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## Series Preface

*Tony Rousmaniere and Alexandre Vaz*

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We are pleased to introduce the Essentials of Deliberate Practice series of training books. We are developing this book series to address a specific need that we see in many psychology training programs. The issue can be illustrated by the training experiences of Mary, a hypothetical second-year graduate school trainee. Mary has learned a lot about mental health theory, research, and psychotherapy techniques. Mary is a dedicated student; she has read dozens of textbooks, written excellent papers about psychotherapy, and receives near-perfect scores on her course exams. However, when Mary sits with her clients at her practicum site, she often has trouble performing the therapy skills that she can write and talk about so clearly. Furthermore, Mary has noticed herself getting anxious when her clients express strong reactions, such as hopelessness, skepticism about therapy, or becoming very emotional. Sometimes this anxiety is strong enough to make Mary freeze at key moments, limiting her ability to help those clients.

During her weekly individual and group supervision, Mary's supervisor gives her advice informed by empirically supported therapies and common factor methods. The supervisor often supplements that advice by leading Mary through role plays, recommending additional reading, or providing examples from her own work with clients. Mary, a dedicated supervisee who shares tapes of her sessions with her supervisor, is open about her challenges, carefully writes down her supervisor's advice, and reads the suggested readings. However, when Mary sits down with her clients, she often finds that her new knowledge seems to have flown out of her head, and she is unable to enact her supervisor's advice. Mary finds this problem to be particularly acute with the clients who are emotionally evocative.

Mary's supervisor, who has received formal training in supervision, employs supervisory best practices, including the use of video to review supervisees' work. She would rate Mary's overall competence level as consistent with expectations for a trainee at Mary's developmental level. But even though Mary's overall progress is positive, she experiences some recurring problems in her work. This is true even though the supervisor is confident that she and Mary have identified the changes that Mary should make in her work.

The problem with which Mary and her supervisor are wrestling—the disconnect between her knowledge about psychotherapy and her ability to reliably perform psychotherapy—is the focus of this book series. We started this series because most therapists experience this disconnect, to one degree or another, whether they are beginning trainees or highly experienced clinicians. In truth, we are all Mary.

To address this problem, we are focusing this series on the use of deliberate practice, a method of training specifically designed for improving reliable performance of complex skills in challenging work environments (Rousmaniere, 2016, 2019; Rousmaniere et al., 2017). Deliberate practice entails experiential, repeated training with a particular skill until it becomes automatic. In the context of psychotherapy, this involves two trainees role-playing as a client and a therapist, switching roles every so often, under the guidance of a supervisor. The trainee playing the therapist reacts to client statements, ranging in difficulty from beginner to intermediate to advanced, with improvised responses that reflect fundamental therapeutic skills.

To create these books, we approached leading trainers and researchers of major therapy models with these simple instructions: Identify essential skills for your therapy model where trainees often experience a disconnect between cognitive knowledge and performance ability—in other words, skills that trainees could write a good paper about but often have challenges performing, especially with challenging clients. We then collaborated with the authors to create deliberate practice exercises specifically designed to improve reliable performance of these skills and overall responsive treatment (Hatcher, 2015; Stiles et al., 1998; Stiles & Horvath, 2017). Finally, we rigorously tested these exercises with trainees and trainers at multiple sites around the world and refined them based on extensive feedback.

Each book in this series focuses on a specific therapy model, but readers will notice that most exercises in these books touch on common-factor variables and facilitative interpersonal skills that researchers have identified as having the most impact on client outcome, such as empathy, verbal fluency, emotional expression, persuasiveness, and problem focus (e.g., Anderson et al., 2009; Norcross et al., 2019). Thus, the exercises in every book should help with a broad range of clients. Despite the specific theoretical model(s) from which one may work, most therapists place a strong emphasis on pantheoretical elements of the therapeutic relationship, many of which have robust empirical support as correlates or mechanisms of client improvement (e.g., Norcross et al., 2019). We also recognize that therapy models have established training programs with rich histories, so we present deliberate practice not as a replacement but as an adaptable, transtheoretical training method that can be integrated into these existing programs to improve skill retention and help ensure basic competency.

## About This Book

This book in the series is on behavioral parent training (BPT), an evidence-based approach that works on changing child externalizing (Daley et al., 2014; McCart et al., 2006; Michelson et al., 2013) and internalizing (Lebowitz et al., 2014; Sanders et al., 2014) behaviors by teaching and reinforcing specific adaptive parenting strategies to promote and maintain behavioral change. The targets of BPT are child symptom resolution, improved parent-child interpersonal functioning, and improved parent functioning (e.g., satisfaction, efficacy, and stress). BPT is a unique therapeutic approach in that the parents are the agent of change, and many trainees find that to achieve competence in delivery of BPT, they have to consider child and parenting behavior and work on creating a new paradigm of learning. Competency in the clinical area requires mastery of knowledge, skills, and attitudes. Integrating readings on child behavior and BPT theory with practicing BPT skills and receiving constructive feedback facilitates learning. Lastly, understanding the mechanism of change within BPT and clinical moderators (e.g., stress) that may interfere with

parents learning and competently applying these skills is essential. Practicing BPT skills with ongoing feedback will allow the clinician to calibrate their BPT practice and ultimately help them integrate their knowledge and skills into deeper BPT clinical practice.

In this book, we adopt deliberate practice methods to support experiential, "learning by doing" training opportunities. The described methods and stimuli facilitate practicing a range of important BPT skills that are present throughout many of the established BPT programs (e.g., the Helping the Noncompliant Child program, McMahon & Forehand, 2019; parent-child interaction therapy, McNeil & Hembree-Kigin, 2010; parent management training, Kazdin, 2005; positive parenting program, Sanders et al., 2007). In addition, by presenting diverse clinical scenarios that vary based on presenting problem, child age, parenting history, and parent emotional responsiveness, the exercises in this book support the fine-tuning of the "how" of intervention delivery. Importantly, this book is not intended to replace core coursework and exposure to foundational BPT theory and principles of practice. Rather, its purpose is to augment other common training components.

