Introduction

Purposes of the Program

As with Barkley's earlier clinical manual for training parents of defiant children (Barkley, 2013), this manual is designed to serve several purposes.

- It provides a contemporary summation of the nature of oppositional defiant disorder (ODD) in children and adolescents as reflected in extant research. ODD is a disorder with which attention-deficit/hyperactivity disorder (ADHD) is often a comorbid disorder, and so occasional references to ADHD occur throughout this manual as the impact of such coexistence may warrant.
- It provides a set of explicit instructions for conducting clinical evaluations of teenagers having defiant or oppositional behavior as part of their clinical presentation. Behavior rating scales for use in such evaluations are also provided here. These forms may be photocopied, as necessary, with permission of the publisher for the clinician's use in his or her own practice. The reader can also use some of these scales for the periodic evaluation of a family's response to the treatment program.
- The manual specifies step-by-step instructions for conducting the procedures that can lead to an effective, empirically validated program to train families in managing teens having defiant or oppositional behavior and in an effective set of problem-solving skills and communication styles. We have paid careful attention to the format of the presentation of each step of the program to make the manual of utmost practical use. The manual itself can lay flat on a desk or clipboard for easy reference during training sessions, as well as on a photocopier for reproduction of the parent handouts and rating scales. Also, purchasers can download and print the reproducible materials from .
- Last, this manual contains a set of handouts for families to use during the program. Some handouts are forms completed by the family members while others are instructions for the family members to use with particular steps or sessions

of the program. We designed the handouts to be brief and easy to read. They are not meant to be used, however, in isolation, without training by a skilled child or family therapist.

The reader wishing to use this program must have appropriate training in delivering mental health services to teens and families. This would include training in child development, child psychopathology, social learning and behavior modification techniques, family therapy, and/or other clinical interventions with families. The program is not a substitute for the requisite clinical training needed to deploy it or for exercising sound clinical judgment and ethics in dealing with teens with behavior problems and their families. Care must always be exercised in tailoring these methods to the particular issues involved in and characteristics of a given adolescent and his or her family.

This manual is not a comprehensive or exhaustive review of the scientific literature on parent training, family therapy programs, or research on defiant adolescents. Such reviews can be found in numerous forums (see Mash & Barkley, 2006, 2007, in press). Instead, the manual serves as a clinician's guidebook for training families in those procedures pertinent to this particular sequence of methods aimed at reducing parent–teen conflict and improving family relationships in teens having clinically significant levels of oppositional or defiant behavior.

Who May Be Appropriate Families for This Program?

As with any clinical procedure, this program was not designed as a blanket method or panacea to be applied to all teens and their families regardless of the family's presenting problems. It is expressly intended for teenagers who display conflict with their parents, usually manifesting noncompliant, defiant, oppositional, stubborn, or socially hostile behavior toward their parents either alone or in conjunction with other disorders. These teens are often referred to as having "disruptive," "externalizing," or "acting out" disorders and may be given the more generic layman's labels of difficult, defiant, or aggressive children, or the more specific clinical diagnoses of ODD, ADHD, conduct disorder (CD), or even juvenile-onset bipolar disorder, provided that noncompliant or defiant behavior is a primary problem. The program is also quite applicable to adolescents with mild developmental delay (mental retardation) where noncompliance or defiance is a problem in parent–teen interactions. Despite being intended for use with clinically referred populations of adolescents, portions of the program also may be quite valuable for use with mild situational family conflicts or behavior problems in otherwise normal teens whose families are being seen for more general parental, marital, or family therapy. In particular, teens 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, when listening to and complying with parental commands or requests or adhering to household or neighborhood rules is problematic for an adolescent, this program may prove quite useful.

The program was designed for teens whose language level, general cognitive developmental level, or mental age is that of a 10- to 12-year-old or older and whose chronological age falls between 13 and 18 years. Although the skills taught in Sessions 1–9 can be used with younger children, it would be preferable to follow the guidelines of the original program for defiant children developed by Barkley (2013). It is our opinion that the problem-solving communication training (PSCT) elements of this program (Sessions 10–18) require a child be at least 13–14 years of age before undertaking those sessions that require adolescent involvement in the problem-focused discussions.

We have successfully used this program with single-parent as well as two-parent families, those of low income or educational levels, and even abusive families, although again the constraints and intended audience of this manual noted above apply here as well. Even when the teen in an abusive family is compliant, this program can serve to provide parents with more humane and effective methods of dealing with the everyday management of a typical teenager if such training of parents is clinically desirable. Indeed, the authors have earlier employed these methods as needed with their own teenagers to help quell potential conflicts.

