Family-Based Interventions for Young Children with Conduct Problems: Lessons Learned and Future Directions

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Disclosure Statement

Co-author of *Helping the Noncompliant Child* and have a royalty agreement with Guilford Publications, Inc.

Member, International Scientific Advisory Committee, Triple P-Positive Parenting Program
Conduct Problems

Cluster of “Acting Out” Behaviors (Overt and Covert)

- Oppositional
  - Arguing
  - Temper tantrums
  - Excessive disobedience

- Aggressive/Violent
  - Fighting
  - Bullying
  - Swearing

- Covert
  - Stealing
  - Lying
  - Cheating
  - Vandalism
Conduct Problems

DSM-5: ODD and Conduct Disorder

>50% of Clinic-Referrals to Children’s Outpatient Mental Health Services

5-9% of General Population

Associated with Variety of Other Problems
Focus of This Presentation

- Linking developmental research with intervention
- Basic approaches to Parent Management Training
- What we know/Don’t know
- Implications for practitioners
**DEVELOPMENTAL PATHWAYS OF CONDUCT PROBLEMS**

**“EARLY STARTER”**
- Preschool/Early School-Age Onset
- Overt And Covert Behaviors
- High Degree Of Continuity
- Poor Prognosis

**“LATE STARTER”**
- Early Adolescent Onset
- Covert Behaviors
- High Degree Of Desistance
- Better Prognosis
DEVELOPMENTAL PATHWAYS OF CONDUCT PROBLEMS

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Developmental Progression of Conduct Problem Behaviors

Oppositional
- Argues, temper tantrums, bragging, stubborn, demands attention, teases, 
  disobeys at home, loud, explosive

Offensive
- Cruelty, fights, disobeys at school, sulks, screams, swears, poor peer relations, 
  lying, cheating

Aggressive
- Destroys, bad friends, threatens, steals at home, attacks

Delinquent
- Sets fires, truancy, steals outside, runs away, alcohol/drug use, vandalism

Edelbrock, 1987
“EARLY STARTER” PATHWAY TO ANTISOCIAL BEHAVIOR

Preschool Years
- Early child, family, and community risk factors

School Entry
- Poor school readiness in cognitive, social, and emotional domains

Early Education Years
- Academic failure
- Peer rejection
- Social coping deficits
- Adult support/supervision

Early Adolescence
- Deviant peers
- Poor adult monitoring
- Alienation/depression

Increased and Diversified Antisocial Behavior
DEVELOPMENTAL MODEL

Preschool Years

Elementary and Middle School Years

Adolescence

- Serious antisocial activity
- School drop-out and failure
- Substance use
- Early/risky sexual activity
- Comorbid psychiatric disorders
DEVELOPMENTAL MODEL

Preschool Years

Elementary and Middle School Years

Adolescence

**Adulthood**

- Psychological problems
- Criminal behavior
- Poor educ/occup adjustment
- Marital disruption
- Increased mortality
Value of Saving a **Single** High-Risk Youth from a Life of Crime: $3.2-$5.5 million

Cohen & Piquero, 2009
NONCOMPLIANCE AS A KEYSTONE BEHAVIOR

Major concern/reason for referral

Appears early

Associated with both overt and covert problems

Associated with several DSM-5 diagnostic categories

Treatment of NC = ↓ other problem behaviors
Parenting Practices Associated With Conduct Problems

- Inconsistent Discipline
- Irritable, Explosive Discipline
- Low Supervision/Involvement
- Inflexible/Rigid Discipline
THE COERCIVE CYCLE

Parent COMMAND
Child NONCOMPLY + HI-RATE AVERSIVE (Whine, cry, tantrum)
Parent WITHDRAW COMMAND

Parent COMMAND + HI-RATE AVERSIVE
Child COMPLY

Parent COMMAND + HI-RATE AVERSIVE
Child NONCOMPLY + HI-RATE AVERSIVE
Other Family Factors Associated with Conduct Problems

- Maladaptive social cognitions
- Personal/interparental distress
  - Antisocial behavior
  - Substance abuse
  - Maternal depression
- Social isolation

