Chapter 2
Cognitive-Behavioral Parenting Programs: Outcomes, Approaches, and Future Directions

This chapter focuses on presenting (1) the underlying principles of the cognitive-behavioral parenting programs for child externalizing disorders, (2) the contents of the tested parenting programs, and (3) the outcomes of the clinical trials testing their efficacy. This chapter also presents the gaps in the literature on the current cognitive-behavioral parenting programs, the limitations of the existing parenting program curricula, and the directions for improvement.

Behavioral approaches to parent programs were the first implemented and investigated for reducing child disruptive behavior (Barlow and Stewart-Brown 2000; Nixon 2002). They were based on behavioral (operant learning) theories and they made use of strategies such as positive reinforcement, extinction, time-out, and contingency contracting. The aim of using these strategies was to reinforce alternative positive behaviors, while at the same time they reduced unwanted inappropriate child behaviors. Based on research documenting the importance of parental attitudes and emotions in changing parenting practices (e.g., Gavita et al. 2014; Ben-Porath 2010), cognitive strategies were currently implemented in cognitive-behavioral parenting programs. Some parenting programs (Webster-Stratton 1990) have integrated strategies from the cognitive theories of emotional control that challenge misattributions about child behavior or stress management. Although there is a great heterogeneity in focus of these curricula, most of the published parenting programs rely mainly or solely on behavioral strategies.

Efficacy and Effectiveness of the Cognitive-Behavioral Parenting Programs

Many clinical trials have documented the efficacy of parenting programs for child externalizing disorders. Meta-analyses (see Bradley and Mandell 2005; Kaminski et al. 2008; Lundahl et al. 2006; Maughan et al. 2005) that have synthesized the results of peer-reviewed studies concluded that the effects were small to moderate

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immediately after treatment (overall $d = 0.22–0.52$, see Lundahl et al. 2006), and the effect sizes were small at follow-up (overall $d = 0.21$).

The meta-analysis by Bradley and Mandell (2005) investigated the efficacy of parenting programs that were mediated by a number of variables. Most of the parenting programs included had a cognitive-behavioral approach. Bradley and Mandell (2005) found a medium magnitude of changes in parent-reported child behavior, while changes on measures that relied on direct observation were low in magnitude. Different effect sizes were found depending on the children's age range. A low level of changes was found in children between the ages of 3 and 5 ($d = 0.40$), no effect was found for children aged between 6 and 8 years ($d = 0.19$), and a high magnitude of change was reported for children between the ages of 9 and 11 years ($d = 1.36$). An interesting result reported by this review was related to the impact of the mean number of treatment sessions. The highest effect size was obtained for the programs using between 1 and 5 sessions ($d = 0.96$), while the lowest magnitude of change occurred in programs using more than 15 sessions ($d = 0.08$).

Although many parenting programs exist, their evidence-based status varies largely. Various organizations promote standards for selecting efficacious and promising interventions for youth mental health promotion (e.g., Blueprints for Healthy Youth Development). According to Small et al. (2009, p. 1), evidence-based programs (EBPs) are "*well-defined programs that have demonstrated their efficacy through rigorous, peer-reviewed evaluations and have been endorsed by government agencies and well-respected research organizations. EBP's are not simply characterized by known effectiveness; they are also well documented so that they are more easily disseminated*." There are parenting programs that meet these criteria for evidence-based practice.

Collins and Fetsch (2012) conducted a critical review that rated the evidence-based status of 16 of the most well-documented parenting programs. They developed a rating scale to assess the degree of empirical support of the programs with values ranging from 0 to 5, where 0 indicated that no evidence was found that the curriculum had been evaluated empirically; 1 indicated that the program was being evaluated but without any published program evaluation research; 2 indicated that the program was evaluated, but the quality of studies was low; 3 indicated that the program had only process evaluations; 4 indicated that the program had positive outcome data from one or two well-designed studies investigating its short-term impact; and 5 indicated that the program had a strong empirical support. Thus, this rating of five included in the criteria that a series of studies existed that showed consistent efficacy over several years. The parenting programs in their top programs' category included (1) the STAR Parenting, (2) Systematic Training for Effective Parenting, (3) Strengthening Families Program for Parents and Youth 10–14, and (4) Triple P. They identified another three programs in the promising category. The top programs included different dosages of sessions that ranged from ten once-weekly sessions to four two-hour sessions. Some programs supplement group interventions with individual sessions. However, a major limitation of this review was that it included only 16 parenting programs.