This therapeutic approach can be a standalone therapy as the primary form of intervention provided to families having defiant teens. Yet we have also found it to serve as a core approach that then employs other forms of adjunctive treatments for troubled parents or families who also happen to have defiant adolescents. For instance, many therapists have told us that using this behavioral family training program provided them with a highly useful adjunct to marital counseling, when disagreements over teen management are an issue in the marriage (see Sanders, 1996, for a discussion of this issue with children with behavior problems). It can also be employed as an adjunct to psychotherapy with anxious, depressed, or otherwise maladjusted adults who are also having problems managing the behavior of their teens. Certainly it can also be part of a larger treatment package for adolescents who are socially aggressive, oppositional, or have conduct problems, and who may themselves benefit from the addition of direct family training in social problem-solving skills as in multisystemic therapy (Henggeler, Cunningham, Schoenwald, Borduin, & Rowland, 2009) or in other behavioral family interventions for defiant children (Kazdin, Esveldt-Dawson, French, & Unis, 1987).

We do not recommend conducting this program with adolescents who are seriously aggressive and assaultive toward others. They often do not respond well, and their reactions to the procedures in some cases may result in an escalation of family conflicts, likely owing to the limit-setting and disciplinary consequences parents may be asked to invoke as part of the program procedures. In rare instances, an increase in the adolescent's already destructive, verbally aggressive, or even physically assaultive behavior can occur when parents attempt to place restrictions on teen behavior, creating even more distress for the family than existed prior to treatment (Barkley, Edwards, Laneri, Fletcher, & Metevia, 2001; Barkley, Guevremont, Anastopoulos, & Fletcher, 1992).

We believe that seriously aggressive and defiant teenagers may be better treated with more intensive and multiple in-clinic therapies (Patterson, Dishion, & Chamberlain, 1993); in-home multisystemic forms of therapy (Henggeler et al., 2009); or

within-treatment foster care; day hospital programs; residential treatment facilities; or inpatient child psychiatry units. At the conclusion of such interventions, parents and teens then can be trained in the procedures in this manual to prepare them for the adolescent's return to the home.

Goals of the Program

The present program has a limited number of goals but is effective at achieving them with many families. They are as follows:

1. To improve parental management skills and competence in dealing with teen behavior problems, particularly noncompliant or defiant behavior.
2. To increase parents' knowledge of what causes defiant behavior in adolescents and the principles and concepts underlying the social learning of such behavior.
3. To improve teen cooperation with parental requests, directives, and rules.
4. To increase family harmony by improving parents' use of positive attention and other consequences with their teens; the provision of clear guidance, rules, and instruction to those teens; the application of swift and just discipline for inappropriate teen behavior; and the reliance on principle-guided parenting behavior more generally.
5. To increase both parental and teen use of problem-solving skills and positive communication styles during problem-focused discussions and interactions that involve the teen.
6. To alter the teen's or the parents' unreasonable beliefs, should they be observed to be guiding either parent or teen behavior during parent–teen problem-focused interactions.

Outcomes Expected from This Program

There is abundant research supporting their utility of the procedures described in Steps 1–9 here when applied to children up to approximately age 12 years of age (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; Hoofdakker et al., 2007; Pisterman et al., 1989; Rejani, Oommen, Srinath, & Kapur, 2012; Thomas & Zimmer-Gembeck, 2007). The research on other highly similar behavioral training programs for parents also supports the effectiveness of these procedures with defiant children (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). Worth noting is that a variation of the first part (Sessions 1–9) of this family therapy program served as the parent training intervention in the landmark Multimodal Treatment Study of Children with ADHD (MTA; Multimodal Treatment of ADHD Group, 1999). That program was one component of the larger 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 treatment component to that of the original MTA study (Rejani et al., 2012). Understand that such success is with self-referred families. We have found that where parents did not seek treatment but whose children were identified through screening at kindergarten for high-risk cases, for example, or through in-home visits by health care professionals, one will find low rates of attendance or compliance and little if any benefits from being enrolled in programs such as this (Barkley et al., 2000; Seeley et al., 2009; Thompson et al., 2009).

Studies of each of the steps of the initial part of this program support their effectiveness in improving child misbehavior, including:

1. *Improving parental selective attending skills* (Eyberg & Robinson, 1982; Forehand & McMahon, 1981; Kaminski et al., 2008; Kelley, Embry, & Baer, 1979; McMahon & Forehand, 1984, 2005; Patterson, 1982; Pisterman et al., 1989; Pollard, Ward, & Barkley, 1983; Roberts, 1985; Webster-Stratton, Hollinsworth, & Kolpacoff, 1989).
2. *Improving parental deliverance of requests* (Blum, Williams, Friman, & Christophersen, 1995; Forehand & McMahon, 1981; Gerdes et al., 2012; Green, Forehand, & McMahon, 1979; McMahon & Forehand, 2005; Patterson, 1982; Roberts, McMahon, Forehand, & Humphreys, 1978; Williams & Forehand, 1984).
3. *Improving children's independent play behavior* (Anastopoulos et al., 1993; Pollard et al., 1983; Wahler & Fox, 1980);
4. *Parental use of time out as a disciplinary method* (Anastopoulos et al., 1993; Bean & Roberts, 1981; Curtis, 2010; Danforth et al., 2006; Day & Roberts, 1982; Eyberg & Robinson, 1982; Forehand & McMahon, 1981; Kaminski et al., 2008; Patterson, 1982; Pisterman et al., 1989; Roberts et al., 1978; Roberts, Hatzenbuehler, & Bean, 1981; Strayhorn & Weidman, 1989; Wahler & Fox, 1980; Webster-Stratton et al., 1989).
5. *Parental use of response cost as a disciplinary method* (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. *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).