McMahon, Wells, & Kotler, 2006
Implications for Intervention

Key Causal/Maintaining Factors

- Maladaptive parenting
- Coercive parenting
- Other family risk factors

Family Based Tx (e.g., PMT) Is Core Component

- *May* be sufficient with younger (i.e., preschool age) children with conduct problems
Parent Management Training (PMT)

Conceptual View

• Based on learning theory/research

A → B → C

• Relationship of behaviour (B) to antecedents (A) and consequences (C)

Active Training for Specific Behavioural Skills in Parent

Integrate Assessment/Evaluation with Treatment

Kazdin, 2005
Continuum of Intervention

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- Implications for practitioners
Parent Management Training

DELIVERY

Collaborative Relationship

Active instruction

• Modeling, roleplay, practice, feedback, discussion, homework

Individual or Small Groups

10-18 Sessions

2-6 Sessions/Content Area

Bloomquist & Schnell, 2002
Two Primary Approaches to PMT

Both Developed in Oregon in 1960s/Early 70s

Connie Hanf

Jerry Patterson
Constance Hanf
• Oregon Health Sciences University
• Key influence as a mentor

Originally for developmentally handicapped children

Five primary versions for children with conduct problems
# Major Hanf-Based PMT Programs

<table>
<thead>
<tr>
<th>Parent Training Program</th>
<th>Developer</th>
<th>Relation to Hanf/Year(s)</th>
<th>Target Population (Parents)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defiant Children (DC)</td>
<td>Barkley</td>
<td>Intern 1976-1977</td>
<td>Parents of youth/teens, ADHD dx</td>
</tr>
<tr>
<td>Incredible Years (IY)</td>
<td>Webster-Stratton</td>
<td>Trained by Hanf trainee (Kate Kogan)</td>
<td>Parents of children with disruptive beh, video delivery</td>
</tr>
</tbody>
</table>

Reitman & McMahon, 2013
Hanf-Based Programs

Common Features

3-8 year-old children (some variation)

Noncompliance

Two-phase program
HNC (Helping the Noncompliant Child)

OVERVIEW

Phase I (Differential Attention)
- Attends
- Rewards
- Ignoring

Phase II (Compliance Training)
- Clear instructions sequence
- Standing rules

McMahon & Forehand, 2003
## Hanf-Based PMT

<table>
<thead>
<tr>
<th>THERAPY</th>
<th>HNC</th>
<th>PCIT</th>
<th>DC</th>
<th>COPE</th>
<th>IY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual/Group</td>
<td>I</td>
<td>I</td>
<td>I/G</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>Skills (A,R,I,Cl,TO)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Performance Criteria</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Child Present</td>
<td>Yes</td>
<td>Partial</td>
<td>No/Partial</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Booster Sessions</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

Based on McMahon & Forehand, 2003
PMT-Oregon (PMTO)

Oregon Social Learning Center

- Gerald Patterson
- John Reid
- Marion Forgatch
Core Elements of PMTO

Presenting Problem
- Excessive noncompliance/aggression

Child Age
- 4 to 12

Participants
- Parent(s)
Core Elements of PMTO (cont.)

Parenting Skills

- Skill encouragement
  - Positive attention, charts, tangible rewards
- Limit setting
  - Time out, response cost, fines, chores
- Monitoring
- Problem solving
- Positive Involvement
## Comparison of HNC and PMT-Oregon

<table>
<thead>
<tr>
<th>THERAPY</th>
<th>HNC</th>
<th>PMT-O</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>3-8 years</td>
<td>4-12 years</td>
</tr>
<tr>
<td><strong>Child Participation</strong></td>
<td>Yes</td>
<td>No*</td>
</tr>
<tr>
<td><strong>Parent-Child Relationship</strong></td>
<td>Extensive</td>
<td>Less</td>
</tr>
<tr>
<td><strong>Focus</strong></td>
<td>Minimal</td>
<td>Extensive</td>
</tr>
<tr>
<td><strong>Tangible Reinforcement</strong></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

*PMTO-Norway includes child to varying degrees*
TRIPLE P
(Positive Parenting Program)

Sanders and colleagues (Australia)

