Article

The Use of a Behavioral Parent Training Program for Parents of Adolescents

Annette K. Griffith

Abstract: *Adolescence can be a period of increased problem behavior, and parents often report this stage of development as being one of increased conflict with high levels of parenting-related stress and lower levels of confidence in parenting abilities. As a result, parents of adolescents seek out parenting information and support much more often than do parents of younger children. However, most parent training programs have been developed for parents of children aged 12 and under; very little is known about the use of parent training programs for parents of adolescents. Therefore, the purpose of this article was to examine the use of a behavioral parent training program for a population of parents with adolescent-aged youth to identify the characteristics of participants and examine pre-post changes. On average, both the parents and their youth had a high number of risk factors (e.g., substance abuse, domestic violence, clinical levels of problem behavior) when the program began. Significant changes were observed across both youth behavior and parent stress. Implications and directions for future research are discussed.*

Introduction

During adolescence, youth engage in higher levels of oppositional and defiant behavior as they seek to become more independent from their families (Schroeder & Gordon, 2002). While most youth typically outgrow these behaviors, for others they can become more severe and can persist over time. In the 2004-2005 school year, over 315,000 youth aged 12 to 17 were identified with an emotional or behavioral disorder (U.S. Department of Education, 2007). While this is a substantial number, it is suspected that many more youth engage in serious levels of problem behavior than are identified within the school system. It has been suggested that as many as 20% of youth engage in levels of problem behavior that are severe enough to warrant a psychiatric diagnosis (American Academy of Pediatrics, 2004; Gresham, 2005). In addition, Roberts, Roberts, and Xing (2007) reported that by the age of 16, 36.7% of U.S. youth could have qualified for at least one Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association [APA], 1994) diagnosis (e.g., conduct disorder, oppositional defiant disorder, attention deficit hyperactivity disorder, bipolar disorder) and 32.6% could have qualified for two diagnoses.

These high rates of problem behavior and mental health diagnoses are particularly concerning, especially for parents, as there is a significant positive correlation between engagement in problem behavior during adolescent and engagement in criminal or antisocial behavior as an adult. For instance, Copeland, Miller-Johnson, Keeler, Angold, and Costella (2007) reported that when youth were followed over time, those who had behavior problems (e.g., conduct disorder, oppositional defiant disorder, or attention-deficit hyperactivity disorder) between the ages of 9 and 16 were more likely to engage in criminal activities between the ages of 16 and 21. Specifically, they found that of those youth who displayed problem behavior during childhood and early adolescence, only 18.2% did not have any history of criminal involvement by the age of 21. They reported that 47% had engaged in serious or violent offences, 36.8% had engaged in moderate offences, and 21.9% had engaged in minor offenses. Although not all youth who display problem behavior will go on to display antisocial behavior in adulthood or have poor long-term outcomes (O'Reilly, 2005), the majority of adults who display such behaviors have a long history of doing so. For example, Hester, Beltodano, Gable, Tonelson, and Hendrickson (2003) reported that 74% of 21-year-old adults who had an emotional or behavioral disorder reported that they engaged in problem behavior as children or adolescents.

As adolescence can be a period of increased problem behavior, parents report this stage of development as being one of increased conflict with high levels of parenting-related stress (Tucker, McHale, & Crouter, 2003) and lower levels of confidence in parenting abilities (Becker, Hogue, & Liddle, 2002). As a result, parents of adolescents seek out parenting information and support much more often than do parents of younger children (Bogenschneider & Stone, 1997). In a recent survey on the behavior of adolescents, parents reported that adolescent problem behaviors were common and that they desired information on how to help their adolescents increase compliance, decrease conflict with parents and siblings, and manage their emotions (Ralph et al., 2003). While parents may often feel

that they have less of an impact on the behavior of their adolescents than they do the behavior of younger children, research has indicated that parents continue to influence the behavior of their youth as they make the transition into adolescence and adulthood (Berg-Neilsen, Viken, Dahl, 2003; Coombs, Paulson, & Richardson, 1991). Metzler, Biglan, Ary, and Li (1998) found that positive parenting practices such as monitoring, rule setting, and reinforcement for positive behaviors, were associated with lower levels of negative adolescent behaviors (e.g., antisocial behavior, substance abuse).

