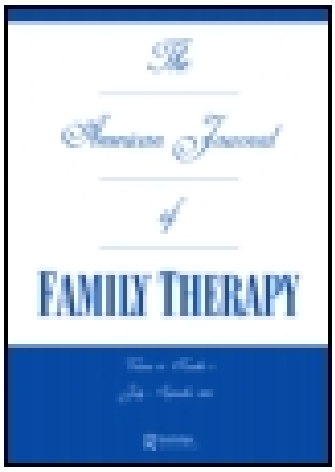

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Implementing Parent Management Training in the Context of Poverty

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Parent management training (PMT) is a well-investigated, effective, and preferred treatment for children's externalizing behaviors and related disorders. Unfortunately, PMT is not as effective for children living in poor families, who disproportionately exhibit the behaviors that PMT is designed to correct. We suggest that PMT is less successful for poor children because (1) the same factors that explain the relation between economic hardship and children's externalizing behaviors also are related to unsuccessful PMT outcomes; and (2) PMT interventions are less acceptable to poor parents, and therefore less likely to be adopted. Clinical implications are drawn from the analysis.

An estimated 11.6 million children in the United States live in poverty (U. S. Census Bureau, 2001). Poverty places children at risk for exhibiting a variety of socioemotional problems, including externalizing behaviors such as aggressiveness, destructiveness, stealing, temper tantrums, and noncompliance (Costello et al., 1996; Takeuchi, Williams, & Adair, 1991; Velez, Johnson, & Cohen, 1989). Depending on the frequency, severity, and type of externalizing behaviors, mental health professionals frequently diagnose children who exhibit such behaviors with conduct, oppositional defiant, or antisocial disorders, using the criteria of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1994).

Externalizing behaviors are among the most frequent reasons children are referred to inpatient and outpatient mental health treatment (American Psychiatric Association, 1994; Kazdin, Siegel, & Bass, 1990). Moreover, if

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children's externalizing behaviors are unsuccessfully treated, they can disrupt peer and family relationships, interfere with academic progress, and evolve into delinquent and criminal behavior, resulting in substantial personal, familial, and social costs (Kratzer & Hodgins, 1997; Patterson, DeBaryshe, & Ramsey, 1989). Identifying effective treatments for externalizing behaviors and related disorders is obviously important, particularly for poor children who disproportionately exhibit them. Researchers have identified several types of therapies that appear to be effective in improving children's externalizing behaviors, with parent management training (PMT) being one of the most effective (Brestan & Eyberg, 1998; Kazdin, 1991).

This article has three main objectives. First, we establish the effectiveness of PMT for children's externalizing behaviors and demonstrate that poor children are less likely to benefit from PMT. Second, we propose two main reasons why PMT is not as effective for poor children. Third, we draw clinical applications from our analysis.

PARENT MANAGEMENT TRAINING

PMT, a treatment based on social learning principles, trains parents to recognize and change the antecedents and consequences that contribute to the development and maintenance of the externalizing behaviors of young children. PMT can be conducted with single families or with small groups of parents (Kazdin, 1997; Spiegler & Guevremont, 1998). Clinicians teach parents to replace the antecedents of vague, inconsistent instructions, warnings, and threats with calm, clear, and age-appropriate instructions. Parents learn to replace the consequences of ignoring or inconsistently reinforcing children's desirable or prosocial behaviors with recognizing and reinforcing these behaviors using a variety of reinforcers (e.g., praise, affection, privileges, and concrete items). Finally, parents are taught to ignore minor, undesirable behaviors. For more serious behaviors, parents learn to replace the consequences of harsh and physical discipline, anger, and threats of future discipline with the use of immediate time-out procedures and removal of privileges.