Thank you for including us in your journey toward psychotherapy expertise. Now let's get to practice!

# Introduction and Overview of Deliberate Practice and Behavioral Parent Training

## CHAPTER

# 1

Behavioral parent training (BPT) is a well-researched (McCart et al., 2006) and effective (Daley et al., 2014) clinical approach designed to treat and prevent problem behaviors among youth. There are many models of BPT, such as helping the noncompliant child (McMahon & Forehand, 2019), parent-child interaction therapy (PCIT; McNeil & Hembree-Kigin, 2010), and the Positive Parenting Program, or Triple P (Sanders et al., 2007), that, although distinct in their training and clinical application, share many common components. Clinical decision making regarding what components to focus on within BPT may vary as a function of the presenting problem(s) as well as the family system. Some parents have limited time to engage in BPT, and parents will differ in terms of the types of skills that they may need to work on. As an example, some parents may benefit from clinical focus on providing positive reinforcement, while for others, targeting parent emotion regulation may be key to allowing them to make better parenting decisions and apply skills learned in BPT. A strength of BPT is that these skills can be delivered to parents in different orders that target their greatest needs. This book provides 12 of the most common skills seen within the BPT literature, defines each skill, and demonstrates how to deliver these skills effectively and competently within the structure of deliberate practice.

While the name implies that the focus of BPT will be on clinical work with the parents, a common question from parents often relates to the fact that since the child is the problem, why are we not working directly with the child? Another typical response from new trainees upon initial exposures to BPT is that it is a simple, almost mechanistic approach to clinical work. Many of the procedures used within BPT are rooted in learning theory, which is often viewed in simplistic terms (i.e., reward the positive and punish the negative). However, the application of these learning principles within BPT for children and adolescents with a range of behavioral, clinical, and emotional difficulties is anything but easy. Although there are many "how to" books when it comes to parenting and myriad podcasts and videos, these can be very misleading. As an example, research has shown that 25% of parents continue to believe that sugar "causes" attention-deficit/hyperactivity disorder (Bussing et al., 2012).

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*Deliberate Practice in Behavioral Parent Training*, by M. D. Terjesen, H. B. Vidair, P. S. Ohr, O. A. Walsh, T. Rousmaniere, and A. Vaz

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A good BPT clinician will have a strong knowledge of learning theory, as well as the core skills of BPT and be able to apply the skills within a therapeutic context. Upon review of the lead authors' collective school and clinical-based training in BPT, it was apparent that there is a gap between skill knowledge and skill application. We have found that in training clinicians in clinical work with parents, it is important to model the skill, have the trainee demonstrate the skill, receive feedback on the skill and then have them continue to demonstrate the skill and receive specific feedback until competency is demonstrated.

Two well-known BPT programs, PCIT (McNeil & Hembree-Kigin, 2010) and Helping the Noncompliant Child (HNC; McMahon & Forehand, 2019), both have a mastery component to the training of their parents, and the extension to working toward developing competency among clinicians is logical. In considering the training of clinicians, it became apparent to us that there were elements of deliberate practice embedded in the provision of training, albeit not as structured or explicit.

Beginning clinicians often want to be told a BPT technique, and although they communicate an understanding of that skill, they often struggle in its application or demonstration, either in supervision or in clinical work with parents. When providing training in BPT, we often ask beginning clinicians about specific BPT skills in which they believe they are not as competent and find difficult to do within clinical practice, then we work on developing that skill. This is consistent with a deliberate practice approach toward skill development. Group settings for skills training are often quite helpful, as peers get to observe the skill development in their colleagues, role-play a number of clinical problems, and demonstrate many skills within BPT. Deliberate practice as it is presented in this series, and specifically in this book on BPT, is a natural and more structured approach to building high-quality training in BPT. The addition of continuing to work on one or several of the specific skills addressed in this book until trainees gain a sense of mastery serves to promote further professional development. The exercises provided for each of the skills included here contain different clinical presentations of parents' descriptions of emotional and behavioral problems seen with their children and offer trainees opportunities to enhance their BPT skills and develop their own unique style of delivering BPT.

## Overview of the Deliberate Practice Exercises

The main focus of the book is a series of 14 exercises that have been thoroughly tested and modified based on feedback from BPT trainers and trainees. The first 12 exercises each represent an essential BPT skill. The last two exercises are more comprehensive, consisting of an annotated BPT transcript and improvised mock therapy sessions that teach practitioners how to integrate all these skills into more expansive clinical scenarios. Table 1.1 presents the 12 exercises.

Throughout all the exercises, trainees work in pairs under the guidance of a supervisor and role-play as a parent and a therapist, switching back and forth between the two roles. Each of the 12 skill-focused exercises consists of multiple scripted parent statements grouped by difficulty—beginner, intermediate, and advanced—that calls for a specific skill. For each skill, trainees are asked to read through and absorb the description of the skill, its criteria, and some examples of it. The trainee playing the parent then reads the statements. The trainee playing the therapist then responds in a way that demonstrates the appropriate skill. Trainee therapists will have the option of practicing a

**TABLE 1.1. The 12 Behavioral Parent Training Skills Presented in the Deliberate Practice Exercises**

| Beginner Skills                                           | Intermediate Skills                                                                       | Advanced Skills                                                 |
|-----------------------------------------------------------|-------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| 1. Psychoeducation about behavioral parent training       | 5. Teaching parents to provide positive attention                                         | 9. Teaching parents about consequence interventions             |
| 2. Psychoeducation about the functions of child behaviors | 6. Teaching parents planned ignoring with positive attention                              | 10. Providing strategies for parent affect management           |
| 3. Identifying and validating parent affect               | 7. Teaching parents about effective communication                                         | 11. Teaching parents about managing behavior in public settings |
| 4. Teaching parents how to provide praise                 | 8. Teaching parents how to implement positive incentives to bring about behavioral change | 12. Development of homework assignments                         |

response using one of the examples supplied in the exercise or immediately improvising and supplying their own.