Because positive parenting behaviors can have an influence on adolescent behavior and can increase the likelihood that adolescents will engage in prosocial and adaptive behaviors, interventions aimed at influencing parent behavior may be an ideal way to address the needs of adolescent-aged youth who engage in or are at risk of engaging in problem behavior. Although there is variability in the way that interventions to alter parent behavior can be delivered (e.g., family therapy, in-home family services), parent training programs are one of the most commonly used interventions for families of children with and at risk for behavioral problems (Kazdin, 2005; Maughan, Christiansen, Jenson, Olympia, & Clarke, 2005). As a result, there have been a sizeable number of studies conducted on parent training programs. Maughan et al. (2005) reported that there have been over 400 data-based studies published on the topic. The effectiveness of parent training programs has been assessed in several reviews of the literature (Bunting, 2004; Lundahl, Risser, & Lovejoy, 2006; Maughan et al., 2005; Reyno & McGrath, 2006). Overall, the findings suggest that parent training is an effective intervention and has positive effects on a variety of outcomes for both parents and youth (e.g., parenting skills, parental stress and anxiety, youth behavior, parent-youth relationships; Assemany & McIntosh, 2002; Lundahl et al., 2006; Maughan et al., 2005; McCart, Priester, Davies, & Azen, 2006). The vast majority of these studies, however, have been conducted for families of young children, under the age of 12 (Maughn et al, 2005; McCart et al., 2006). As a result, the evidence base for the effectiveness of parent training interventions for adolescents is limited (Kazdin, 2005). Those studies that have examined the effectiveness of various parent training programs for parents of adolescent-aged youth have focused on the prevention of very specific problems (e.g., substance abuse, problems during the transition to high school) rather than addressing the needs of families of youth with already existing, broad types of problem behavior (Ralph & Sanders, 2003). Very little is known about the needs of parents of adolescents who participate in these programs, whether or not parent training interventions are useful for parents of adolescents who are already engaging in problem behavior, or the effects of parent training interventions for both parents (e.g., parent stress) and youth (e.g., youth behavior). Therefore, there is a need for additional research that can examine the use of parent training programs for families of adolescent-aged youth, particularly families of youth who may have high levels of risk or who are already engaging in high levels of problem behavior.

The purpose of the current study was to examine the use of a behavioral parent training program for a population of parents with adolescent-aged youth. Specifically, the study sought to: (a) examine the characteristics of the parents and youth who became involved with the program to identify the needs of families who seek out or are referred to the program, and (b) the changes that occurred for parents and youth following parent participation in the program. Specifically, changes in parenting-related stress and youth externalizing behavior were examined.

Method

Participants

The Common Sense Parenting (CSP) program is advertised in the local community through flyers (sent to community agencies and doctors' offices) and newspaper advertisements. In addition to parents who sought out the program on their own, parents were also referred through child welfare, juvenile justice, local pediatric clinics, and local school districts. To participate, parents had to: (a) be aged 19 or over, (b) be present at the first class session of the CSP program, (c) have not previously participated in a CSP program, and (d) have an adolescent-aged youth between 12 and 16 years old. Forty-two parents met the criteria to participate and consented to be a part of the study.

Common Sense Parenting Program

The CSP program is a behavioral parent training program for parents of children and youth aged 6 to 16. The program is based on operant learning principles (e.g., positive and negative reinforcement, positive and negative punishment, stimulus control; Kazdin, 2005) with training methods founded in Social Learning Theory (e.g., modeling, training in self-instruction; Bandura & Walters, 1963). It was designed to teach parents positive parenting techniques and behavior management strategies to help increase positive behaviors and decrease negative behaviors.

The program is taught in a series of six 2-hour sessions during which parents work with a parent facilitator in a group format of approximately 6 to 12 parents. The session topics include: (a) Parents as Teachers, (b) Encouraging Good Behavior, (c) Preventing Problems, (d) Correcting Problem Behavior, (e) Teaching Self-Control, and (f) Putting It All Together. For each of the sessions, parents use a parent manual (Burke, Schuchmann, & Barnes, 2006) that describes the CSP skills and provides parenting advice, scenarios, a CSP skill card that can act as a quick reference for parents, and a personal parenting plan workbook where the parents complete written activities and create their personal parenting plans. The CSP sessions center on five key training components: (a) review, (b) instruction, (c) modeling, (d) practice, (e) feedback, and (f) summary. In addition, between class sessions, parents are assigned readings from the program manual (Burke et al., 2006) and homework activities from the parenting plan workbook to become more familiar with and practice the use of the newly taught skills.