System of multiple levels of intervention

Birth-16 years (primarily 2-8 years)
Triple P System

- Intensive family intervention
- Broad focused parent training
- Narrow focus parent training
- Brief parenting advice
- Communications strategy

Levels:
- Level 5: Intensive family intervention
- Level 4: Broad focused parent training
- Level 3: Narrow focus parent training
- Level 2: Brief parenting advice
- Level 1: Communications strategy

Breadth of reach
Intensity of intervention

Calam, 2012
17 Core Parenting Skills

Promoting positive relationships
- Brief quality time
- Talking to children
- Affection

Encouraging desirable behaviour
- Praise
- Positive attention
- Engaging activities

Teaching new skills and behaviours
- Modelling
- Incidental teaching
- Ask-say-do
- Behaviour charts

Managing misbehaviour
- Ground rules
- Directed discussion
- Planned ignoring
- Clear, calm instructions
- Logical consequences
- Quiet time
- Time-out

Calam, 2012
Focus of This Presentation

- Linking developmental research with intervention
- Basic approaches to Parent Management Training
- What we know/Don’t know
- Implications for practitioners
PMT for Children with CP
SELECTED META-ANALYTIC REVIEWS

- de Graaf et al. (2008)
- Dretzke et al. (2009)
- Epstein et al. (2015)
- Gardner et al. (2015)
- Kaminski et al. (2008)
- Leijten et al. (2013)
- Lindhiem et al. (2014)
- Lundahl et al. (2006)
- Maughan et al. (2005)

- McCart et al. (2006)
- Menting et al. (2013)
- Michelson et al. (2013)
- Nowak & Heinrichs (2008)
- Piquero et al. (2009)
- Reyna & McGrath (2006)
- Sanders et al. (2014)
- Serketich & Dumas (1996)
WHAT WE KNOW
Outcome and Generalization

Settings and Formats

Clinic and home settings

Individual families and groups

Self-administered can be effective with some families

McMahon, 2015
**WHAT WE KNOW**

**Outcome and Generalization**

### Immediate Treatment Outcome

<table>
<thead>
<tr>
<th>Parent behavior</th>
<th>Child behavior</th>
<th>Parental adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ES = .45</strong></td>
<td><strong>ES = .30-.86</strong></td>
<td><strong>ES = .44-.53</strong></td>
</tr>
<tr>
<td>↓ Directive, controlling, critical</td>
<td>↓ Verbally/physically aggressive</td>
<td></td>
</tr>
<tr>
<td>↑ Positive</td>
<td>↑ Compliant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>↓ Destructive</td>
<td></td>
</tr>
</tbody>
</table>

Dretzke et al., 2009; Lundahl et al., 2006; Maughan et al., 2005; Sanders et al., 2014; Serketich & Dumas, 1996
WHAT WE KNOW
Outcome and Generalization

Generalization of Positive Effects
- Home
- Untreated siblings
- Untreated behaviors
- Long-term maintenance (10+ years)

Generalization to School
- Limited

McMahon, 2015
WHAT WE KNOW
Outcome and Generalization

Social Validity

Consumer satisfaction

Improvement to normative range

Serketich & Dumas (1996) meta-analysis

- 17/19 tx groups dropped below clinical range on ≥1 measure
- 14 tx groups did so on all measures

McMahon, 2015
WHAT WE KNOW
Outcome and Generalization

Comparison Studies

Control conditions
• No tx
• Waiting-list/attention placebo

Other treatments
• Family systems (Wells & Egan, 1986) /Other PMT (Abikoff et al., 2014)
• Available community mental health services (Taylor et al., 1998)
• Youth cognitive behavior therapy (McCart et al., 2006) (ES: .45 [PMT] vs. .23 [CBT])

McMahon, 2015
WHAT WE KNOW
Outcome and Generalization

Comparison Studies

Other treatments

• Family systems (Wells & Egan, 1986)
• Available community mental health services/TAU (Stattin et al., 2015; Taylor et al., 1998)
• PMT head-to-head comparisons (Abikoff et al., 2015; Stattin et al., 2015)
• PMT=PMT+child tx (Epstein et al., 2015)
• Youth cognitive behavior therapy (McCart et al., 2006) (ES: .45 [PMT] vs. .23 [CBT])

McMahon, 2015
WHAT WE KNOW

Common Elements

**Successful parenting outcomes**

- Positive P-C interaction skills
- Emotional communication skills
- Require Ps to practice with C during session

**Successful for ↓ child conduct problems**

- Correct use of time out
- Consistent responding to C
- Positive interaction with C
- Require Ps to practice with C during session

Kaminski et al., 2008
WHAT WE KNOW
Fidelity

Fidelity is essential!