After each parent statement and therapist response couplet is practiced several times, the trainees will stop to receive feedback from the supervisor. Guided by the supervisor, the trainees will be instructed to try statement–response couplets several times, working their way down the list. In consultation with the supervisor, trainees will go through the exercises, starting with the least challenging and moving through to more advanced levels. The triad (supervisor–parent–therapist) will have the opportunity to discuss whether exercises present too much or too little challenge and adjust up or down depending on the assessment.

Trainees, in consultation with supervisors, can decide which skills they wish to practice and for how long. Based on our testing experience, we have found practice sessions last about 1 to 1.25 hours to receive maximum benefit. After this, trainees become saturated and need a break.

Ideally, BPT learners will both gain confidence and achieve competence through practicing these exercises. Competence is defined here as the ability to perform a BPT skill in a manner that is flexible and responsive to the parent and their needs and concerns about their child. Skills have been chosen that are considered essential to BPT and that practitioners often find challenging to implement.

The skills identified in this book are not comprehensive in the sense of representing all one needs to learn to become a competent BPT clinician. Some skills will present particular challenges for trainees. A short overview of BPT and a brief description of the deliberate practice methodology is provided to explain how we have arrived at the union between them.

## The Goals of This Book

The primary goal of this book is to help trainees achieve competence in core BPT skills. Therefore, the expression of that skill or competency may look somewhat different across clients or even within a session with the same client.

The BPT deliberate practice exercises are designed to achieve the following:

1. Help BPT therapists develop the ability to apply the skills in a range of clinical situations and across child ages.
2. Move the skills into procedural memory (Squire, 2004) so that BPT therapists can access them even when they are tired, stressed, overwhelmed, or discouraged.
3. Provide BPT therapists in training with an opportunity to exercise a particular skill using a style and language that is congruent with who they are.
4. Provide the opportunity to use the BPT skills in response to varying parent statements and affect that represent a range of clinical problems seen among children. This is designed to build confidence to adopt skills in a broad range of circumstances within different parent-child contexts.
5. Provide BPT therapists in training with many opportunities to fail and then correct their failed response on the basis of feedback. This helps build confidence and persistence.

Finally, this book aims to help trainees discover their own personal learning style so that they can continue their professional development long after their formal training is concluded.

### Who Can Benefit From This Book?

This book is designed to be used in multiple contexts, including in graduate-level courses, supervision, postgraduate training, and continuing education programs. It assumes the following:

1. The trainer is knowledgeable about and competent in BPT.
2. The trainer can provide good demonstrations of how to use BPT skills across a range of therapeutic situations, via role-play and/or video. Or the trainer has access to examples of BPT being demonstrated through the many psychotherapy video examples available.
3. The trainer can provide feedback to students regarding how to craft/improve their application of BPT skills.
4. Trainees will have accompanying reading, such as books and articles, that explain the theory, research, and rationale of BPT and each particular skill. Recommended reading for each skill is provided in the sample syllabus (Appendix C).

The deliberate practice exercise formats covered in this book series were piloted in training sites from 16 countries across four continents (North America, South America, Europe, and Asia). This book is designed for trainers and trainees from different cultural backgrounds worldwide.

This book is also designed for those who are training at all career stages, from beginning trainees, including those who have never worked with real clients, to seasoned therapists. All exercises feature guidance for assessing the adjusting of the difficulty to precisely target the needs of each individual learner. The term *trainee* in this book is used broadly, referring to anyone in the field of professional mental health who endeavors to acquire BPT skills. For further guidance on how to improve multicultural deliberate practice skills, see the book *Deliberate Practice in Multicultural Therapy* (Harris et al., 2023).

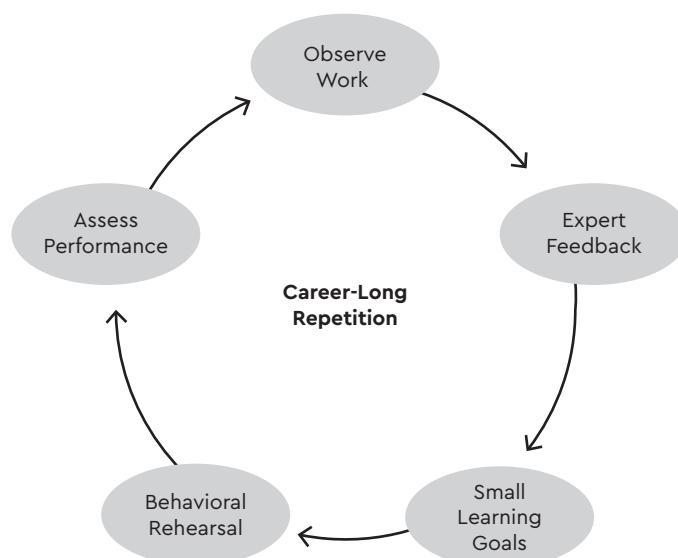
## Deliberate Practice in Psychotherapy Training

How does one become an expert in their professional field? What is trainable, and what is simply beyond our reach, due to innate or uncontrollable factors? Questions such as these touch on our fascination with expert performers and their development. A mixture of awe, admiration, and even confusion surround people such as the artists Mozart, Mary Cassatt, and Leonardo da Vinci, or more contemporary top performers such as the painter Frida Kahlo, basketball legend Michael Jordan, and chess virtuoso Garry Kasparov. What accounts for their consistently superior professional results? Evidence suggests that the amount of time spent on a particular type of training is a key factor in developing expertise in virtually all domains (Ericsson & Pool, 2016). "Deliberate practice" is an evidence-based method that can improve performance in an effective and reliable manner.