Furlong et al. (2012) conducted a Cochrane review to document the efficacy of group parenting programs for improving behavioral problems in children aged 3–12 years. They found that behavioral and cognitive-behavioral group-based parenting programs were clinically effective and cost-effective in improving children's conduct problems, parents' mental health, and parenting skills in the short term. However, they suggested that the long-term outcomes of such programs need further investigation.

Although many randomised clinical trials document the outcomes of parenting programs, only a few of them document their mechanisms of change. A meta-analysis by Kaminski et al. (2008) investigated the treatment components related to better outcomes in parenting programs. The three components associated with better outcomes were teaching parents emotional communication skills, teaching parents positive parent–child interaction skills, and requiring parents to practice with their child. Emotional communication skills had the greatest effect size and were connected to relationship-building and improving parent–child bonding. Emotional communication referred to using relationship-building communication skills and coaching children to identify and appropriately express their emotions.

Another systematic Cochrane review (Barlow et al. 2014) was limited to randomized controlled studies published up until 2011 and documented the effects of group-based parenting programs on the parents' psychosocial health. They identified 48 studies that included 4937 participants. Primary parental outcome measures included measures of depression, anxiety, stress, self-esteem, anger, aggression, and guilt. The authors coded the programs as being in one of three categories: behavioral, cognitive-behavioral, and multimodal. The results showed that parenting programs were effective in the short run with low-to-medium effect sizes, and they were effective in the long run in producing effects for parents' stress and confidence. Among the cognitive-behavioral programs mentioned in this review was the Rational-Emotive Parent Education program investigated by Joyce (1995).

The REBT Approach of the Parenting Programs

Rational-Emotive and Cognitive-Behavioral Therapy (RE&CBT; Ellis 1962) represents the first modern form of cognitive-behavioral therapy (CBT). Psychopathology is conceptualized by RE&CBT (Ellis et al. 1966; DiGiuseppe et al. 2014) as changing dysfunctional emotional and behavioral responses that are thought to be caused by irrational beliefs. Maladaptive patterns of beliefs and behaviors can be learned from the environment and can serve as endogenous vulnerability factors that lead to psychopathology. Ellis' (1956, 1962, 1991, 1994) ABC(DE) model the (known also the ABC model) represents the central theory of RE&CBT. The theory states that parents' behavioral and emotional reactions (C) are not determined by the activating events (A) they face, such as their children's behavior, but by the way they think (believe) about these activating events (B) (Fig. 2.1).



Fig. 2.1 The ABC model of RE&CBT (Ellis 1956, 1991)

The primary focus of RE&CBT is thus on changing irrational beliefs, which represent a specific type of faulty cognitions hypothesized to lead to disturbance. The most important of these is what Ellis called demandingness. Parents' IBs include unrealistic and absolutistic demands on themselves as parents, on others such as their children, or on life, and are responsible for parents' dysfunctional emotional reactions to negative events (e.g., children's misbehavior). To change their dysfunctional emotions that are the consequences of their irrational beliefs, parents learn to actively dispute (D), challenge, examine their beliefs and replace them with more effective beliefs (E) to achieve a new functional (F) life philosophy (Ellis 1962, 1994). To be irrational, a belief would meet one of the following criteria. Irrational beliefs are illogical, inconsistent with empirical reality, or inconsistent with accomplishing one's long-term goals (Ellis 1994). Any one of these three criteria is sufficient for a belief to be irrational; not all three are necessary to meet the definition. DiGiuseppe et al. (2014) identify the following characteristics of irrational beliefs: (1) An irrational belief is absolute, dichotomous, rigid, and unbending; (2) it is illogical; (3) it is not consistent with reality; (4) it does not help one to achieve one's goal; and (5) it leads to unhealthy/dysfunctional emotions. Consequently, the features of a rational belief are the opposite: (1) Rational beliefs are flexible with (rational beliefs acknowledge that one could have many possible possibilities or different shades between black and white); (2) They are logical; (3) they are consistent with empirical reality; (4) they help one in pursuing one's goal; and (5) they lead to healthy, functional negative emotions even when the person is facing negative event.

REBT theory maintains that "demandingness," or absolutistic, rigid adherence to an idea is the core of disturbance. However, other types of irrational thinking are less central and are psychologically deduced from or created from demandingness. The major irrational beliefs and explanations concerning what makes them irrational appear below (David et al. 2014).

Demandingness (DEM) *is an unrealistic and absolute expectation of events or individuals being the way a person desires them to be.* An example of a parent's demanding IB would be when a parent thinks, "I must be obeyed by my child."