Measures

Social History Questionnaire

The Social History Questionnaire is a parent-report form designed specifically for this study to obtain information about a parent and his or her youth in regards to demographics and social history factors (e.g., education level, history of domestic violence). If a parent had more than one youth between the ages of 12 and 16, he or she was asked to select the one youth who presented the greatest level of problem behavior. The Social History Questionnaire was comprised

of 10 questions across four areas: (a) parent education and employment (e.g., level of education completed, type of employment); (b) parent history (e.g., history of domestic violence, substance abuse, mental illness); (c) youth history (e.g., history of physical abuse, psychiatric hospitalization, substance abuse); and (d) parent belief about the potential benefits of the CSP program in reducing levels of youth problem behavior.

Child Behavior Checklist (Externalizing Scale)

The Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2001) is a 120-item parent-report measure that was designed to assess the level of child problem behavior. Because the CSP program focuses primarily on child externalizing behavior, the CBCL Externalizing Scale was used for this study. The CBCL Externalizing Scale is comprised of 33 questions and covers both aggressive (e.g., gets in many fights, physically attacks people) and rule-breaking behavior (e.g., steals at home, uses drugs for nonmedical purposes). The items of the CBCL Externalizing Scale are scored on a 3-point Likert-type scale ranging from 0 (i.e., Not true) to 2 (i.e., Very true or often true). The psychometric properties of the CBCL have been well established. Specifically, the Externalizing Scale has adequate levels of content, construct, and convergent validity. Inter-rater, test re-test, and long-term reliability coefficients ranged from .66 to .90 (Achenbach & Rescorla, 2001).

Parent Stress Index 3rd Edition—Short Form

The PSI-SF (Abidin, 1995) was developed to assess an adult's level of stress in association with parenting. This parent-report measure was selected because previous research has shown significant improvements in levels of parent stress following parent participation in behavioral parent training programs (Ralph & Sanders, 2003). Two subscales of the PSI-SF were used for this study: (a) the Parental Distress Scale, and (b) the Parent-Child Dysfunctional Interaction Scale. These two subscales were selected because they measure constructs targeted by the CSP program; specifically, parent stress related to childrearing and parent interactions with their youth. Each of these subscales is comprised of 12 items that are rated using a 5-point Likert-type scale ranging from 1 (i.e., Strongly Disagree) to 5 (i.e., Strongly Agree). Research on the PSI-SF has shown adequate psychometric properties. Specifically, test-retest reliabilities ranged from .68 for the Parent-Child Dysfunction Scale to .85 for the Parent Distress Scale and convergent validity with the full version of the PSI ranged from .87 to .95 (Abidin, 1995).

Data Collection

Prior to the first CSP session parents were provided with an information packet that contained each of the three data collection forms to be completed (i.e., Social History Form, CBCL, PSI-SF). Parents completed the same information packet, with the exception of the Social History Form, immediately following the last CSP session. All of the measures were self-report and parents completed them independently. If any parents had difficulties with reading the items on the form, the items or entire forms were read aloud to those parents.

Treatment Integrity

To obtain information on adherence to the program content, two program sessions (Session One and Session Five) for each of the 14 classes were observed. Previous work on the development of the CSP treatment integrity forms indicated that the level of treatment integrity for both Session One and Session Five were highly, positively correlated with the overall level of treatment integrity for the entire program (Burke, 1995). Therefore, treatment integrity data were collected for these sessions only. When treatment integrity data were examined, it was found that overall mean scores ranged from 1.81 to 2.33 (on a scale from 1 to 3), with a mean score of 2.12 (SD = 0.13). A score of 2.0 indicates adequate implementation (i.e., implementation of necessary components occurred, but not exactly as specified). Of the 14 classes for which treatment integrity data were collected, only two had scores below 2.0. These two classes were attended by 13.9% (n = 10) of parents.