PMT not only is one of the most frequently used treatments for children's externalizing behaviors and related disorders, but is a well investigated, effective, and preferred treatment for these problems (Brestan & Eyberg, 1998; Kazdin, 1997; National Institute of Mental Health, 1990; Patterson, Dishion, & Chamberlain, 1993; Serketich & Dumas, 1996). Outcome studies indicate that PMT results in substantial behavioral improvement for children referred for treatment and also for their non-referred siblings. Behavioral improvements can be maintained for at least one year after follow-up, with some studies indicating that treatment gains can be maintained up to 10 to 14 years after training (Eyberg, Edwards, Boggs, & Foote, 1998; Kazdin, 1997).

Unfortunately, evaluations of PMT effectiveness for poor children's ex-

ternalizing behaviors are not as favorable. Studies indicate that low income or socioeconomic disadvantage is related to premature termination of PMT (Kazdin, 1990; McMahon, Forehand, Griest, & Wells, 1981; Prinz & Miller, 1994). Even if parents complete the training, economic hardship is associated with less favorable outcomes at termination (Dumas, 1984a; Dumas & Wahler, 1983; Webster-Stratton & Hammond, 1990) and at followup (Dumas, 1989; Routh, Hill, Steele, Elliott, & Dewey, 1995). Thus, poverty places children in double jeopardy: poor children are more likely to exhibit externalizing behaviors and less likely to benefit from a frequently used, empirically supported treatment for these behaviors.

FACTORS RELATED TO FEWER BENEFICIAL OUTCOMES

We propose that poor children are less likely to benefit from PMT for two main reasons. First, the same factors that explain why poor children are at risk for developing externalizing behaviors also interfere with successful PMT. Second, PMT interventions are less acceptable to poor parents, and therefore less likely to be adopted. We will discuss each of these explanations separately.

Mediating Influences of Poverty

Researchers have made progress in explaining the relationship between family economic disadvantage and children's externalizing and related behaviors (Brody et al., 1994; Conger, Ge, Elder, Lorenz, & Simmons, 1994; Eamon, 2001). These studies indicate that family economic hardship creates economic stress (e.g., from the inability to pay bills and satisfy the family's needs and desires), which results in parental psychological distress such as depression. Psychological distress precipitates marital conflict and disrupts supportive co-parenting. Both psychological distress and marital conflict, in turn, are linked to the harsh, physical, inconsistent, and coercive parenting practices that predict children's externalizing behaviors. Studies indicate that influences outside of the home, such as residing in disadvantaged neighborhoods and lack of parental social support, also partially explain the relation between poverty and children's externalizing behaviors (Dodge, Pettit, & Bates, 1994; Eamon, 2002; Simons, Beaman, Conger, & Chao, 1993)

Notably, the same mediating influences that explain why poor children are at risk for externalizing behaviors—high levels of stress, parental depression, marital discord, low social support, and residence in disadvantaged neighborhoods—also have been found in evaluation studies of PMT to predict unsuccessful outcomes for children (Dadds & McHugh, 1992; Dumas, 1984a; Dumas & Wahler, 1983; Kazdin & Wassell, 1999; Webster-Stratton & Hammond, 1990). These parallel findings suggest that poor children do not

benefit as much from PMT as do nonpoor children, because poor parents experience these negative influences more frequently.

Dumas's (1984b) observations during her PMT evaluation are consistent with more recent studies examining the mediating effects of poverty on children's externalizing behaviors. Dumas observed that mothers who were unsuccessful in PMT (disproportionately socioeconomically disadvantaged) responded to their children in a more hostile and inconsistent manner than did mothers who successfully completed PMT. The aversive, inconsistent behaviors were observed during the initial phase of the training, and during subsequent stages as well. Dumas observed that these aversive and inconsistent behaviors were in response to the harsh circumstances to which poor mothers were regularly exposed, making it difficult for them to implement the parenting techniques taught in PMT. Similar conclusions have been reached by other researchers as well (Miller & Prinz, 1990; Webster-Stratton, 1997).