Awfulizing (AWF) *is an exaggeration of the negative consequences of a situation to an extreme degree, so that an unfortunate occurrence becomes "terrible."* An example of a parent's awfulizing IB would be when a parent thinks, "If my child does not obey me, it is awful."

Frustration intolerance (FI) *stems from demands for ease and comfort, and reflects an intolerance of discomfort.* An example of a parent's frustration intolerance IB would be when a parent thinks, "I can't stand when my child misbehaves."

Global evaluations of human worth, either of the self or others, imply that human beings can be rated, and that some people are worthless, or at least less valuable than others are. An example of a parent's IB about global evaluation of the self would be a parent thinking, "I am not respected and thus I am worthless." An example of a parent's IB about global evaluation of others would be a parent thinking, "I am not respected by my child, and they are worthless for not respecting me."

A vast literature (see David et al. 2010) has documented the empirical support concerning the association between irrational beliefs and dysfunctional emotions and maladaptive behavioral reactions. The rational alternative belief patterns thought by REBT/CBT to promote healthy, adaptive albeit negative emotions in both adults and children are preferences (PREF; e.g., "I prefer to be obeyed by my child") rather than DEM. Badness is the rational alternative to awfulizing (BAD; e.g., "When my child does not obey, it is bad but not awful".) Unconditional self-acceptance is the rational alternative for global self-evaluation. An example of a parent's RB about self-acceptance would be, "If am not respected by my child, I can still accept myself and recognize that I am not a worthless person." The rational alternative to global evaluation of others would be unconditional other acceptance. An example of a parent's RB concerning unconditional other acceptance (UOA) would be, "If am not respected by my child I can accept him/her and recognize that they are worthwhile even though they do not respect me now." The rational alternative to frustration intolerance would be frustration tolerance. An example of a parent's RB concerning frustration intolerance would be, "I do not like it when my child misbehaves, but I can stand this situation even though it is unpleasant."

When facing adverse life events (e.g., child misbehavior), irrational thinking is associated with dysfunctional consequences (e.g., dysfunctional emotions), while rational thinking is associated with functional, adaptive negative emotions (Dryden 2002). According to this binary model of emotions derived from REBT, functional and dysfunctional emotions constitute qualitatively different emotional experiences that are not only quantitatively different (e.g., intensity). Although functional negative emotions constitute adaptive reactions to everyday adverse life events, dysfunctional emotions correspond to subclinical and clinical type of problems and reactions (David and Cramer 2010). Dysfunctional emotions and their functional counterpart categories of emotions appear in Table 1.

The RE&CBT framework (see Ellis and Bernard 2006) conceptualizes rational beliefs (RBs) and irrational beliefs IBs of parents and their children, as important resiliency mechanisms (RBs) or vulnerability factors IBs, which have a strong impact on their parenting practices and mental health (e.g., Bernard and Joyce 1984; DiGiuseppe and Kelter 2006; Terjesen and Kurasaki 2009) (Fig. 2.2).

Thus, rational parenting refers to parents' endorsement of all four categories of rational beliefs, with unconditional acceptance of self and other as the key

Table 2.1 Functional and dysfunctional emotions and corresponding thinking based on Dryden (2002)

Emotion	Functionality of emotion	Type of associated belief
Anxiety	Dysfunctional	Irrational
Concern/apprehension	Functional	Rational
Depression	Dysfunctional	Irrational
Sadness/disappointment	Functional	Rational
Anger	Dysfunctional	Irrational
Annoyance	Functional	Rational
Guilt	Dysfunctional	Irrational
Remorse	Functional	Rational

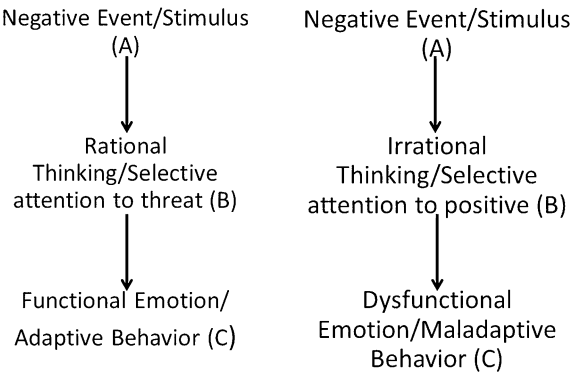


Fig. 2.2 The ABC model of functional versus dysfunctional reactions (Ellis 1956, 1991)

components that is fundamental for mental health and positive parenting. Rational beliefs can be transmitted to and learned by children through the parents' explicit use of such irrational language. In addition, they can be learned implicitly by the parents' modeling of self-acceptance and showing unconditional acceptance of the child and other when they engage in critical events.