Data Analysis

Data from this study were analyzed in two phases. In the first phase, descriptive analyses (e.g., frequencies, means, standard deviations) were conducted to provide a summary of the characteristics of parents and children who participated in the CSP program. Second, analyses were conducted to examine changes that occurred from pretest to posttest. Paired t-test analyses were conducted to examine the statistical significance of pre-post changes that occurred in parents and children during the course of the study. Cohen's d effect sizes were also conducted to determine the magnitude of the changes. In addition, frequencies were obtained to identify changes in the numbers of parents or youth who were reported to have scores in the clinical level before and after the CSP program.

Results

Descriptive Analyses

In order to obtain information about the parents who participated in the CSP program and their youth, a series of descriptive analyses were conducted. Results for parents and youth are presented in Tables 1 and 2 respectively. Overall, both parents and youth had higher frequencies of risk than would be expected for the general population (National Institute on Drug Abuse [NIDA], 2008; National Institute for Mental Health [NIMH], 2008; Samuelson & Campbell, 2005). Although over one third of parents reported experiencing domestic violence, experience of risk was particularly high for the youth; almost half (42.9%) had experienced at least one psychiatric hospitalization and almost 10% had attempted suicide. In addition, parents reported clinical levels of stress related to parent-youth interactions and clinical levels of youth externalizing behavior (see Table 3).

Prior to beginning the CSP program, the majority of parents (69%) had expectations that the program would be beneficial in helping them to reduce levels of youth problem behavior. Only 19% of parents did not agree that it would be helpful. During the course of the CSP program, parents attended the majority of the class sessions. The number of classes attended ranged from four to six (the program is comprised of six class sessions), with a mean of 5.46 (SD = 0.61).

Table 1

Parent Demographics and Social History Information

	Frequency	Percent
Gender		
Female	24	57.1%
Male	11	26.2%
Unknown	7	16.7%
Education Level		
No High School	1	2.4%
Some High School	1	2.4%
High School Graduate	12	28.6%
Some College	18	42.9%
College Graduate	10	23.8%
Socioeconomic Level (Hollingshead Index)		
Lower	4	9.5%
Lower/Middle	7	16.7%
Middle	23	54.8%
Upper/Middle	4	9.5%
Upper	0	
Unknown	4	9.5%
Experienced Risks		
Domestic Violence	15	35.7%
Mental Illness	7	16.7%
Conviction of a Crime	7	16.7%
Substance Abuse	5	11.9%
Psychiatric Hospitalization	4	9.5%

Table 2

Youth Demographics and Social History Information

	Frequency	Percent
Age		
12	3	7.1%
13	3	7.1%
14	9	21.4%
15	16	38.1%
16	11	26.2%
Gender	15	35.7%
Female	27	64.3%
Male		
Ethnicity	32	76.2%
Caucasian	3	7.1%
African American	1	2.4%
Hispanic	6	14.3%
Other		
Experienced Risks	18	42.9%
Psychiatric Hospitalization	7	16.7%
Substance Abuse	7	16.7%
Identification for Special Education	6	14.3%
Physical Abuse	4	9.5%
Attempted Suicide		

Table 3

Changes From Pretest to Posttest

Measure	N	Pretest Mean (SD)	Posttest Mean (SD)	t-value	Degrees of Freedom	p-value	ES (d)
CBCL Rulebreaking	41	66.17 (8.62)	60.90 (7.09)	4.01	40	< .001	.67
CBCL Aggressive	41	68.83 (9.92)	62.56 (7.59)	3.69	40	.001	.71
CBCL Externalizing	41	68.00 (7.80)	62.02 (7.02)	4.47	40	< .001	.81
PSI-SF Parent Distress	42	27.43 (6.37)	24.02 (7.05)	3.80	41	< .001	.51
PSI-SF Parent Child Dysfunctional Interaction	42	31.76 (8.06)	26.88 (8.53)	4.16	41	< .001	.59

Changes From Pretest to Posttest

In order to examine the changes from pretest to posttest, paired t-test analyses were conducted. Results are presented in Table 3. For each of the measures, there were significant differences from pretest to posttest in the anticipated directions. Specifically, there was a significant decrease from pretest to posttest for the two subscales of the PSI-SF and for the CBCL. With the exception of the Parent Distress subscale of the PSI-SF, pretest scores were in the clinical range. Posttest scores for the CBCL subscales dropped to the borderline range and the Parent Child Dysfunctional Interaction subscale of the PSI-SF dropped to just above the clinical cutoff score of 26. Based on standards put forth by Cohen (1988), the effect sizes were all medium (.50 to .80) to large (over .80).