- Poor fidelity may result in no effects or even negative ones!! (e.g., PMTO, FFT, MST)
WHAT WE KNOW
Dissemination and Effectiveness

Cross-national disseminations

- Triple-P, Incredible Years, PCIT, PMTO
- North America, Europe, Australia, Asia
- At least as effective as “original” (Gardner et al, 2015)

Effectiveness trials

- Community MH centers, volunteer organizations, child welfare/protection systems
Triple P: International dissemination
1996 onwards...
58,475 training places

Australia
New Zealand
Canada
United States
Ireland
Scotland
England
Wales
Iran
Curacao
Luxembourg

Germany
The Netherlands & BES Islands
Belgium
Switzerland
Sweden
Singapore
Japan
Hong Kong
Austria
Romania

Chile
France
Portugal
Turkey
Estonia
Panama

Watch this space......
WHAT WE KNOW
PMT Works in “Real-World” Settings

- Clinic-referred samples
- Non-specialist therapists
- Routine settings
- Part of a routine service

Michelson et al., 2013
## Cost-Benefit of PMT

**Washington State Institute of Public Policy**

<table>
<thead>
<tr>
<th>PMT Program</th>
<th>Benefit-to-Cost Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incredible Years</td>
<td>$1.20</td>
</tr>
<tr>
<td>PCIT International</td>
<td>$2.53</td>
</tr>
<tr>
<td>Triple P</td>
<td>$1.98 (ind-Level 4)</td>
</tr>
<tr>
<td></td>
<td>$5.63 (grp-Level 4)</td>
</tr>
</tbody>
</table>

Lee et al., 2012
WHAT WE KNOW
Outcome and Generalization

Not effective for 25-33% of families

- Mean = 28% (Forehand et al., 1983)

Dropout can be high

McMahon et al., 2006
## WHAT WE KNOW

### Predictors of Outcome/Dropout

<table>
<thead>
<tr>
<th>PREDICTORS</th>
<th>OUTCOME</th>
<th>DROPOUT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low SES</td>
<td>XXX</td>
<td>X</td>
</tr>
<tr>
<td>Single parent</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Younger maternal age</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Minority status</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Maternal adjustment</td>
<td>XX</td>
<td></td>
</tr>
<tr>
<td>Pretx child conduct probs</td>
<td>XX</td>
<td></td>
</tr>
<tr>
<td>Referral source</td>
<td>XX</td>
<td></td>
</tr>
<tr>
<td>Tx attendance</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Tx barriers</td>
<td>XX</td>
<td></td>
</tr>
</tbody>
</table>

X=small; XX=medium; XXX=large ES  
Reyno & McGrath, 2006
Mechanisms of PMT

“The study of mechanisms of treatment is probably the best short-term and long-term investment for improving clinical practice and patient care.”

Kazdin, 2004
How, Why, and For Whom Does PMT Work?

- Big Questions – *How* and *Why* Does PMT Work, and for *Whom*?
- Gordon Paul (1967)
  “*What* treatment, by *whom*, is most effective for *this* individual with *that* specific problem, and under *which* set of circumstances?”
How, Why, and For Whom Do These Interventions Work?

- Don’t really know! *(Nock, 2003)*
- Relatively little research addressing questions of:
  - Mediation
    - *How and why* does tx work?
  - Moderation
    - For *whom* does this tx work?
WHAT WE KNOW
Parenting Behavior As a Mediator

25 studies (8 tx, 17 prevention)

45% (39/86 analyses) support mediation

Composite (90%), discipline (56%), positive (45%), negative (26%), monitoring (10%)

Prevention (72%) > Treatment (32%)

Children <10 years (61%) > 10+ years (29%)

Forehand et al., 2014
WHAT WE KNOW
Moderation: “For Whom Does PMT Work?”