The rational parenting concepts in the RE&CBT parenting programs (Gavita et al. 2013) rest on the assumption that RBs and IBs lead to distinct adaptive or maladaptive parenting styles, respectively. Indeed, demanding beliefs about one's self in the parenting role and non-acceptance of one's self were found (Gavita et al. 2014; Joyce 2006) to be associated with dysfunctional emotions in parents and thus led to maladaptive discipline.

Hauck (1967) proposed several types of parenting styles. These are the "unkind and firm" and the "kind and not firm" parenting styles. Both of these are maladaptive for child development, and both are based on low levels of parental self and child unconditional acceptance. In turn, the "kind and firm" parenting style is an adaptive form of parenting and is based on unconditional acceptance of both self and child. Thus, a fundamental focus of the RE&CBT parenting interventions is to help parents to identify their IBs that produce their maladaptive consequences

(the B–C connection) and then to learn the tools of cognitive restructuring/disputing and rehearsal for the new rational thinking patterns.

The RE&CBT-based interventions applied to the parenting field have been labeled with many terms. Some of these names include Rational-Emotive Parent Education (Joyce 1995, 2006), Rational-Emotive Behavior Parent Consultation (Vernon 1994), Rational-Emotive Family Therapy (Woulff 1983; Huber and Baruth 1989; DiGiuseppe and Kelter 2006), and more recently the enhanced parenting program in the form of the Rational Positive Parenting Program (David 2014; David et al. 2014; Gavita et al. 2013). The RE&CBT Parenting Program (Joyce 2005) was the first program tested in a rigorous study (Joyce 1995) using a comparison group of parents assigned to a waiting-list control group. The program focused on a non-clinical population and treated parental distress by teaching parents the ABC model, fostering rational thinking, and developing rational problem-solving skills. The results showed that parents receiving the RE&CBT parenting program reported significantly lower child behavior problems, endorsed fewer parental irrational beliefs, and reported less parent guilt and parent anger at the end of the program. The resulting decreases in both child behavior problems and parental negative global evaluation/self-downing were maintained at a 10-month follow-up.

Future Directions Based on Recent Findings

We now know that cognitive-behavioral parenting programs can successfully address child behavior problems (i.e., 4–12-year-old children; Kaminski et al. 2008). However, up to half of all participating parents fail to derive benefits from these programs (Kazdin 1993; Webster-Stratton 1990). Moreover, the attrition rate for families of children with conduct disorder is more than 50 % (Fireston et al. 1980; Patterson 1974). Previously, Morrissey-Kane and Prinz (1999) proposed that addressing the cognitions underlying parents' negative emotions and maladaptive behavior could represent an important addition in improving the treatment process.

Parental distress, poor parental emotion-regulation abilities, and parental psychopathology represent serious risk factors for poor parenting, and they correlate with child disruptive behavior (Burke et al. 2004; Hoza et al. 2000). Patterson and Capaldi (1991) found that parents of children with conduct disorder (CD) and oppositional defiant disorder (ODD) had poor abilities to regulate their anger and reported a higher incidence of using corporal punishment and abusive/excessive discipline. Moreover, Ben-Porath (2010) showed that parents who presented with difficulties in anger regulation were also less effective in regulating their child's affect when the child becomes emotionally upset. Kaiser et al. (2010) found that changes in the parents' dysfunctional cognitions improved parenting and child functioning. More specifically, self-efficacy, parents' negative attributions concerning their children's problem behavior, and parents' depressive cognitions have been identified (see also Hoza et al. 2000, 2006) as important

targets for parenting programs to improve the outcomes for the treatment of child disruptive behavior. Thus, we proposed (Gavita et al. 2011, 2013) that parental emotion-regulation components should be an important focus of parenting programs for preventing and/or treating child externalizing disorders. More recently, such enhanced or cognitively enhanced versions of parenting programs have been developed (see Gavita and Joyce 2008). Such programs focus more specifically on both parental distress/psychopathology and their underlying cognitive self-regulation mechanisms.