Although the t-test analyses indicated that changes across each measure were statistically significant, frequencies were also obtained to examine changes in the distributions of scores. Specifically, frequencies were obtained to determine the percentages of parents who had scores that reduced from the clinical to normal ranges of the PSI-SF and the percentages of youth who had scores that reduced from the clinical to borderline to normal ranges of the CBCL. These findings are presented in Table 4. Across all subscales of all measures, there were greater percentages of both parents and youth with scores in the normal level at posttest than there had been at pretest.

Discussion

This study was conducted to address the need for research on the use of parent training programs for parents of adolescent-aged youth. The specific purpose of this study was to conduct an evaluation of the CSP program to determine: (a) the characteristics of the parents and youth who became involved to identify the needs of families who seek out or are referred to the program and (b) the changes that occurred after parent participation in the program.

Descriptive Analyses

Examination of the demographics and social history of the parents and youth who were involved in the program indicated that, at the time the program began, many families had higher levels of risk than would be expected in the general population. For example, 35% of parents reported experiencing domestic violence, compared to 8% to 12% of the general population; 12% had experienced substance abuse, compared to 8.2% of the general population; and 9.5% of youth had attempted suicide, compared to 6.9% nationally (NIMH, 2008). The presence of these risk factors in addition to clinical levels of parental stress and child problem behavior indicate that these families likely had a high level of need for intervention. As such, the CSP program really was serving as an intervention program opposed to one of prevention. Although the CSP program was originally intended to be a prevention program, it has evolved over time to address the needs of parents who seek an intervention program by including information on how to deal with youth who may be demonstrating out of control behavior (e.g., temper tantrums) and discussions about how to involve school personnel and how to seek additional family supports (e.g., accessing mental health agencies). The addition of these services was due to previous research findings that the families who sought out the program often had a need to deal with high levels of already occurring problem behavior (Friman, Soper, & Thompson, 1993). This was true for all age levels, but was particularly true for parents of older youth who engaged in higher levels of problem behavior (Ruma, Burke, & Thompson, 1996). While it is likely that there are families who would benefit from preventive programs such as those aimed to reduce substance abuse or prevent problems during the transition to high school, the current findings suggest that there is also a need for intervention programs that are aimed at parents who have youth already engaging in high levels of externalizing problem behavior. This is consistent with the findings of Ralph and Sanders (2003) who reported that parents of adolescents want information on how to deal with already existing behavior problems (e.g., conflict within the family, dealing with emotions).

Table 4

Changes in Distributions of Scores From Pretest to Posttest

	Percentage With Normal Scores		Percentage With Borderline Scores		Percentage With Clinical Scores	
	Pretest	Posttest	Pretest	Posttest	Pretest	Posttest
CBCL						
Rulebreaking	23.8	36.6	14.3	24.4	61.9	39.0
Aggressive	16.7	39.0	4.8	17.1	78.6	43.9
Externalizing	19.0	39.0	9.5	17.1	71.4	43.9
PSI						
Parental Distress	85.7	90.5			14.3	9.5
Parent Child Dysfunctional Interaction	14.3	42.9			85.7	57.1

Changes From Pretest to Posttest

Across all measures there were significant improvements, with large-sized effects. This is consistent with findings from previous studies of the CSP program conducted with parents of youth aged 6 to 16 (Thompson, Grow, Ruma, Daly, & Burke, 1993). These findings are promising, as they suggest that behavioral parent training programs may be helpful for high-risk families whose adolescent-aged youth exhibit clinical levels of problem behavior. Although changes on the CBCL Externalizing scale indicated that, on average, scores were reduced only to the borderline range ($M = 62.02$, $SD = 7.02$), the percentage of parents who reported their youth in the normal range increased by 20% and the percentage that reported their youth in the clinical range decreased by almost 30%. Findings were similar for the Parent-Child Dysfunctional Interaction subscale of the PSI-SF. For a 6-week program that did not specifically target families of adolescents with such high levels of risk (e.g., psychiatric hospitalizations, substance abuse, suicidality, clinical levels of problem behavior), these results are impressive.