Our experience and research show that up to 60 to 75% or more of the families of defiant children undergoing training in such management methods report significant improvement in their children's behavior and their own parenting abilities. Yet research also suggests that when used alone with older adolescents who have ODD (or ADHD), the behavioral parent training program benefits only about 25% of families, while 35% or so benefit from the separate PSCT component (Barkley, Guevremont, et al., 1992). The combination of these two approaches as set forth in this manual also achieves significant improvement in families having defiant teens (Barkley, et al., 2001).

These results may seem disappointing. But consider that more traditional family therapy programs may produce even fewer positive responders to treatment, on the order of just 10% in one of our earlier projects (Barkley, Guevremont, et al., 1992). Thus, the present program is three to four times more effective than traditional family therapies are likely to be with highly oppositional teens. Also note that research finds many forms of parent and family training declining in their utility with the transition to adolescence (Dishion & Patterson, 1992). We believe that combinations of methods are needed to address the more long-lasting and intransigent defiant behavior of adolescents with ODD (and often ADHD), such as that used in multisystemic therapy developed by Henggeler and colleagues (Henggeler et al., 2009). That is why we have combined Barkley's behavioral parent training with Robin's PSCT program and thereby extended therapy from 9 to 18 sessions. The need for doing so comes from the results of our previous research (funded by the National Institute of Mental Health [NIMH]) on family training with defiant teens. That research project clearly suggested that the combination of these two programs was superior to either of them used alone. For instance, we found that many more families dropped out of therapy if we provided them with just the PSCT component of this manual rather than starting with the behavior management strategies developed by Barkley (Barkley et al., 2001).

It is also possible that the reduction in the effectiveness of family-focused interventions with clinic-referred defiant adolescents in comparison to defiant children may arise from another source rarely discussed in the family therapy literature. That process is the increasing contribution of genetic influences to parent–child conflict and the child's antisocial behavior as he or she gets older. That is, research seems to suggest that within-family social influences on child misbehavior may be greater during early childhood, diminishing with the age of the child (Rowe, 1994). In contrast, the genetic contribution to individual differences in antisocial behavior and parent–teen conflict increases with age, particularly when there is comorbidity with ADHD (Braungart-Reiker, Rende, Plomin, DeFries, & Fulker, 1995; Elkins, McGue, & Iacono, 1997; Knopik, Heath, Bucholz, Madden, & Waldron, 2009; Lifford, Harold, & Thapar, 2009; Pike, McGuire, Hetherington, Reiss, & Plomin, 1996; Pike, Reiss, Hetherington, & Plomin, 1996). In short, genetic factors account for most of the variance in parent-teen conflict and teen antisocial behavior at late adolescence.

Why? Perhaps as Scarr and McCartney (1983) suggested, teens have more choices in the kinds of environments in which they can participate or even create for themselves including what, if any, relationships to have with their parents. Called "niche-picking" (Scarr & McCartney, 1983; Scarr, 1992) or "the extended phenotype" (Dawkins, 1982) by Barkley (2012a). It refers to the likelihood that individuals with given genotypes not only increasingly choose the kinds of environments in which to live but increasingly construct such environments around themselves. Consequently gene–environment interactions would be expected to increase with age. The environments and relationships in which teens participate, then, increasingly reflect aspects of their own phenotype, or extensions of their genotype further into their environmental ecologies. With increasing age, then, children are likely to exert increasing influence on their environment and to be less affected by the environment themselves. Individual differences in both behavior toward and relationships with parents in adolescence may therefore be reflective more of teens' effects on parents than of parental effects on children or teens. It is also likely that parent–teen conflict results from a shared genetic risk between teen and parent for comparable forms of psychopathology that would increase risk for conflict. Thus, to the extent that such differences in child behavior and personality are genetically influenced, and many are (Pinker, 2002; Rowe, 1994), those genetic influences in both the teen and parent will explain a greater proportion of the variance in conflicts and relations between them by adolescence than occurred earlier in life.

The net result of these processes for clinicians working with clinic-referred adolescents is that those adolescents are likely to be considerably more difficult to treat successfully than is the case with defiant children. Adolescent ODD, antisocial conduct, and negativity in parent–teen interactions may be far more influenced by genetic factors than by environmental ones, especially if ADHD is a coexisting condition. This is the case more so than are similar problems in younger clinic-referred children, who are much more responsive to parent training interventions. This is not to argue that biology is destiny or that such conflicts are therefore immutable; that would be a mistaken interpretation of the meaning of heritability in research on this issue. It is to say that such studies suggest that the shared environment (rearing environment) may not make as much a contribution to parent–teen conflict as do genetics and influences outside the home, and so if the intent of family-based therapy is to address the root cause of such conflict, it is not likely to meet great success. This suggests that clinicians might need to be content with far lower success rates in their adolescent cases of ODD and CD than would be acceptable in child cases. It also suggests that clinicians need to focus on factors influencing the adolescent outside the home, such as deviant peer relationships, antisocial or criminogenic neighborhoods, failing schools, or relationships with antisocial adults, if change in adolescent behavior beyond this level is to be achieved.

