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Reviewing the need for technological and other expansions of evidence-based parent training for young children

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ABSTRACT

This conceptual review addresses the need for a "portfolio of models of delivery" for parent training services for young children, with a focus on two bodies of literature: barriers that prevent traditional parent training and emerging and novel approaches to parent training that overcome barriers. Traditional, face-to-face parent training programs have an abundance of empirical support for promoting positive parenting and treating mental health conditions in young children, particularly disruptive behavior disorders. Yet available research suggests that only a small minority of those who could benefit from evidence-based parent training actually receives them. Numerous barriers, discussed in one section of the review, prevent families of children with emotional and behavioral challenges from completing, connecting with, and seeking parent training services. For example, parents' negative perceptions of services, unavailability of services, and stigma are all salient barriers that limit the reach of traditional parent training. In the next section of the review, we review preliminary empirical investigations evaluating emerging novel approaches to parent training including modifications to traditional delivery formats, self-directed parent training programs and delivery of parent training in pediatric care settings. For each of these approaches, technology shows promise for expanding the reach of parent training services. If fully developed, this portfolio of models for delivering parent training has the potential to overcome many barriers that prevent parents from receiving parent training information. Ultimately, the purpose of the review is to articulate the need to add additional focus on developing and evaluating novel approaches that can increase the reach of parent training. Next steps for expanding the reach of parent training services are considered.

Most children with mental health challenges do not receive intervention services. Overall, estimates suggest that only approximately 20% of school-aged children with an indicated mental health need have received any mental health services in the past year (Kataoka, Zhang, & Wells, 2002). This gap between treatment need and treatment receipt is likely to be even higher for preschool-aged children, approximately 20% of whom meet diagnostic criteria for a mental health disorder, particularly Oppositional Defiant Disorder (ODD), Attention-Deficit Hyperactivity Disorder (ADHD), and Separation Anxiety Disorder (Egger & Angold, 2006). Available data suggests that only approximately 3% of preschool-aged children with an indicated mental health need receive services (Kataoka et al., 2002; Lavigne, Lebailly, Hopkins, Gouze, & Binns, 2009). The current system of mental health service provision is failing the vast majority of at-risk young children.

The profound gap between children needing and receiving mental health services, and the low likelihood of children receiving evidence-based interventions, led Kazdin and colleagues (Kazdin & Blase, 2011; Kazdin & Rabbitt, 2013; Kazdin, 2008; Kazdin, 2010; Kazdin, 2011) to call for diversified delivery approaches aimed at ameliorating mental health challenges at the population level. In particular, Kazdin and colleagues urge mental health professionals to expand services beyond face-to-face individual or group psychotherapy in order to increase the reach of services. Kazdin and Blase (2011) specify the need for a *portfolio* of services making use of primary care, technology, nonprofessionals, self-help, and the media. This paper expands on this idea with a particular focus on parent training programs for parents of young children by providing specific information about barriers that limit the reach of parent training and delineates specific examples from the literature on promising, novel approaches to parent training—highlighting the potential of technology. Traditional parent training programs are plentiful, indicated for a range of common mental health problems, and supported by a rapidly accumulating evidence-base (Bagner & Eyberg, 2007; Brestan & Eyberg, 1998; Nowak & Heinrichs, 2008; Reid, Webster-Stratton, & Hammond, 2003; Webster-Stratton, Reid, & Beauchaine, 2013; Zisser & Eyberg, 2010), but are too often not received (e.g., Sanders, Bor, & Morawska, 2007) or fully completed (e.g., Pearl et al., 2012; Werba, Eyberg, Boggs, & Algina, 2006) by families and children in need.

This review will articulate the need for diversified delivery of parent training programs; creating a spectrum of services available to parents ranging from intensive face-to-face services to brief, self-directed

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parent training. In doing so, it will highlight the extent to which parents, especially some subgroups of parents, are not benefiting from traditional delivery formats. Following a brief review of prominent evidence-based parent training programs, we review some of the barriers that parents of young children face in completing, connecting with, and seeking traditional services. Fig. 1 depicts groups of families along this continuum and summarizes barriers along the continuum that prevent parents from receiving parent training information. Following this, we review recent examples and initial successes from the literature on emerging, novel approaches to parent training. These approaches include modified traditional parent training interventions and unique, non-traditional approaches to parent training. In both respects, the use of technology is highlighted as an emerging tool for overcoming barriers (see Table 1). Finally, we present a consideration of next steps, including a possible technology-based approach to parent training that overcomes many barriers and incorporates promising features of recent approaches to parent training. Ultimately, the need to further develop and evaluate a portfolio of parent training services is indicated.

1. Parent training interventions for parents of young children

Young children's disruptive behavior creates a great deal of stress for parents to manage (Williford, Calkins, & Keane, 2007), which relates to parents seeking and receiving mental health services (Lavigne et al., 1998; Pavuluri, Luk, & McGee, 1996). Parent training programs are a first-line recommendation for the treatment of disruptive behavior programs in young children. These programs teach parents to reward cooperative child behavior, prevent challenging behavior, and discourage disruptive behavior when it does occur. These programs also often provide parents with guidance aimed at improving the parent–child relationship, communication, and the home structure.