Relatively little research

- Large samples often needed

Lundahl et al. (2006) meta-analysis

- Child behavior (outcome)
- Parent behavior/adjustment (outcomes)
- Participant characteristics and features of PMT (moderators)
WHAT WE KNOW
Moderation: “For Whom Does PMT Work?”

Significant moderators of poor outcomes
- SES, single-parent status, ↓ pretx conduct problems
- Group PMT

Child age NOT a moderator

Disadvantaged families
- Individual PMT > group PMT

Leijten et al., 2013; Lundahl et al., 2006
## Effect Sizes of PMT for Disadvantaged Families

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Individual PMT</th>
<th>Group PMT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Behavior</td>
<td>0.76</td>
<td>0.12</td>
</tr>
<tr>
<td>Parent Behavior</td>
<td>0.70</td>
<td>0.22</td>
</tr>
<tr>
<td>Parent Adjustment*</td>
<td>0.59</td>
<td>0.25</td>
</tr>
</tbody>
</table>

* Nonsignificant

Lundahl et al., 2006
WHAT WE KNOW
Prevention

Prevention of serious conduct problems may be our best bet!
Summarizing the Evidence for Prevention
Beelmann & Raabe (2010)

- 26 reviews/meta-analyses
- 1,075 independent studies
- Published between 1990-2008

<table>
<thead>
<tr>
<th>Type of Intervention</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent focused</td>
<td>.56</td>
</tr>
<tr>
<td>Child focused</td>
<td>.41</td>
</tr>
<tr>
<td>School/community</td>
<td>.28</td>
</tr>
</tbody>
</table>
Focus of This Presentation

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- Basic approaches to Parent Management Training
- What we know/Don’t know
- Implications for practitioners
PMT for Children with CP

WHAT WE DON’T KNOW /
FUTURE DIRECTIONS

Subgroup-specific treatments

• Fathers
• Single parents (e.g., PMTO)
• Maternal psychopathology (e.g., depression)
• Culturally-specific tx?
• Gender-specific tx?
# Effect Sizes of Triple P for Fathers

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child “SEB”</td>
<td>.38</td>
</tr>
<tr>
<td>Parenting practices</td>
<td>.35</td>
</tr>
<tr>
<td>Parent satisfaction/efficacy</td>
<td>.23</td>
</tr>
<tr>
<td>Parental adjustment*</td>
<td>.07</td>
</tr>
<tr>
<td>Parental relationship</td>
<td>.14</td>
</tr>
</tbody>
</table>

* $p = .06$

Sanders et al., 2014
• Fathers
• Single parents (e.g., PMTO)
• Maternal psychopathology (e.g., depression)
• Culturally-specific tx?
• Gender-specific tx?
PMT for Children with CP

WHAT WE DON’T KNOW/ FUTURE DIRECTIONS

Comorbid patterns of child behavior

- CP+anxiety
- CP+ADHD
- CP + callous-unemotional “traits”*

*DSM-5: “with limited prosocial emotions”
Summary of Conduct Problem Pathways

Conduct Disorder

Childhood-onset Subtype
  - Primarily Impulsive Type

Adolescent-onset Subtype
  - Callous-unemotional Type

Frick & Dickens, 2006
Developmental Model Involving Callous-Unemotional “Traits”

- Fearlessness or low behavioral inhibition
  - Poor arousal to misfortune of others
  - Insensitivity to parental and societal sanctions
  - Ignoring the potential harmful effects of behavior

- Callous and unemotional personal style

- Especially severe antisocial behavior that includes instrumental aggression

Frick 2011
DSM-5 Specifier: 
Limited Prosocial Emotions

- Lack of remorse/guilt
- Callous-lack of empathy
- Unconcerned about performance
- Shallow/deficient affect

At least 2 of 4 in past 12 months; >1 setting
Do High CU “Traits” Affect Treatment?