The degree of success of any family therapy program is likely to be affected by the extent, nature, and severity of the teen's psychopathology, the psychopathology of the other family members, and other factors (see "Predictors of Success and Failure," p. 11). With adolescents whose major problem is oppositional behavior yet whose families are not seriously dysfunctional, this program usually results in the normalization of the

parent–teen conflicts for up to 70% of families (Barkley et al., 2001; Robin & Foster, 1989). In our experience, however, teenagers with more serious forms of mental disorders that may be chronic in nature, such as ADHD, ODD, CD, bipolar disorders, autism spectrum disorders, or their combinations, may have improved interactions with their parents under this program. Nevertheless, even after treatment, such cases may continue to be more deviant in their behavior than normal cases, particularly if the teens had significant symptoms of ADHD before treatment (Barkley, Guevremont, et al., 1992). This same phenomenon has also been observed in studies of parent training with children having ADHD (Anastopoulos et al., 1993; Chacko et al., 2009; Drugli, Larsson, Fossum, & Morch, 2010; Johnston, 1992). For those cases, we recommend adopting the view that one is training families to "cope" with the teen's disorder-driven problems rather than "cure" them. Even so, we believe that this program can reduce the extent to which parent–teen conflict exists and creates distress within the family.

Even within the adolescent age range, older teens may benefit less than younger ones from such family therapies. However, even with older teens some benefits still accrue to them and their families (Barkley, Guevremont, et al., 1992; Barkley et al., 2001; Dishion & Patterson, 1992; McCart et al., 2006). We think this is because older teens have had more years of effectively utilizing coercive behavior with their parents than is the case with younger teens or even more so with defiant children. This means older teens have had more time to practice and acquire various means of resisting parental authority, especially those involving verbal resistance, high expressed negative emotion, and even physical resistance. Combined with the fact that older teens may have more severe defiant and conduct problems due to persistence alone (persistent cases of defiance from childhood onward tend to be more severe than less persistent ones), as well as more psychiatric disorders and more disrupted or impaired families (Dishion & Patterson, 1992; Patterson, Reid, & Dishion, 1992), and it is easy to understand why family therapies may not be as effective with older as compared to younger oppositional teens.

While data are lacking on the issue, we believe that defiant adolescents and particularly those with frank ODD or CD who have comorbid ADHD are likely to respond much more positively to the program presented here if those teens are on an ADHD medication. Research does show that those medications can result in a substantial reduction in impulsive, inattentive, and hyperactive behaviors (Connor, in press), as well as emotional impulsiveness (Barkley, 2010, 2014; Findling et al., 2012; Manos et al., 2012), all of which can contribute to improved parent–child interactions and general social and academic success (Danforth, Barkley, & Stokes, 1991; Johnston & Mash, 2001; Prasad et al., 2013). These medications have also been found to reduce both instrumental (proactive) and hostile (reactive) aggressive behavior (King et al., 2009). For these reasons, we believe that adjunct medication may make such adolescents more amenable to and cooperative with the family training recommended in this manual.

Our experience finds that parents with at least a high school education and with a minimal degree of personal or family distress do quite well in acquiring and utilizing the skills and knowledge taught in this program. We have found that such parents are also more likely to report high levels of consumer satisfaction with the training procedures

(Barkley et al., 2001; Robin & Foster, 1989) as have others (Calvert & McMahon, 1987; Forehand & McMahon, 1981; McMahon & Forehand, 1984; Patterson, 1982; Sanders, 1996; Webster-Stratton & Spitzer, 1996).

High ratings of social acceptability have been provided to these methods of behavioral parent training either by the parents who are the direct recipients of the training or when reviewed by other adults (Barkley et al., 2001; Calvert & McMahon, 1987; Kazdin, 1980; Sanders, 1996; Webster-Stratton & Spitzer, 1996). Improvements are found as well in both parent ratings of child misbehavior (Anastopoulos et al., 1993; Bernal, Klinnert, & Schultz, 1980; Drugli et al., 2010; Dubey, O'Leary, & Kaufman, 1983; Eyberg & Robinson, 1982; Forehand & McMahon, 1981; Patterson, Chamberlain, & Reid, 1982; Pisterman et al., 1989; Pollard et al., 1983) and in directly observed parental behavior (Patterson, 1982; Patterson et al., 1992). Some studies also found improved attitudes of parents toward their children as a consequence of behavioral parent training programs like the methods taught here (Sessions 1–9) (Forehand & McMahon, 1981; McMahon & Forehand, 1984; Webster-Stratton et al., 1989). Trained parents also reported increased knowledge of parenting skills, reduced parenting stress, improved self-esteem and parenting competence (Anastopoulos et al., 1993; Barkley et al., 2001; Spaccarelli, Cotler, & Penman, 1992; Spitzer, Webster-Stratton, & Hollinsworth, 1991), better sibling behavior (Eyberg & Robinson, 1982; Humphreys, Forehand, McMahon, & Roberts, 1978), and better marital and family functioning (Forehand & McMahon, 1981).