Cognitive theories of psychotherapy differ in whether they target inferential (cold cognitions) or evaluative (hot cognitions) (DiGiuseppe et al. in press). Most of the literature concerned with parental cognitions has focused on parental attributions for the child misbehavior, parental expectations of children's behavior, and parental perception of their own abilities. These types of cognitions represent the "cold" cognitions that infer or describe some characteristic of the parent or the child or some reason for the failure to change the child or labeling the parent as ineffective. Thus, most of the parenting programs have targeted parental distress by identifying and challenging inferential cognitions. These thoughts are specific examples of the negative automatic thoughts identified by Beck and Haigh (2014). However, it was long noted by Ellis (1962, 2003) that such biased cognitions result in distress only if these inferences are negatively appraised. Research in clinical cognitive sciences and emotion-regulation paradigm supports this claim, showing (Aldao et al. 2010) that reappraisal or the targeting of evaluative cognitions is the most effective emotion-regulation strategy. Several recent studies (Gavita et al. 2014; Gavita 2011) have documented the relationships between parents' irrational beliefs ("hot"—evaluative cognitions) and unhealthy negative emotions. More specifically, a mediation effect was obtained for the irrational cognitions on the connection between self-efficacy (a cold cognition) and parent distress. Thus, we maintain that evaluative (or hot) cognitions are the important cognitive structures to target in parenting programs. These will be the targets of cognition change in this program (Fig. 2.3).

Although the efficacy of the cognitive-behavioral parenting programs is well established (Lundahl et al. 2006; Kaminsky et al. 2008), another limitation of these programs from an evidence-based perspective is that we do not yet understand how they work. Besides parenting skills, an important variable found across many studies to moderate the efficacy of parent training regardless of the degree of child psychopathology is difficulties in parental affect regulation and distress (Ben-Porath 2010; Webster-Stratton and Hammond 1990; David 2014). Thus, teaching parents emotion-regulation strategies should be a key component of any parenting programs, based on the studies documenting its mediating role for the child outcomes. This understanding is important if we are to select components to add to parenting programs that are based on general and specific mechanisms that will improve their effects.

The cost-effectiveness of delivering a program is yet another important aspect concerning parenting programs. The cost of such programs becomes an essential factor when planning to treat populations from underdeveloped countries or low

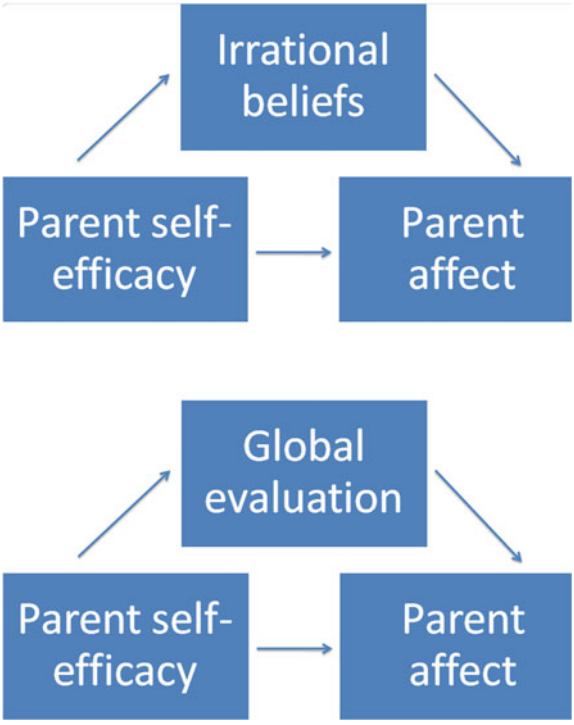


Fig. 2.3 The mediating effect of irrational beliefs based on the findings of Gavita et al. (2014)

SES backgrounds. The access to parenting programs is a limited resource that could be expanded by the widespread access to Internet. We mentioned above that the length of parenting programs was not related to their outcomes. Thus, shorter programs that address the key documented mechanisms of change should be further investigated so that cost-effective programs can be developed online to reach underserved populations.

In conclusion, research in clinical cognitive sciences mentioned above (see also Gavita et al. 2013) suggests that the following directions could be pursued in developing parenting programs' curricula to increase their efficacy and cost-effectiveness: (1) Emotion regulation strategies need to be implemented in parent programs for optimal results and improvement in children's behavior and (2) the emotion-regulation component should address parental evaluative cognitions/appraisals (hot cognitions). The RE&CBT framework, that focuses on rational and irrational beliefs of parents offers a coherent approach consistent with recent advancements in parenting and core constructs involved in psychopathology, and promotes a "kind and firm" parenting style.

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