The concept of deliberate practice has its origins in a classic study by K. Anders Ericsson and colleagues (1993). They found that the amount of time practicing a skill and the quality of the time spent doing so were key factors predicting mastery and acquisition. They identified five key activities in learning and mastering skills: (a) observing one's own work, (b) getting expert feedback, (c) setting small incremental learning goals just beyond the performer's ability, (d) engaging in repetitive behavioral rehearsal of specific skills, and (e) continuously assessing performance. Ericsson and his colleagues termed this process deliberate practice, a cyclical process that is illustrated in Figure 1.1.

Research has shown that lengthy engagement in deliberate practice is associated with expert performance across a variety of professional fields, such as medicine, sports, music, chess, computer programming, and mathematics (Ericsson et al., 2018). People may associate deliberate practice with the widely known "10,000-hour rule" popularized by Malcolm Gladwell in his 2008 book *Outliers*, although the actual number of hours required for expertise varies by field and by individual (Ericsson & Pool, 2016). This idea, though, perpetuates two misunderstandings—first, that this is the number

**FIGURE 1.1. Cycle of Deliberate Practice**



Note. From *Deliberate Practice in Emotion-Focused Therapy* (p. 7), by R. N. Goldman, A. Vaz, and T. Rousmaniere, 2021, American Psychological Association (<https://doi.org/10.1037/0000227-000>). Copyright 2021 by the American Psychological Association.

of deliberate practice hours that everyone needs to attain expertise, no matter the domain. In fact, there can be considerable variability in how many hours are required.

The second misunderstanding is that engagement in 10,000 hours of work performance will lead one to become an expert in that domain. This misunderstanding holds considerable significance for the field of psychotherapy, where hours of work experience with clients has traditionally been used as a measure of proficiency (Rousmaniere, 2016). Research suggests that the amount of experience alone does not predict therapist effectiveness (Goldberg et al., 2016). It may be that the quality of deliberate practice is a key factor.

Psychotherapy scholars, recognizing the value of deliberate practice in other fields, have called for deliberate practice to be incorporated into training for mental health professionals (e.g., Bailey & Ogles, 2019; Hill et al., 2020; Rousmaniere et al., 2017; Taylor & Neimeyer, 2017; Tracey et al., 2015). There are, however, good reasons to question analogies made between psychotherapy and other professional fields, like sports or music, because by comparison psychotherapy is so complex and free form. Sports have clearly defined goals, and classical music follows a written score. In contrast, the goals of psychotherapy shift with the unique presentation of each client at each session. Therapists do not have the luxury of following a score.

Instead, good psychotherapy is more like improvisational jazz (Noa Kageyama, cited in Rousmaniere, 2016). In jazz improvisations, a complex mixture of group collaboration, creativity, and interaction are coconstructed among band members. Like psychotherapy, no two jazz improvisations are identical. However, improvisations are not a random collection of notes. They are grounded in a comprehensive theoretical understanding and technical proficiency that is only developed through continuous deliberate practice. For example, prominent jazz instructor Jerry Coker (1990) lists 18 different skill areas that students must master, each of which has multiple discrete skills including tone quality, intervals, chord arpeggios, scales, patterns, and licks. In this sense, more creative and artful improvisations are actually a reflection of a previous commitment to repetitive skill practice and acquisition. As legendary jazz musician Miles Davis put it, "You have to play a long time to be able to play like yourself" (Cook, 2005, p. 112).

The main idea that we would like to stress here is that we want deliberate practice to help BPT therapists become themselves. The idea is to learn the skills so that you have them on hand when you want them. Practice the skills to make them your own. Incorporate those aspects that feel right for you. Ongoing and effortful deliberate practice should not be an impediment to flexibility and creativity. Ideally, it should enhance it. We recognize and celebrate that psychotherapy is an ever-shifting encounter and by no means want it to become or feel formulaic. Strong BPT therapists mix an eloquent integration of previously acquired skills with properly attuned flexibility. The core BPT responses provided are meant as templates or possibilities, rather than "answers." Please interpret and apply them as you see fit, in a way that makes sense to you. We encourage flexible and improvisational play!

### **Simulation-Based Mastery Learning**

Deliberate practice uses simulation-based mastery learning exercises (Ericsson, 2004; McGaghie et al., 2014). That is, the stimulus material for training consists of "contrived social situations that mimic problems, events, or conditions that arise in professional encounters" (McGaghie et al., 2014, p. 375). A key component of this approach is that the stimuli being used in training are sufficiently similar to the real-world experiences so that what they mimic provokes similar reactions. This facilitates *state-dependent*

*learning*, where professionals acquire skills in the same psychological environment where they will have to perform the skills (Fisher & Craik, 1977). For example, pilots train with flight simulators that present mechanical failures and dangerous weather conditions, and surgeons practice with surgical simulators that present medical complications. Training in simulations with challenging stimuli increases professionals' capacity to perform effectively under stress. For the psychotherapy training exercises in this book, the "simulators" are typical parent statements that might actually be presented in the course of therapy sessions and call upon the use of the particular skill.