Despite such abundant research on behavioral parent training with children, substantially less research exists on training families with defiant adolescents or those who have frank ODD or CD. It is therefore unclear whether the same types and degrees of improvement can be expected with these behavioral management methods with older teens having these conditions. What research exists suggests that behavioral parent training programs as well as methods similar to PSCT do produce significant treatment effects on parent and teen functioning (Barkley, Guevremont, et al., 1992; Barkley et al., 2001; Dishion & Andrews, 1995; Robin, 1981; Robin & Foster, 1989).

Maintenance of Treatment Gains over Time

Do the gains related to treatment in parent–child relations and child behavior last after treatment ends? Far fewer studies have addressed this issue with teens than is the case with children having conduct problems. Those studies of children with defiant behavior or ODD have found that improvements in child behavior, parent behavior, and parental attitudes toward their children can be maintained over periods of 3 months to 4½ years and even 9 to 14 years after treatment termination (see Estrada & Pinsof, 1995, for a review; Drugli et al., 2010; Dubey et al., 1983; Forehand & McMahon, 1981; McMahon & Forehand, 1984; Patterson, 1982; Patterson & Fleischman, 1979; Patterson et al., 1993; Pisterman et al., 1989; Strain, Steele, Ellis, & Timm, 1982; Webster-Stratton, 1982; Webster-Stratton et al., 1989). Some research noted that parental use of positive attending skills to prosocial child behavior are less likely to be maintained at follow-up than are

the parents' use of other skills taught in the program (Patterson, 1982; Webster-Stratton, 1982; Webster-Stratton et al., 1989). Despite this decline in parental positive attending skills after treatment termination, gains in child behavior found at the end of treatment continued to be maintained across follow-up periods up to 4½ years later. Such research demonstrating the maintenance of treatment gains over time after ending therapy is encouraging. But we must note that it is not found in all research studies of parent training. A few studies have not found long-term effects of behavioral parent training (Bernal et al., 1980; Strayhorn & Weidman, 1991), suggesting that lasting gains are not always the norm for all forms of behavioral parent training.

As before, we are compelled to state that research on the maintenance of treatment gains from behavioral parent training with teenagers who have defiant behavior or ODD is far, far less substantial than with children. It therefore is not clear to what extent gains produced by family-based training programs such as this one are maintained over time after termination. We found that fathers and teens reported continued improvement in parent–teen conflict even after treatment is terminated over the subsequent 2-month follow-up, but mothers' reports of such conflicts do not show such continuing improvement (Barkley et al., 2001). Encouraging findings of maintenance of treatment effects over a 10-week follow-up period have been reported for families undergoing the PSCT component of this program (Robin, 1981). Dishion and Andrews (1995) have also reported that reductions in behavioral problems (as reported by parents) achieved by the treatment program were maintained for up to 1 year after treatment termination for their own variation of this family therapy program. Important to note in that study was the finding that treatments that focused only on teens in groups actually resulted in an increase in both problem behaviors and tobacco smoking by 1-year follow-up. Such findings argue for the inclusion of parent-focused treatment efforts in dealing with teens with behavior problems. Suffice to say here that this issue of maintenance of treatment gains from family training with adolescents who have defiance or ODD is a most important one deserving of more research.

Generalization of Treatment Gains to School Settings

Do the gains achieved from behavioral family therapy programs like this one generalize 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 teen behavior at school. Unfortunately, most studies of children with behavior problems have not found generalization of treatment gains to school settings (Barkley et al., 2000; Horn, Ialongo, Greenberg, Packard, & Smith-Winberry, 1990; Horn, Ialongo, Popovich, & Peradotto, 1987; McMahon & Forehand, 1984; Patterson, 1982). But at least one did so (Strayhorn & Weidman, 1989, 1991). Some studies have found that children whose parents received parent training, or at least a subset of such children, manifest improved school conduct, but just as many children either showed no change in school behavior or demonstrated

a significant worsening of such behavior (Firestone, Kelly, Goodman, & Davey, 1981; McMahon & Forehand, 1984). In fairness to the investigators conducting this research, none of the studies that failed to find generalization of treatment effects to school settings directly targeted school behavior as part of the parent training program. Studies have shown that when school misbehavior is targeted, as when using daily school behavior report cards, conduct improves (Atkeson & Forehand, 1978; Fabiano et al., 2010; Jurbergs et al., 2008, 2010; Kelley, 1990). This finding was one of the reasons why we have added a session to the original version of Barkley's program to help parents assist teachers with improving their child's school conduct and performance through the use of home-based reward programs and homework goal-setting procedures. Such procedures have been shown to result in improved teacher ratings of school behavior and improved homework performance. For now, we recommend that therapists using traditional behavioral parent training programs that do not directly target school misbehavior should not state that generalization of gains to school behavior is likely to occur.