Acceptability of PMT

Few studies have examined relations between the acceptability of PMT, compliance, and treatment outcomes among different income groups. However, research suggests that if behavioral interventions are unacceptable to clients, they are more likely to drop out of treatment and less likely to comply with the treatment plan and to demonstrate behavioral change (Cross Calvert & Johnston, 1990; Heffer & Kelley, 1987). In a rare study examining the acceptability of PMT interventions among different client groups, Heffer and Kelley (1987) found that low-income parents (particularly low-income, African American parents) rated time-out procedures as less acceptable and physical punishment as more acceptable than did middle- to upper-income parents. Implementing time-out procedures in the less spacious homes of poor families appeared to be impractical or difficult because of the unavailability of a socially isolated area in which to place the child. The researchers also observed that the daily stressors associated with living in poverty (e.g., struggling to meet the basic needs of the family) likely decreased the ability or tendency of parents to use methods such as time outs that require time and patience. Spanking, in contrast, is more acceptable to poor parents because it is quicker, requires less effort, and might result in immediate (although not long-term) correction of the child's behavior.

Although Heffer and Kelley found that low income was associated with lower acceptance of using positive reinforcers for desirable behaviors only among African American parents, related research indicates that poor parents would have difficulty in reinforcing their children's desirable behaviors with reinforcers such as concrete items, privileges, and activities. Just as studies indicate that poverty constrains parents' ability to provide their children with a variety of materials and activities (Bradley, Corwyn, McAdoo, &

García Coll, 2001; Guo & Harris, 2000), poverty also would constrain parents' ability to purchase even low-cost concrete reinforcers (such as stickers or small toys), pay for special activities and related transportation costs (such as a video rental or a trip to the local fast food restaurant), or acquire the play equipment necessary to engage in reinforcing activities (such as riding a bicycle or playing catch). Even the use of privileges that require no money (such as playing in a public park or visiting a friend) are likely to be less acceptable to poor parents, who disproportionately live in high-risk, unsafe neighborhoods (Wilson, W. J., 1996). In these disadvantaged neighborhoods, parents frequently protect their children by restricting their unsupervised activities (Outley & Floyd, 2002; Wilson, W. J., 1996).

Because children of color, particularly African Americans and Latinos, are disproportionately represented among poor children in the United States (31% of African American, 28% of Latino, and 9% of white children are poor [U.S. Census Bureau, 2001]), cultural influences also can contribute to the lower rates of PMT effectiveness among poor children. The low acceptance of time-out procedures and use of positive reinforcers and the high acceptance of spanking among low-income African American parents (Heffer & Kelley, 1987) provide evidence for this proposition. Other researchers (Forehand & Kotchick, 1996; Prinz & Miller, 1991) provide examples of ways in which cultural influences can affect PMT. In both Latino and African American families, extended family and kin are actively involved in assisting with child rearing responsibilities, whereas PMT generally targets the parents, most frequently the mother. Parenting practices and parent–child interactions are culturally defined; if reinforcers, ignoring, and time-out procedures are not accepted within their cultural reference group, parents are less likely to use them. Parents also might be reluctant to correct externalizing behaviors such as aggressiveness if families reside in neighborhoods where exposure to deviant adult and peer behaviors is high. In these environments, parents might view children's verbal and physical aggression as adaptive. Moreover, parents who live in high-risk neighborhoods might perceive the use of harsh, physical punishment as necessary, either to protect their children from deviant influences or to assist them in surviving in these adverse environments.

IMPLICATIONS FOR CLINICAL PRACTICE

This analysis suggests two main assessment and intervention strategies that practitioners can use to increase the effectiveness of PMT for children living in poor families. First, assessing and addressing economic hardship and the mediating influences of poverty; second, assessing and increasing the acceptability of PMT interventions.