### Declarative Versus Procedural Knowledge

Declarative knowledge is what a person can understand, write, or speak about. It often refers to factual information that can be consciously recalled through memory and often can be acquired relatively quickly. In contrast, procedural learning is implicit in memory, and "usually requires repetition of an activity, and associated learning is demonstrated through improved task performance" (Kozioł & Budding, 2012, p. 2694). Procedural knowledge is what a person can perform, especially under stress (Squire, 2004). People can display a wide difference between their declarative and procedural knowledge. For example, an "armchair quarterback" is a person who understands and talks about athletics well but would have trouble performing it at a professional ability. Likewise, most dance, music, or theater critics have a very high ability to write about their subjects but would be flummoxed if asked to perform them.

**The sweet spot for deliberate practice is the gap between declarative and procedural knowledge.** In other words, effortful practice should target those skills that the trainee could write a good paper about but would have trouble actually performing with a real client. We start with declarative knowledge, learning skills theoretically and observing others perform them. Once learned, with the help of deliberate practice, we work toward the development of procedural learning, with the aim of therapists having "automatic" access to each of the skills that they can pull on when necessary.

Let us turn to a little theoretical background on BPT. This will help contextualize the skills of the book and how they fit into the greater training model.

### Behavioral Parent Training: Theoretical Overview

Research indicates behavioral or conduct problems are the most common disorders children and adolescents face, with more than half of these children undergoing mental health treatment (Ghandour et al., 2019). BPT is an evidence-based treatment designed to reduce child misbehavior, increase desired/adaptive behaviors, and improve parent-child interactions. A substantial body of research has demonstrated the efficacy of BPT, which is a well-established intervention for treating childhood externalizing behavior disorders, such as oppositional defiant disorder, conduct disorder, and attention-deficit/hyperactivity disorder (Evans et al., 2014; Eyberg et al., 2008; Kaminski & Claussen, 2017). Treatment gains from several BPT programs have demonstrated maintained gains over time (Eyberg et al., 2008; Kaminski & Claussen, 2017). BPT prevention programs have also demonstrated the ability to improve child behavioral and emotional outcomes (e.g., Lebowitz et al., 2014; Sanders et al., 2014; Webster-Stratton, 1998). BPT has also been shown to increase parent functioning, such as improvements in parental efficacy and competence and reductions in parenting stress (Colalillo & Johnston, 2016; Gardner et al. 2006; Graf et al., 2014).

There are a variety of BPT programs that are evidence-based with considerable content overlap, including praise, positive attention and planned ignoring, positive incentives/token economies, and consequences (e.g., time out, response cost); however, various programs have slightly different structures. For example, the Parent Management Training (Kazdin, 2005) program focuses on meeting with a parent individually, although parents may occasionally be asked to bring their children into sessions. In some BPT programs such as parent-child interaction therapy (McNeil & Hembree-Kigin, 2010) and HNC (McMahon & Forehand, 2005), parents practice BPT skills directly with their child while the therapist observes and provides feedback in the form of live coaching. This live, in-the-moment coaching and feedback to build parental skill competency is very similar to the deliberate practice approach to building clinician competency in BPT that is demonstrated within this book. The Incredible Years program (Webster-Stratton, 2012) includes parent groups with video vignettes demonstrating parenting skills, while the Defiant Children program (Barkley, 2013) can be used with individual parents or in a group setting. Some programs for older children, like Defiant Teens (Barkley & Robin, 2014), include parent sessions alone as well as some joint parent-child sessions. Regardless of structure, across BPT programs, clinicians typically teach a parent the rationale behind a skill, explain how to implement it with their child, model the skill, and then have the parent practice it, often in the form of a role-play, where they provide immediate feedback. Parents are then assigned homework to practice skills learned in session with their child. The demonstration, feedback, and practice often seen in BPT is why deliberate practice lends itself nicely to teaching this approach.

Much of BPT is based on reducing what is referred to as the coercive cycle that can develop between parents and children (Patterson, 1982). This cycle is rooted in social learning theory and suggests that children have their noncompliant behavior reinforced through maladaptive interactions with their parents (Wierson & Forehand, 1994). Similarly, parents' negative behaviors are reinforced through their child's responses, leading to a coercive cycle in which both parent and child reinforce each others' negative behaviors. For example, a parent might ask a child to turn off the television. If the child says no, the parent is likely to raise their voice and demand the television be turned off. This can lead to the child tantruming, the parent frustratingly leaving the room, and the child getting to continue to watch TV. Unfortunately, this has taught the child that escalating their negative behavior gets their parent to leave them alone and they get what they want (i.e., continue to watch TV). At the same time, the parent learns that backing off leads to the child's tantruming stopping in the short term. Over time, this coercive cycle becomes faster, more frequent, and more intense, leading to a variety of negative parent-child interactions.

BPT programs typically start by providing parents with psychoeducation about child misbehavior, as well as relevant treatment strategies. They then focus on improving parent-child interactions via a variety of positive parenting skills. For example, it is common for parents of children with behavioral problems to focus selectively on their child's negative behaviors. BPT focuses on shifting parents' attention from negative to positive behaviors using strategies such as "catch your child being good" because a child is more likely to comply with a parent when they feel good about the parent-child relationship (Barkley, 2013). Many BPT programs have parents purposefully implement a short, daily "special playtime" with their child, teaching the parent strategies to focus only on positive comments and actions during this time, such as providing specific praise, describing what the child is doing, and conveying enthusiasm for it (e.g., Barkley, 2013; McNeil & Hembree Kigin, 2010). Additional goals of special playtime

include improving the parent-child relationship and improving a child's self-esteem (McNeil & Hembree Kigin, 2010).