In the case of clinic-referred adolescents undergoing similar types of parent and family training, far less research exists on the issue of generalization of treatment effects across settings. Dishion and Andrews (1995) found only a marginally significant immediate treatment effect of parent training on teen school behavior problems (as rated by teachers). And this effect dissipated to some degree over the 1-year follow-up period. Thus it seems wise to continue to counsel families that parent/family training programs with teens, as with children, are unlikely to result in automatic improvements in school conduct and performance in the absence of specific treatment methods designed to promote such generalization or active treatment in the school.

Predictors of Success and Failure

Research on similar such programs when used with children, especially the behavior management methods taught initially in this program, suggests a number of factors that are related to program effectiveness as indexed by number of sessions attended, completion of training or return for follow-up, and of course improvement in parent–child conflicts. There is no reason to believe similar factors would not emerge as moderators of treatment success with adolescents. Therapists should consider such factors as a possible basis on which to assign families to group parent training (good likelihood of responding with some assistance) versus individual training (higher number of risk factors; need for more intensive personal counseling) or to offer parent training versus other, more parent-focused treatments (Holden, Lavigne, & Cameron, 1990).

Child Factors

Far less is known about the characteristics of adolescents related to therapeutic response to programs such as ours than is known for children. Just a few child characteristics have been identified. One relatively consistent predictor of diminished effectiveness noted

above is the child's age. Preschool children (< 6 years old) appear to have the highest rates of positive responding to behavioral parent training programs (65% or more); school-age children are somewhat less likely to improve (50–64%) (Anastopoulos et al., 1993; Dishion & Patterson, 1992; Strain et al., 1982; Strain, Young, & Horowitz, 1981). Our study of adolescents found a response rate at this older age to be lower (25–35%; Barkley, Guevremont, et al., 1992). However, this effect of age actually might be an inverted-U-shape or curvilinear function, in that within the preschool-age group, there exist higher parental dropout rates and lower degrees of responding associated *with younger* ages of the children (Holden et al., 1990). In the elementary age range, sometimes the effect of age has been found to be the opposite of that noted above, with parents of younger children more likely to discontinue treatment prematurely (Firestone & Witt, 1982). Besides age, higher intelligence or mental age in children has also been associated positively with better response to parent training or parental persistence through a parent training program (Firestone & Witt, 1982).

Another child factor is severity of the child's behavioral problems, and specifically their defiance. Some research finds that child defiance is related to more limited treatment efficacy and a greater likelihood of parental premature termination from training (Dumas, 1984; Holden et al., 1990). Also, higher levels of childhood internalizing symptoms (anxiety, depression, withdrawal) may also predict lesser degrees of effectiveness of such programs (Drugli et al., 2010). But this relationship of severity of child psychopathology to training outcomes might be explained by another one. This mediator of treatment response is 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 simply serves as a marker for more important parent factors (see "Parent Factors," p. 13). Those factors may cause parents to terminate training prematurely or to fail to respond positively to the training. In contrast to these findings, other studies found that children with more severe levels of disruptive behavior benefited the most from behavioral parent training (Hautmann et al., 2010). We know of at least one study that found 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). But this finding has not been seen in other studies, so it may not be reliable. To make matters more confusing, in our earlier research on teens using this program, we were unable to identify pretreatment variables that significantly predicted the degree of change that occurred during treatment (Barkley, Guevremont, et al., 1992; Barkley et al., 2001).

Whereas that earlier research showed that between 30 and 70% of families of defiant teens with ADHD were normalized (fell below the 75th percentile) after treatment, depending on the measure we examined (Barkley et al., 2001), the inverse of these statistics shows that at least a substantial minority are not normalized. As noted above, adolescents with ADHD who are also defiant and whose parents undergo this training program should not be guaranteed to be "recovered" or normalized in all of their behavioral problems as a consequence of this program. Research with both children and adolescents suggests that defiant and hostile behavior is likely to improve the most from this program, and ADHD symptoms are likely to improve only somewhat or not at all (Anastopoulos et

al., 1993; Barkley, Guevremont, et al., 1992; Johnston, 1992). For this reason, and others, we suggested above that medications may need to be added to the treatment package provided for defiant teens having ADHD so as to address that comorbid ADHD that may interfere with treatment response (Firestone et al., 1981).

One characteristic of the child or teen that may be reliably associated with outcomes of therapy may be symptoms of psychopathy. These symptoms include lack of conscience, empathy, and guilt and are often referred to as a callous–unemotional (CU) constellation or component of 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 traits makes distinct predictions across time beyond just the symptoms of the other disruptive behavior disorders like ADHD, ODD, and CD in that it 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, Carey, Willoughby, King, & Andrade, 2007). Low heart rate has also been found in children with conduct problems prior to behavioral parent training to be a predictor of decreased effectiveness of the training program (Stadler et al., 2008). This association is relevant because such low heart rate may be a marker for low autonomic arousability more generally, and low autonomic activity is associated with a greater likelihood of CU traits and persistent conduct problems (Stadler et al., 2008). In this study low heart rate, therefore, may have simply served as an index for higher CU traits in these children prior to training.