Parent–Child Interaction Therapy (PCIT), The Incredible Years (IY) parent program, and the Positive Parenting Program (Triple P) are three of the most widely-researched parent training interventions for young children. Although each of these programs has available adapted delivery formats (e.g., self-directed version of Triple P, to be discussed later in this review), the mostly widely researched format for each program includes face-to-face meetings with parents, either in groups or individually. Each program has demonstrated ability to improve parenting practices and reduce disruptive child behavior (Bagner & Eyberg, 2007; Brestan & Eyberg, 1998; Nowak & Heinrichs, 2008; Reid et al., 2003; Webster-Stratton et al., 2013; Zisser & Eyberg, 2010). Moreover, in addition to treating children's disruptive behavior problems, face-to-face parent training programs show promise for applicability to a variety of young children's mental health challenges and to many populations facing parenting challenges. For instance, PCIT has been adapted to treat separation anxiety (Pincus, Eyberg, & Choate, 2005) and depression (Lenze, Pautsch, & Luby, 2011) in young children. Each highlighted parent training program also has demonstrated efficacy for improving parenting practices in parents at risk for child maltreatment and those involved in the child welfare system (Chaffin et al., 2004, 2009; Hurlburt, Nguyen, Reid, Webster-Stratton, & Zhang, 2013; Petra & Kohl, 2010; Sanders et al., 2004; Thomas & Zimmer-Gembeck, 2011).

Although the three programs use different approaches to parent training (e.g., IY uses a group format while PCIT typically uses an individual format), there is a degree of overlapping content within each. Generally speaking, each of these programs is highly influenced by social learning theory (Thomas & Zimmer-Gembeck, 2007). PCIT and IY are both influenced by the work of Constance Hanf and the "Hanf model" of parent training, which emphasizes building a positive parent–child relationship through responsive play prior to teaching discipline techniques (Reitman & McMahon, 2013). In terms of specific content, each of these programs is built around two major goals: building a positive parent–child relationship, in which attention to positive behavior is maximized, and teaching specific skills for implementing an effective time-out procedure. The similar theoretical context and specific content of these programs may account for similarly positive efficacy and effectiveness results. In a meta-analysis of parent training programs, Kaminski, Valle, Filene, and Boyle (2008), demonstrated that programs focusing on building positive parent–child interactions and teaching parents appropriate use of time-out have larger effect sizes in the reduction of disruptive child behavior. Each of these elements is included in PCIT, IY, and Triple P.

Completion of these face-to-face interventions, however, takes significant commitment; dropout is common. Dropout rates from PCIT range from 34% to 77%, with lower dropout rates in one randomized clinical trial (RCT; Werba et al., 2006) and higher dropout rates in a community medical setting (Pearl et al., 2012). In a meta-analysis of the Triple P, the average dropout rate was 19.5%, with a high of 59% (Nowak & Heinrichs, 2008). Damashek, Doughty, Ware, and Silovsky (2011) reported that 43% of at-risk parents dropped out of SafeCare, an in-home parent training program aimed at preventing child maltreatment. Some have suggested that a subset of parents that may discontinue services early are actually quick responders, meaning that some dropout could reflect a positive outcome (Nock & Ferriter, 2005), however parent training research does not support this suggestion. In a unique study that followed up with families who completed

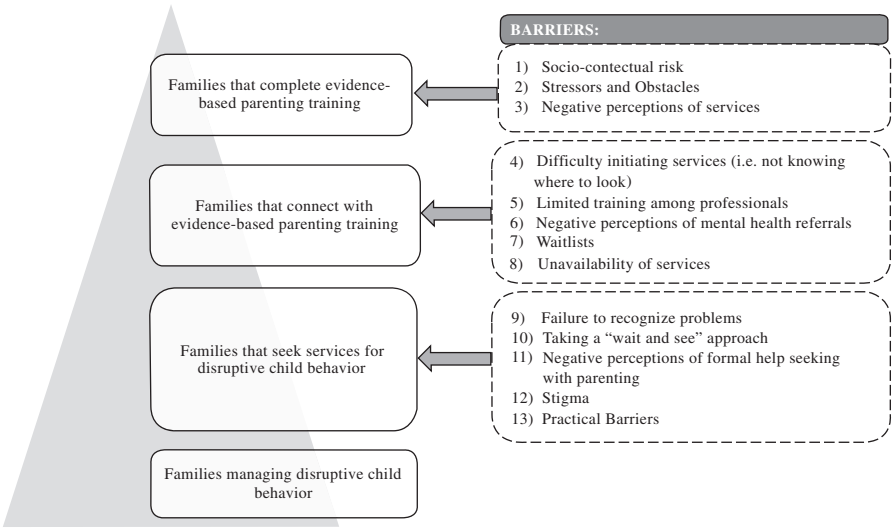

Fig. 1. Heuristic depicting groups of families along the continuum of receiving evidence-based parent training for disruptive child behavior and preventative barriers along this continuum.