BPT programs also focus on having parents strategically positively reinforce desired child behaviors because this makes it more likely that the child will perform these behaviors again. Parents can be taught various methods for positively reinforcing their child's behavior, including providing specific praise, tangible rewards, and privileges. Parents are taught how to communicate praise effectively, such as by providing labeled praise immediately after a behavior they wish to see more of, every time they see it (McNeil & Hembree-Kigin, 2010). They can also learn to develop contingencies, which involves identifying specific child behaviors they would like to see and incentivizing their performance by pairing them with specific rewards or privileges their child would like to earn. Children can earn a small reward or privilege immediately, or they can be awarded points, chips, or checks for each behavior that can be saved and exchanged later for a larger reward or privilege as part of a token economy (e.g., Barkley, 2013). An effective incentive involves choosing items or activities that the child likes and will be motivated to earn. It can be useful to involve the child in developing a contingency plan to ensure the child is excited about the rewards or privileges being offered. A parent and child can be encouraged to sign a contract to ensure each family member is clear on what is expected of them (e.g., Barkley & Robin, 2014).

Although BPT programs often first teach parents positive parenting skills designed to increase wanted child behaviors, they also involve teaching parents strategies for reducing negative child behaviors. For example, they are typically taught the concept of differential reinforcement, or focusing on their child's desired behaviors while ignoring mildly aversive behaviors (e.g., McNeil & Hembree-Kigin, 2010). When a child aims to obtain parental attention through negative behavior, actively ignoring them will eventually lead to a decrease in the behavior. Parents are also taught strategies for how to tell their child exactly what is expected of them through a direct command, rather than ask or tell them indirectly (e.g., Barkley, 2013). In addition, parents are taught how to provide consequences for negative behavior, such as time-out, removal of a desired item or privilege, or logical consequences (e.g., losing cell phone privileges if not getting homework done due to phone use; Kazdin, 2005; Webster-Stratton, 2012). Once parents have a good deal of practice using BPT skills in session and at home, clinicians typically work with parents to generalize their skill use to managing challenging behaviors in public settings, such as stores, restaurants, and playgrounds (Barkley, 2013). Parents of older children can be taught problem solving and communication strategies (Barkley & Robin, 2014).

Although many variables can interfere with application of skills learned within BPT to real-world situations (e.g., Kazdin et al., 1997), we have also chosen to focus on skills that address parent affect and emotions. A considerable body of research links parents' maladaptive emotional responses and child behavior problems (Johnson et al., 2017). Further, negative parent emotions are linked to ineffective parenting behaviors (Lunkenheimer et al., 2023; Rueger et al., 2011; Zitzmann et al., 2024). Given calls for incorporating emotion regulation strategies into parent interventions (e.g., Hajal & Paley, 2020; Zalewski et al., 2018), we thought it important to introduce these types of skills for BPT clinicians to develop.

Finally, to provide BPT clinicians with an opportunity to learn about applications of BPT for different age groups, the parent statements within each difficulty level in every exercise reflect concerns with children and adolescents across various development stages.

Overall, the exercises included in this book are designed to develop BPT skills across all the aforementioned concepts. We accomplish this through deliberate practice.

### **The Role of Deliberate Practice in Teaching Behavioral Parent Training**

Returning to the discussion earlier in this chapter, training in BPT has always focused on skill knowledge and development through a variety of approaches to develop competencies in BPT skills among parents. Training clinicians in BPT draws the distinction between declarative and procedural knowledge, which is similar to deliberate practice. Knowing the learning theory principles that BPT is based on and the skills that are among the core components of BPT is one thing, but then carrying this knowledge into clinical work with parents can often be challenging for clinicians at varied levels of experience. Practicing skills in BPT is crucial.

Three of the authors (M.T., H.V., and P.O.) have been training clinicians in BPT for many years and using training activities similar to, but not using the term, deliberate practice are often part of this training. While working in separate institutions, the clinical training and supervision that they have provided generally involved three types of activities. First, they learn declarative knowledge about the theory and activities of BPT from readings and lectures. Second, the core skills of BPT are modeled for the learners. Finally, we have learners identify specific BPT skills that they want to work on that would be beneficial for their clinical work with parents, and they role-play this with either a peer or their supervisor. They then receive feedback on their performance of the skill. This approach is consistent with that of deliberate practice skill training in therapist training, just not as explicitly as we now do in this book.

We also have used therapy recordings as an opportunity to provide supervision and offer clinical feedback, but without direct practicing of the skill and receipt of immediate feedback, this approach is limited. Although recordings remain part of the supervisory experience, they do not provide an opportunity for immediate feedback after live practice sessions. Offering immediate feedback of a specific skill, even during a simulated setting (i.e., role-play), we have found is an approach that helps move skill development from conceptual to procedural, helps build competence, and is consistent with the deliberate practice approach to developing clinical skills.

We also thought it important to point out that although we focus on BPT skills in this book, we cannot ignore that such skills have the common factors in psychotherapy (Wampold, 2015) as cornerstones of good clinical practice. The common factors such as therapeutic alliance, empathy, goal consensus, and positive regard are not directly taught within this book nor are they evaluated as skill criterion; nonetheless, it is important for BPT clinicians to consider these factors in their work with parents.

With the focus of BPT being to teach parents skills to have an impact on their child's behavior, we thought it important to stress the role of data collection throughout BPT. While we do offer a number of examples of how and where data collection could occur throughout the exercises, we do not have this as a discrete skill. We believe that it is important for clinicians to gather data at the outset of treatment as to how problematic the parent views the child behavior with specific data as to frequency, intensity, and duration of the behavior to allow for progress monitoring, the context of these misbehaviors from a functional analytic perspective (see Exercise 2), and how their own behavior and affective responses may need to change. From the onset, we suggest BPT

clinicians make data collection a weekly expectation for between-session work. We also like to have parents engage in self-reflection as to their competency in delivering the BPT techniques applied and will often have them demonstrate these skills in session and provide feedback in a manner that is consistent with a competency/mastery-based approach of PCIT (Thomas et al., 2017) and HNC (McMahon & Forehand, 2005).