Where ADHD medications are used, therapists may find that there is sometimes little additional benefit provided to families by adding a parent training program, as was found in some studies of ADHD children (Abikoff & Hechtman, 1995; Firestone et al., 1981; Horn, Ialongo, Pascoe, Greenberg, Packard et al., 1991). Given that ADHD medications have proven to be among the most effective treatments for children and adolescents with ADHD (MTA Study Group, 1999; Swanson, McBurnett, Christian, & Wigal, 1995), we have amended the training program to suggest a discussion of this issue for parents of ADHD teens in the initial session of the program, when the subject of ADHD arises. Therapists wishing more information about psychopharmacology for ADHD children and teens to share with parents are referred to the book by Wilens (2008).

Parent Factors

Given the available research, one could argue that parent factors have a greater influence on response to behavioral family therapy. This makes intuitive sense given that it is primarily the parents who are participating in, implementing, and maybe even benefiting from the therapy. Research on behavioral parent training for child behavior problems finds that parents who are relatively younger than the average of those seeking training, are less intelligent, have less than a high school education, and are of lower socioeconomic status (SES) usually do not have as much success as do others (Dumas, 1984;

Firestone & Witt, 1982; Holden et al., 1990; Knapp & Deluty, 1989; Webster-Stratton & Hammond, 1990). Even so, low SES has not always been noted to influence treatment response to behavioral parent training with children (McMahon & Forehand, 1984; Rogers, Forehand, Griest, Wells, & McMahon, 1981). Family ethnicity may be another factor affecting treatment outcome. One study did examine this issue. It noted that minority groups had more dropouts and less change in parent and child behavior than the majority group (Holden et al., 1990). But in this study the family's social class showed the same relationship to poor treatment response, and so it may be SES rather than ethnic group that mediated this difference, especially given the differential representation of minority groups across SES levels. Not surprisingly, some studies found the number of required sessions the parents' actually attended to be related to better treatment efficacy (Strain et al., 1981). Finally, a lower sense of parenting self-efficacy has been shown to be a predictor of greater improvement in child behavior in some behavioral parent training programs (Hautmann et al., 2010).

Once more, far less research exists on parent factors mediating treatment response in teens in family therapy than has occurred with behavioral parent training using children. Whether the parent factors noted above are associated with success in family treatments focusing on adolescents with behavior problems is uncertain, given the relatively limited research examining this issue with teens in treatment.

More than 30 years ago, studies observed diminished benefits from parent training and even higher dropout rates from training with parents (mothers) who are socially isolated from adult peers in their community. This was even more so for those mothers who encountered aversive interactions with their extended family (Dumas, 1984; Dumas & Wahler, 1983; Salzinger, Kaplan, & Artemyeff, 1983; Wahler, 1980; Wahler & Afton, 1980). In those studies, even families that improved may have a greater likelihood of relapse after training if such social isolation existed in a family (Dumas & Wahler, 1983; Wahler, 1980; Wahler & Afton, 1980). Known as maternal insularity (isolation), this factor when combined with low SES accounted for nearly 50% of the variance in treatment effectiveness (Dumas & Wahler, 1983). If replicated by other studies, such robust findings would indicate that these may be two of the most important factors in assessing the likelihood that a family will respond positively to behavioral parent training. These isolated families may require greater involvement and training from the therapist as well as more time for practice to benefit from the program (Knapp & Deluty, 1989). Also, the mothers' social isolation may need to be improved before undertaking training or during training to optimize results (Dadds & McHugh, 1992; Dumas & Wahler, 1983; Wahler, Cartor, Fleischman, & Lambert, 1993).

Also not surprising, parental psychopathology (psychosis, severe depression, alcohol/drug dependency, etc.) may moderate or even mediate treatment response to family therapies such as this one (Chronis et al., 2004; Chronis-Tuscano et al., 2011; Patterson & Chamberlain, 1994; Sonuga-Barke, Daley, & Thompson, 2002). Early research showed that such parents did not do well in behavioral training (Patterson & Chamberlain, 1994). Those parents start out more resistant to training and to doing homework assignments and seem to remain so throughout treatment. Parental negativity, helplessness, and anger are factors in some research predicting parents who do not respond well in such training

programs; they are also more likely to drop out of treatment (Fernandez & Eyberg, 2009; Frankel & Simmons, 1992). Some evidence suggests that providing training in more effective general problem-solving skills along with specific training in child behavior management may facilitate improved treatment results (Pfiffner et al., 1988; Prinz & Miller, 1994; Spaccarelli et al., 1992). This may also prove true for training parents in anger-management skills prior to or as an adjunct to parent training in child management (Chacko et al., 2009; Goldstein, Keller, & Erne, 1985; Sanders, 1996).

