This change is also retained into this third edition.
4. This edition also continues to include a step (now Step 8) dealing with helping parents to implement Daily School Behavior Report Cards, which parents can use to assist teachers in improving a child's behavior and academic performance in the classroom. That component was added to the second edition and has been retained here because of its demonstrated utility. Obviously, this step is intended for school-age children and can be skipped in preschool-age children.
5. Added to the second edition was a means of coping with a child who resisted remaining within the time out location once time out had been instituted. That method involved the use of a barrier restraint, such as isolation of the child to his or her bedroom and even closing and locking the door if necessary to preclude escape from time out. This method has been retained into this third edition.
6. The original Step 8 of this program ("Managing Noncompliance in Public Places") was broadened in the second edition as Step 7 to include the use of "think aloud–think ahead" steps by parents in places other than just public ones. It also incorporated the use of "planned activities" as a preventive measure to ward off the likelihood of child behavior problems in immediately upcoming home and public situations. Again, all this has been retained into this edition.

7. And finally, a Spanish translation of the assessment tools and parent handouts was created as a separate supplement to the second edition of this manual that is available from the publisher. Given that no substantive changes have been made here to the parent handouts, that translation would continue to be of use to therapists implementing this third edition of the program with parents who speak Spanish.

Summary

The procedures detailed in this manual are designed specifically for families with children who are noncompliant, defiant, or oppositional and who range in age from 2 to 12 years. The methods are meant for use by experienced clinicians with adequate training in delivering psychological services to families of defiant children. Although highly effective, the success of these procedures is dependent on the nature and severity of the child's problems, the child's age, the extent and severity of parental and family psychopathology, and the level of parental intelligence and motivation to utilize these methods, among other factors. When taught properly, this program can be significantly effective in diminishing or eliminating behavior problems in children.

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