Further, behavioral problems experienced by parents are often reported by professionals within the schools as well. Given that students spend a significant portion of their day in school, there obviously may be school- and peer-based factors that influence their behavior. Within the structure of this book, we could not adequately address how to engage effectively with the school to develop a comprehensive plan, but we do strongly believe that BPT clinicians will better serve the parents with whom they work if they promote effective parent-school communication as well as gather data from school-based professionals as to child behavior within the school.

The deliberate practice exercises in this book are not sufficient by themselves to obtain competence in BPT and are intended to supplement other training and education protocols. The skills included here are suited to a first course in BPT and are presented in a sample syllabus (see Appendix C). Trainees should have more extensive exposure to BPT theory and application in subsequent coursework and readings and supervisory experiences.

## **Behavioral Parent Training Skills in Deliberate Practice**

Next, we outline each of the core skills that are the focus of Exercises 1 through 12, including how they fit into BPT's general goals and processes.

### **The Behavioral Parent Training Skills Presented in Exercises 1 through 12**

When parents initiate BPT, they often begin by describing their concerns about the behavior of their child, their past efforts to address this behavior and, at times, some of their own thoughts and emotional responses to their child's behavior. Unlike with traditional self-referred clients for psychotherapy who want to change how they feel and behave, here in BPT, they often want to change how someone else (their child) feels and behaves. The exercises presented in this book follow the format that represents how a BPT clinician would progress through helping a parent understand their role as an agent of change for their child and then progress through the steps of doing BPT. The exercises are presented in the sequence that therapists usually follow in applying BPT for a clinical problem. The order of exercise presentation was an area that we discussed considerably and were informed by our own clinical experience, as well as the sequence structure of many of the evidence-based approaches of BPT. These 12 exercises represent skills from a beginning level early in the BPT sequence, to later skills that are of more moderate difficulty, to the late-stage skills that are more advanced and more difficult. The order of the exercises is provided in Table 1.1.

Although not specific skills taught here, as described earlier, many of the common factor skills of psychotherapy (Wampold, 2015) are integrated throughout the core BPT skills. That is, as an example, through discussion about child behavior and clinical steps, the BPT clinician is achieving agreement on the goals and tasks of therapy, which form two steps in the formation of the therapeutic alliance. The alliance is considered pantheoretical and a component of the common factors of psychotherapy, not a formal skill we teach within this book; we still believe it is an essential skill for BPT clinicians.

The beginning steps include teaching the parent about child behavior and about BPT (Exercise 1), an analysis of the context of the child's behavior to help understand why the behavior has developed and persisted (Exercise 2), recognition and validation of parents' own emotional responses as they relate to their child's behavior (Exercise 3), and then introducing the concept of praise as a beginning step toward building change in their child's behavior (Exercise 4). We think educating parents about BPT and child behavior (Exercise 1) is an important beginning skill and allows the BPT clinician to correct any misperceptions about clinical work and also orient parents to specific goals and their role (i.e., tasks) in actively working toward addressing the problem. The second skill (Exercise 2) involves a functional analysis of the child's behavior to help address the "why" of their behavior but also to set the stage for subsequent interventions. As we begin to move toward teaching specific interventions, we thought it important to recognize and validate early on parental emotional responses within the context of their child's behavior and their role as parents. Strong emotions may interfere with effective parenting as well as skill acquisition. This leads to the next skill, which is validating and discussing their emotional responses (Exercise 3). The final beginning skill (Exercise 4) involves teaching parents the concept of praise and how to use it effectively to bring about behavior change. Praise can, and very often will, be integrated within many of the subsequent skills.

The intermediate skills involve many core aspects seen across BPT models and are skills that help facilitate change by parents changing how they respond to their child's behavior. Exercise 5 builds on praise and teaches parents how to pay attention to the behaviors that they want to see. This may also help address the function (i.e., attention) of many children's behaviors, which links back to Exercise 2. Often, parents will report that it is difficult to provide positive attention when their child is misbehaving. Further, if negative behavior has a history of being reinforced by parental attention, this becomes even more challenging to change. This leads to Exercise 6, where the BPT clinician teaches the parent how to ignore misbehavior. Although we think that teaching parents how to offer praise (Exercise 4), provide attention (Exercise 5), and ignore misbehavior (Exercise 6) are the building blocks toward change, it still may not provide the kind of specific behavior change toward adaptive behaviors that parents want to see. Communication (Exercise 7) teaches parents how to use effective commands to increase compliance and problem-solving in situations where the parent is open to negotiation. This skill may also serve to enhance the parent-child relationship within the context of the therapeutic alliance. That is, they may now be working toward what they want to see behaviorally in their child (e.g., compliance) rather than what they do not want to see (e.g., oppositionality). We then build on these skills by teaching parents about the use of incentives to change behavior (Exercise 8). The placement of this skill toward the end of the intermediate level was intentional in that we believe that the preceding skills are important and more natural skills to learn before having parents use incentives to change behavior.