One now well-established parent characteristic that adversely affects parent training is parental ADHD. ADHD in children is known to have a strong hereditary predisposition (see Nigg, 2006) with an average of 25–35 % of immediate family members likely to have the disorder. This means that there is at least a 50% chance that one of the biological parents of the child with ADHD also has ADHD. Given that up to 65% or more of children with ODD are likely to have ADHD, therapists working with families of children with ADHD can expect to see an elevated rate of parental ADHD as well. Parental ADHD has detrimental effects on parenting behavior (Chen & Johnston, 2007; Chronis-Tuscano, Raggi, et al., 2008; Griggs & Mikami, 2011), and is a strong predictor of parenting distress (Theule, Wiener, Rogers, & Marton, 2011). It is not surprising, then, that adult ADHD is 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 ADHD adult (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). We believe such findings argue for the screening of parents entering training for ADHD especially if the target child carries such a diagnosis. This screening 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 enrollment in a parent training program.

Marital discord is also associated with lower effectiveness of parent training (Chronis et al., 2004; Forehand & McMahon, 1981; Patterson, 1982; Webster-Stratton & Hammond, 1990). Providing marital therapy in these cases might prove beneficial to training in behavior management (Dadds, Schwartz, & Sanders, 1987). Or divorce counseling may be needed to help resolve their marital problems before parent training in child management is offered. Another factor predicting treatment success is single parent status, with single-parent families responding less well than two-parent households (Chronis et al., 2004; Drugli et al., 2010; Strain et al., 1981, 1982; Webster-Stratton & Hammond, 1990). Single mothers do respond positively to behavioral training (Chacko et al., 2008, 2009), although their degree of improvement in child defiant behavior may be less than the gains seen in intact families (Chacko et al., 2009).

Some research shows that greater life stress within the past year may be associated with lower treatment response (Webster-Stratton & Hammond, 1990). It is not clear as yet whether these same predictors would apply equally well to predicting response to

family training programs involving teens with conduct problems, but there is little reason to believe that they would not apply.

Therapist Factors

As discussed in the manual for Barkley's parent training program (Barkley, 2013a), some early attention has been paid in research to the role that therapist factors play in the success of behavioral parent training programs. Such factors long have been known to be important in studies of psychotherapy outcomes with adults (Garfield & Bergen, 1986) and, more recently, in psychotherapy studies with children (Crits-Christoph & Mintz, 1991; Kazdin, 1991). 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). Among experienced therapists, those who tend to teach and confront parents are more likely to encounter resistance to training than are those who facilitate and support parents in the process of training (Patterson & Forgatch, 1985). Therapists working with families of seriously antisocial children can expect to encounter resistance from most families at the start of treatment, and such resistance is likely to increase until the midpoint of treatment. In less serious cases and with parents of younger children, therapists may address and resolve this resistance by treatment termination (Patterson & Chamberlain, 1994). In more difficult cases, resistance is likely to persist at high levels, foreboding fewer changes in parental management skills and an overall less positive outcome. Such client resistance is likely to provoke the therapist to confront behaviors, but this, as noted above, may increase client resistance. Thus, parent-training therapists must achieve a delicate balance between teaching and confronting parental resistance and providing facilitation and support to motivate the parents to undertake behavioral change (Patterson & Chamberlain, 1994). It has been our experience in working with families of clinic-referred teenagers with conduct problems that the issue of family resistance to change is even more applicable (and more frustrating to therapists!) than it might be in families of children with behavior problems.

Program Factors

As implied above, there may be factors associated with the family therapy program for defiant teens itself that affect response to treatment, such as the kind of therapy conduct (behavioral vs. traditional) and what content is taught first (behavior management techniques or PSCT). Although not the case yet for behavioral family therapy for adolescents, there have been sufficient studies of behavioral parent training programs for children 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 program's effectiveness. One such analysis was conducted by Kaminski and colleagues (Kaminski et al., 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 might be expected to result in greater effectiveness in improving parent–teen conflict and teen behavior and adjustment than programs not utilizing these methods.

Organization of the Manual

Like its child-focused counterpart (Barkley, 2013a), this training manual has been organized into three sections: Part I provides information on the background of this program, its theoretical and research basis, methods of evaluating oppositional and defiant teen behavior both before and after treatment, and various prerequisite information to consider before undertaking this program of therapy. As noted earlier, much of this information has been taken directly from the earlier manual on defiant children (Barkley, 2013a) with modification, as appropriate, for an adolescent population. Part II provides detailed instructions on conducting each of the 18 steps of the program. Clinicians should acquaint themselves thoroughly with the steps and periodically review the contents of each one while training families. Each step in this section begins with the goals of that step followed by an outline of the material to be taught in that step such that a clinician experienced in this program need only refer to these outlines during training sessions with a family. Part III contains the assessment tools that are used during the pre- and posttreatment evaluation of the teenagers and their families as well as the handouts to be used with each step of the program.

Summary

The procedures we have set forth in this manual are designed specifically for families with adolescents who are noncompliant, defiant, or oppositional and who range in age from 13 to 18 years. The methods are meant to be employed by experienced clinicians with adequate training in delivering psychological services to families of defiant adolescents. Although effective, the success of these procedures depends on the nature and severity of the teen's problems, the teen'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, we believe that this program can be beneficial in diminishing or eliminating parent–adolescent conflict and behavior problems in teenagers.

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