Assessing and Ameliorating Poverty and Its Mediating Influences

Researchers and basic texts on cognitive-behavioral applications (e.g., Granvold, 1994; Luiselli, 1991; Spiegler & Guevremont, 1998) stress the importance of individualized client assessment and treatment; that is, identifying and changing the maintaining antecedents and consequences of the behavior targeted for change. Although the importance of conducting individualized client or family assessments and using individualized interventions might seem obvious to most clinicians, these texts and other researchers (e.g., Wilson, G. T., 1996) also support the application of standardized treatment approaches (e.g., PMT and systematic desensitization) that have demonstrated effectiveness for particular client problems (e.g., children's externalizing behaviors and phobias). Despite the detrimental consequences that can occur when clinicians apply standardized interventions without performing an individualized assessment (Davison & Lazarus, 1995), some researchers in practice-related fields (such as social work and psychology) advocate using empirically validated standardized interventions, while either failing to acknowledge the need for individualized assessments or challenging the value of such assessments (e.g., Myers & Thyer, 1997; Wilson, G. T., 1996). Moreover, when applying behavioral interventions, clinicians do not consistently assess environmental factors (Gambrill, 1994), and when conducting assessments of client problems, clinicians are more likely to overemphasize personal rather than interpersonal and environmental factors (Rosen & Livne, 1992). As the PMT outcome research reviewed in this article indicates, even when important antecedents such as economic hardship and parental depression are assessed, they are neglected areas of treatment.

Before referring parents to PMT groups or conducting individual training sessions, clinicians should adequately assess and/or treat the multiple maintaining antecedents of the child's externalizing behaviors. Clinicians should assess first the family's economic status. If parents have experienced a recent economic loss, assessing their knowledge of effective parenting practices might be helpful. Related research suggests that parents in this situation might not even need parent training, but are experiencing a temporary breakdown in parenting skills as the family reacts to or copes with the economic loss (McLeod & Shanahan, 1993). If families are experiencing economic hardship, assisting parents to access community resources such as employment agencies, job training, medical assistance, public aid and housing, food stamps, subsidized child care, and so forth, should ease economic hardship.

Some researchers have acknowledged the need to include interventions that assist poor families in obtaining economic resources (Miller & Prinz, 1990; Webster-Stratton, 1997), but little research has evaluated the impact of alleviating economic hardship on PMT treatment outcomes. Some related studies, however, indicate that assisting families to access community re-

sources and participation in job training programs and employment that results in increased family income and reduced financial strain, can reduce parental depressive symptoms (Vinokur & Schul, 1997) and child behavior problems (Fishman, Andes, & Knowlton, 2001; Gennetian & Miller, 2002).

Practitioners also should assess parental stress, depression, marital/partner discord, available social support, and other environmental stressors and provide appropriate interventions when needed. Although the research reviewed in this article suggests that these are important areas of assessment and intervention for all families with children exhibiting externalizing behaviors, assessing these factors in poor families is particularly important because these families disproportionately experience these negative influences. In response to the limitations of PMT for children whose parents experience depression, marital/partner discord, low social support, and environmental stressors, program evaluators have incorporated various "enhancement" strategies into traditional PMT. Further research is required before conclusions about the effectiveness of these enhancement strategies can be determined (Kazdin, 1997; Miller & Prinz, 1990), but several of these strategies have shown promising results. For example, adding cognitive-behavioral problem-solving, communication, and self-control skills training to traditional PMT appears to increase couples' problem solving and communication skills (Webster-Stratton, 1994). Partner support training for marital/partner discord and a combination of interventions that focus on parental perceptions of the child's behavior and increasing personal, marital, and extrafamilial adjustment also can result in increased child behavior improvement compared to traditional PMT (Dadds, Schwartz, & Sanders, 1987; Griest et al., 1982).

Assisting families to change environmental stressors or to increase economic resources might be difficult, impractical, or even impossible in some cases. To address these difficulties, other expansions of PMT have focused not on changing the adverse environmental conditions, but on changing parents' cognitive processes that mediate reactions to environmental stressors (Miller & Prinz, 1990). However, if clinicians apply cognitive-behavioral interventions such as problem solving and cognitive restructuring without assessing or taking into consideration environmental stressors or economic resources, they might find that changes in cognitive processes are short-lived and problem-solving solutions unrealistic. An instructional video featuring Judith Beck (Communications Services, 1999) illustrates these points.