The advanced-level skills in Exercises 9 and 11 involve two more clinical interventions for parents to change child behavior. There was a degree of intentionality on our part in having consequential interventions (Exercise 9) later in the process and being part of an advanced skill. We have found that many parents want to know how to best punish their child to stop the negative behaviors and want to know this early on in the BPT process. In the earlier exercises, we discussed ways to promote the behaviors that we want to see, and we believe it is important to instill in parents that before specifically teaching consequential interventions to change negative behaviors, we want to have a system in place that promotes desired or adaptive behaviors that will also compete with these negative behaviors. Exercise 10 describes a skill in which the BPT clinician

discusses strategies to help parents manage their own emotional responses. As discussed in Exercise 3, parents often have strong thoughts and emotional reactions to their child's behavior, and these reactions often interfere with their parenting responses and ability to apply the skills taught. These responses may also lead to parents discontinuing treatment earlier. We recognize that typically parents do not come to BPT to work on their own thoughts and feelings, but we do believe that the ability to understand and communicate about how their emotional responses affect their parenting can be an important part of effective BPT and is seen in Exercise 10. Exercise 11 moves clinical work beyond the home environment and focuses on helping parents apply the earlier skill in public settings, which parents often find more challenging—and hence why we view this as an advanced skill. The final skill in Exercise 12 involves assignment of between-session work to build on skills taught and begin the process of applying parent training skills taught earlier in the process. Ultimately, it's what happens between the sessions that will begin the process of change beyond the clinical office and provide the best reflection as to BPT skills competence and the effectiveness of BPT. In the last skill (Exercise 12), clinicians will work with parents on collaboratively developing homework activities for them to do between sessions. Although assigning homework is presented as a separate exercise, we believe it is an essential addendum to each skill from the preceding exercises—that is, after parents have learned a skill in session, the clinician can ask them to practice it as homework. In the next session, the clinician should evaluate whether the homework was attempted, the process of attempting it, and the outcome. In addition, based on parental response, the clinician is encouraged to address any barriers encountered or help modify the homework so the skill is more feasible or effective going forward.

Effectively teaching the previously described skills to parents is often the initial step in BPT, but it is the application of the taught skill that may often be a challenge for many parents. The difficulties in transition between knowledge and application/practice are important for the clinician to consider. To that end, for many of the skills in this book, we have examples of questions that reflect any barriers to BPT skill application. These barriers may involve understanding of the skill; assessing parent belief that they can complete the skill effectively (i.e., self-efficacy); and clarifying if they think that this intervention would be effective, if they are willing to try this intervention, and whether they foresee any barriers (practical or emotional) that would interfere with the application of this intervention. These concepts may be broadly understood under the umbrella of treatment acceptability (Kazdin, 2000). Many of the concepts of treatment acceptability described earlier could in fact be their own skill that would be helpful for clinicians to develop, but that is beyond the scope of this book. As such, in many of the skills, we have set forth a criterion in which the clinician is asked to demonstrate competency for not just communicating about the skill itself but also in checking about treatment acceptability. This can, and very often will, involve many of the aforementioned areas, and in our examples of clinical responses, we provide multiple demonstrations of each of these areas.

## Overview of the Book's Structure

This book is organized into three parts. Part I contains this chapter and Chapter 2, which provides basic instructions on how to perform these exercises. We found through testing that providing too many instructions up front overwhelmed trainers and trainees, and they skipped past them as a result. Therefore, we kept these instructions

as brief and simple as possible to focus only on the most essential information that trainers and trainees will need to get started with the exercises. Further guidelines for getting the most from deliberate practice are provided in Chapter 3, and additional instructions for monitoring and adjusting the difficulty of the exercises are provided in Appendix A. **Do not skip the instructions in Chapter 2, and be sure to read the additional guidelines and instructions in Chapter 3 and Appendix A once you are comfortable with the basic instructions.**

Part II contains the 12 skill-focused exercises, which are ordered based on the order that they would be used in an actual therapy situation. This order corresponds to the difficulty levels of the skills: beginner, intermediate, and advanced (Table 1.1). The discussion of each of the 12 skills contains a brief overview of the exercise, example client–therapist interactions to help guide trainees, a list of criteria for mastering the relevant skill, and step-by-step instructions for conducting that exercise. The client statements and sample therapist responses are then presented, also organized by difficulty (beginner, intermediate, and advanced). The statements and responses are separated so that the trainee playing the therapist has more freedom to improvise responses without being influenced by the sample responses, which should only be turned to if the trainee has difficulty improvising their own responses.

The last two exercises in Part II provide opportunities to practice the 12 skills within simulated psychotherapy sessions. Exercise 13 provides a sample psychotherapy session transcript in which the BPT skills are used and clearly labeled, thereby demonstrating how they might flow together in an actual therapy session. BPT trainees are invited to run through the sample transcript with one playing the therapist and the other playing the client to get a feel for how a session might unfold. Exercise 14 provides suggestions for undertaking mock sessions, as well as client profiles ordered by difficulty (beginner, intermediate, and advanced) that trainees can use for improvised role-plays.

Part III contains Chapter 3, which provides additional guidance for trainers and trainees. While Chapter 2 is more procedural, Chapter 3 covers big-picture issues. It highlights six key points for getting the most out of deliberate practice and describes the importance of appropriate responsiveness, attending to trainee well-being and respecting their privacy, and trainer self-evaluation, among other topics.

Three appendixes conclude this book. Appendix A provides instructions for monitoring and adjusting the difficulty of each exercise as needed. It provides a Deliberate Practice Reaction Form for the trainee playing the therapist to complete to indicate whether the exercise is too easy or too difficult. Appendix B includes a Deliberate Practice Diary Form that can be used during a training session's final evaluation to process the trainees' experiences, but its primary purpose is to provide trainees a format to explore and record their experiences while engaging in additional, between-session deliberate practice activities without the supervisor. Appendix C presents a sample syllabus demonstrating how the 12 deliberate practice exercises and other support material can be integrated into a wider BPT training course. Instructors can choose to modify the syllabus or pick elements of it to integrate into their own courses.

Downloadable versions of this book's appendixes, including a color version of the Deliberate Practice Reaction Form, can be found in the "Resources" tab at <https://www.apa.org/pubs/books/deliberate-practice-behavioral-parent-training>.