Although these findings suggest that the program may be effective for reducing levels of parent stress and decreasing rates of youth externalizing behavior, because the study used a pre/post design and did not include comparison groups, this cannot be definitively determined. Several factors, other than the CSP program, may have been responsible for the observed changes. Factors such as regression to the mean or confounding variables (e.g., interactions with the facilitator and other parents, time out of the home, expectations about the CSP program) may have contributed to outcomes either wholly or in part. For example, previous studies found that a large number of mothers who participated in parent training programs had few informal supports such as family or friends (Dumas, 1984; Webster-Stratton, 1990) and that parent training programs offered in groups had the benefit of a "support group"-like atmosphere that allowed for socialization with other parents also experiencing difficulty with child behavior (Dumas, 1984; Dumas & Wahler, 1983). Although social insularity was not a variable measured in the present study, parents were informally observed to form friendships with one another during the course of the program. Therefore, it is possible that the changes on outcome measures were the result of a socialization aspect of the program, or other confounding variables, rather than the specific CSP content. In order to evaluate the effects of the program content controlling for other factors such as socialization, future studies need to be conducted that use more rigorous research designs (e.g., waitlist control, randomized clinical trial).

Limitations

In addition to a lack of a control group, there are several limitations of this study that should be noted. First, the participants in the study were all residents of one medium-sized city in the Midwest. As such, the parents and youth involved in the current study may differ on important characteristics from those in other areas of the United States (e.g., there was limited representation of various racial/ethnic groups with over 75% of children being Caucasian). These differences may affect the generalizability of the current results to parents and youth in other geographic areas. As such, additional research is needed on more diverse and nationally representative samples.

Second, all of the measures used in the present study were parent self-report measures. Although Baydar, Reid, and Webster-Stratton (2003) found that self-report measures of parenting practices and child behavior were highly correlated with staff observations, the validity of self-report measures have been questioned in many other studies (Wickstrom, Jones, & LaFleur,1998). In research on parenting and parent training programs, it has been found that parents who have high levels of stress or depression may overestimate their children's levels of problem behavior (Dumas & Wahler, 1983). As such, findings obtained using self-report measures should be viewed with caution. Additional research is needed that uses other forms of data collection, such as observation.

Finally, the findings of the current study are based upon the 42 parents who met all of the requirements for participation and who completed the data collection process. Although previous research did not identify any demographic differences between parent training program completers versus noncompleters (Werba, Eyberg, Boggs, & Algina, 2006), it is not possible to determine how parents who chose to participate may have differed from those who did not. Future studies would benefit from attempting to determine reasons why parents do not choose to participate in studies and why they may not complete parent training programs and what outcomes are like for these families.

Future Research

In addition to examining the effects of behavioral parent training programs for parents of adolescents using more rigorous research designs, future research needs to be conducted to identify subgroups that may exist (e.g., families who need prevention versus intervention, families with different types of risk). Effects of parent training programs need to be examined for these different groups, and the specific variables that may serve to predict their outcomes need to be identified. In addition, there needs to be an increased emphasis on the examination of process factors (e.g., treatment integrity, dosage, parent engagement, measurement approaches) and how these factors are related to outcomes. Process factors need to be examined to determine how they relate to other variables that have been found to predict outcomes. Finally, a systematic line of research needs to be conducted to determine if behavioral parent training programs are effective for adolescent-aged youth with high levels of risk. This will require that studies be conducted (a) using rigorous experimental designs that include control groups, (b) using follow-ups to determine if effects maintain over the course of at least one year, and (c) by researchers at multiple sites.

Conclusions

Adolescents who engage in problem behavior are at an increased risk to engage in antisocial and criminal activities as adults. The current study suggests that parents of adolescent-aged youth have a need and a desire to obtain information on how to deal with problem behavior. Although the current study cannot definitively determine if behavioral parent training programs are effective in reducing rates of adolescent problem behavior, results are promising and future research is warranted.

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Author

Annette K. Griffith, Ph.D., is an Assistant Research Professor at the Center for At-Risk Children's Services at the University of Nebraska-Lincoln. She is interested in understanding more about youth who are involved in out-of-home care and in examining interventions to help improve their outcomes.