In the video, Beck assists a young, African American mother of three children, then a student, working part time, and living with her elderly mother, to identify the thought "if I lose my mother before I become independent, I might not make it" as maintaining her depression. Consistent with cognitive restructuring procedures, Beck assists the client to evaluate the evidence underlying the thought and to formulate a more functional thought. Beck

also uses a problem solving intervention to assist the client in choosing among several options to reach her goal of gaining independence; the client chooses to move out of her mother's home. Although this young mother was noticeably less depressed by the end of the session, Beck failed to address a relevant problem that the client had revealed earlier in the session: she was unable to locate affordable housing. The solution generated by the problem solving intervention is unlikely to be successful without assistance in securing affordable housing or additional economic resources. We also might speculate that the client's improved mood will be short lived. When the client attempts to carry out the solution of leaving her mother's home, she will likely realize that, given her economic situation, gaining independence will be a very difficult goal to achieve.

The client situation depicted in the instructional video is consistent with Krantz's (1985) position that cognitions of depressed individuals are not necessarily unrealistic or distorted. In fact, her research demonstrates that depressed individuals experience more negative life events, circumstances, and feedback from others compared to the non-depressed. Unless techniques are used to alter these undesirable circumstances, achieving and maintaining cognitive changes that result in improved mood and behavior will be difficult. If practitioners implement PMT in poor families, but do not increase the family's economic resources, treating other contributing factors such as depression, marital discord, and parenting behaviors are likely to be less successful (Kim, 2000), resulting in less successful outcomes for poor children exhibiting externalizing behaviors.

Assessing and Increasing Acceptability of PMT

When using PMT with low-income parents, clinicians should assess whether parents have the resources necessary to effectively implement the parenting techniques. This assessment might include whether housing space poses a barrier to implementing time-out procedures or financial constraints prohibit the use of particular reinforcers that involve purchases, activities, or privileges. Clinicians might acknowledge the difficulty that parents can have in locating an isolated area in their home and explore possible ways in which a space in the home might be moderately altered. Alternatively, suggesting other types of consequences such as a "time-out" from a specific object or activity (e.g., removing a toy or game that children are arguing over for a specified period of time) or the loss of a privilege might be more acceptable to parents. Devoting extra time to brainstorming with parents and children to identify a variety of affordable reinforcers (e.g., special time with an extended family member) might be particularly helpful. Finally, clinicians can assist parents in identifying low-risk privileges or activities for parents living in high-risk neighborhoods, who might find it unacceptable to use as reinforcers activities or

privileges that require low levels of supervision. A qualitative study of African American families living in a high-risk neighborhood (Outley & Floyd, 2002) provides examples of strategies that parents have used to provide their children with safe outside activities. These included parents asking members of their kinship or social networks or older children to provide activities and supervision. Parents also took advantage of community activities offered by nonprofit organizations such as neighborhood clubs and centers, after-school programs, and church groups.

To address the problem of cultural beliefs posing additional barriers to effective PMT treatment of low-income children, Prinz and Miller (1991) provided several ways to accommodate culture. They suggested (1) involving the relevant extended family and kin in the training; (2) using staff from the parent's cultural reference group; (3) avoiding words such as "parent training," which implies that parents need to be told by practitioners how to be parents; (4) adapting materials and tailoring examples of concrete reinforcers, activities, privileges, and social reinforcers to the client's cultural reference group; and (5) assisting children and parents to distinguish between parenting practices and externalizing behaviors that might be adaptive in high-risk settings from parenting practices that are unnecessarily harsh and externalizing behaviors that are excessive or inappropriately directed.

In summary, PMT is an effective and widely used intervention for children's externalizing behaviors and related disorders. PMT, however, is not as effective for children who live in poor families. We proposed two main reasons why PMT is not as effective for poor children, and discussed a variety of assessment and intervention strategies that can assist clinicians in increasing the effectiveness of this training in poor families. Finally, our analysis suggests that unless practitioners become aware of, assess, and address the economic hardship and the adverse contexts that this hardship creates, poor children not only will continue disproportionately to exhibit externalizing behaviors, but also to experience less beneficial outcomes from PMT.

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