Research at early stage

Really multiple questions:

• Respond to treatment at all?
• If so, comparable to other youth with conduct problems with low CU?
• Do CU “traits” decrease?

Hawes et al., 2014; Waller et al., 2013
Are CU “Traits” Related to Treatment Outcome?

CU associated with poorer PMT outcomes

- 9/11 studies (81%)
- ODD > conduct disorder

However, children with CU still respond to PMT

- Just not as well/to same degree

Hawes et al., 2014
Do CU “Traits” Respond to PMT?

CU ↓ after PMT

Two RCTs

- McDonald et al. (2011)
- Somech & Elizur (2012)

Hawes et al., 2014
Indicated Clinical Strategies for Children with CU “Traits”

PMT as the basis for tx

- Promotion of warmth/positive reinforcement especially important
- Discipline strategies

Potential adjunctive components

- Emotional engagement in P-C relationships (reciprocal eye contact; Dadds)
- Emotion coaching (Katz, McMahon)

Hawes et al., 2014
PMT for Children with CP

WHAT WE DON’T KNOW/
FUTURE DIRECTIONS

- Development of tx selection/matching guidelines
- Identification/elaboration of processes of family engagement and change (e.g., Family Check-Up)
- Enhancing tx outcome/generalization
- Incorporating technological advances into PMT design/delivery
PMT and Technology: Two Examples

Triple P Online (TPOL)

- Eight modules of Triple P vs. use of internet as usual (CO) (Sanders et al., 2012)
- TPOL>CO: child and par behavior, parent confidence and anger (post-tx and 6-mo follow-up)

Smartphone apps as adjuncts

- Skills video series, brief daily surveys, text message reminders, video recording home practice, and midweek video video calls (Jones et al., 2014)
- Compared to HNC alone, enhanced engagement of low-income families and fewer sessions
Focus of This Presentation

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- Basic approaches to Parent Management Training
- What we know/Don’t know
- Implications for practitioners
PMT for Children with CP

Implications for Practitioners

Know the problem!

Screen/assess broadly using evidence-based assessment practices

- Conduct problems, comorbid conditions, risk/protective factors
- MOST IMP: Developmental pathways
PMT for Children with CP

Implications for Practitioners

PMT is core component of tx (and prevention)

- *Can* be sufficient with younger (i.e., preschool age) children
- Less effective for single parents, economically disadvantaged families
- Unclear if more/less effective with children with more severe conduct problems
- *May* be more effective when administered to individual families rather than in groups
- Comparable for boys/girls and majority/minority samples
PMT for Children with CP

Implications for Practitioners

Multicomponent txs often necessary with older youth

• Example: child skills training, academics, peer relations

PMT is still an essential component
# Examples of Multicomponent Interventions

<table>
<thead>
<tr>
<th>TREATMENT</th>
<th>DEVELOPERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multisystemic Therapy (MST)</td>
<td>Webster-Stratton</td>
</tr>
<tr>
<td>Coping Power</td>
<td>Henggeler</td>
</tr>
<tr>
<td></td>
<td>Augimeri</td>
</tr>
<tr>
<td></td>
<td>Lochman, Wells</td>
</tr>
</tbody>
</table>

Adapted from McMahon et al., 2006
PMT for Children with CP

Implications for Practitioners

Fidelity is essential!

BUT – “Flexibility within fidelity” (Kendall, 2001)
Examples of Low/High-Risk Variations to PMT

Low risk  Process Variations  High risk

- More sessions when additional support required
- ↑ or ↓ session length

- Not structure sessions with an agenda
- Not routinely review HW

Content Variations

- Modify examples to fit family’s circumstances

- Suggest Ps stay away from principles underpinning strategies

Mazzucchelli & Sanders, 2010
PMT for Children with CP

Suggestions for Student Researchers

Let clinical experience (yours and others) stimulate and inform your research

Much to be gained from parametric analog studies ("microtrials") that examine components of txs or techniques

- Example: Mark Roberts’ series of studies re parameters of time out

Leijten et al., 2015
Prevention of serious conduct problems must be a key focus!
Thank you!

For your attention today

For the work that you do with children and families
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