

# Family-Based Treatment for Childhood Antisocial Behavior: Experimental Influences on Dropout and Engagement

Ronald J. Prinz and Gloria E. Miller

Antisocial behavior in childhood and adolescence is an unquestionably serious problem for society. Family-based treatments are promising but face the challenging obstacle of premature parental dropout. To systematically study dropout, we randomly assigned 147 families with a markedly aggressive child (age 4 to 9 years) to a standard family treatment (SFT) focusing exclusively on parental management or to an enhanced family treatment (EFT) that also promoted frequent discussions of adult issues. EFT produced a significantly lower dropout rate than SFT overall, but particularly for high-adversity families. Dropouts were clearly distinguishable from completers on several dimensions. The results underscore the importance of addressing contextual variables such as family adversity in the treatment of childhood antisocial behavior.

Structured family-based intervention, primarily in the form of parent management training based on a social-learning approach (Kazdin, 1987; Miller & Prinz, 1990; Patterson, 1986), is a promising treatment approach for serious childhood antisocial behavior. Expansion of parent-training regimens by adding, for example, a marital component (Dadds, Schwartz, & Sanders, 1987) or other adjunct (Kazdin, Siegel, & Bass, 1992) has increased treatment effectiveness (Miller & Prinz, 1990). However, optimal success rates have not yet been achieved for childhood conduct problems by any interventions, including family-based approaches (Kazdin, 1987). A major obstacle to successful family intervention for children with conduct disorders is a high rate of sporadic participation and premature dropout (Firestone & Witt, 1982; Horne & Patterson, 1980; McMahon, Forehand, Griest, & Wells, 1981). Although many studies fail to report dropout rates (Forehand, Middlebrook, Rogers, & Steffe, 1983), it is not uncommon for half of a sample to drop out without completing the treatment protocol (cf. Firestone, Kelly, & Fike, 1980; Firestone & Witt, 1982; Kazdin, 1990).

Despite the concern, researchers have studied parental dropout using descriptive and post hoc methods primarily in general clinic populations (Gould, Shaffer, & Kaplan, 1985; Kazdin, 1990; McMahon et al., 1981; Weisz, Weiss, & Langmeyer, 1987). One exception by Kazdin (1990) compared children and families referred for the child's severe antisocial behavior who

terminated prematurely to those who completed treatment, and it was found that the premature terminators reflected more severe conduct disorder and delinquent behaviors, greater life stress for the mothers, and greater socioeconomic disadvantage than the completers. However, a theoretical explanation for treatment dropout has not been established.

The present study tested an experimental manipulation aimed at affecting dropout rate, described how dropout and completer families differ while still in treatment, and examined key variables related to dropout in family treatment of child conduct problems.

The role of parents' tacit expectations about their involvement in treatment has emerged as a critical factor affecting outcomes in social-learning family treatments (Miller & Prinz, 1990; Wahler & Dumas, 1989). This assumption was explicitly tested by means of a treatment manipulation designed to assess whether greater attention to parents' tacit expectations about the treatment process leads to less dropout. On one hand, it may be argued that parents of children with conduct problems who are experiencing stress from multiple sources (e.g., economic, familial, interpersonal, and intrapersonal sources) may have a strong but unexpressed need to focus on a larger set of life problems besides child management and parent-child interactions. Thus, adding time for general consultation on such issues within standard family treatment may improve overall engagement and reduce dropout. Alternatively, because multistressed parents may not feel comfortable or predisposed to discuss personal issues and may prefer to focus on managing child behavior even in the face of many external stressors, a strict adherence to the child management agenda may result in lower dropout.

---

Ronald J. Prinz and Gloria E. Miller, Department of Psychology, University of South Carolina.

This work was supported by funding from the National Institute of Mental Health (Research Grant MH-38667) and from the William T. Grant Foundation.

We acknowledge the fine contributions of Donita White and Amy Moore as coordinators; Lamia Barakat, Joseph Boland, Robin Finkenthal, Susan Nay, Brad Norford, John Prestby, Connie Raybuck, Kevin Turner, and Melissa West as therapists; and Frank Moncher for fidelity and data assistance.

Correspondence concerning this article should be addressed to Ronald J. Prinz, Department of Psychology, University of South Carolina, Columbia, South Carolina 29208.

## Method

Using a multiple-gating strategy, we selected a sample of 4- to 9-year-old boys who clearly exhibited conduct problems and high rates of aggression in multiple settings (see Table 1). Families who met criteria and agreed to begin treatment were randomly assigned to either standard family treatment (SFT), a traditional social-learning approach focused exclusively on parent-child interactions and improvement of child be-

Table 1  
*Summary of Screening and Design*

Category	<i>n</i>
No. of families seeking treatment	609
Families meeting criteria (three gates) <sup>a</sup>	160 (26%)
Nonstarters (families declining treatment)	13 (8%)
Families assigned to EFT or SFT	147

*Note.* The 147 families were randomly assigned using stratification on one- versus two-parent household, socioeconomic status level, and age of child (4–6 years old versus 7–9 years old). EFT = enhanced family treatment; SFT = standard family treatment.

<sup>a</sup> Multiple gates are as follows: (a) telephone screening for type of problem, age, and situational factors (residing at home, evidence of chronic child aggression as opposed to acute reaction to major stressor); (b) aggression at home (Child Behavior Check List–Parent aggressive scale T score above 66); (c) aggression at school (Child Behavior Check List–Teacher Report Form aggressive scale T score above 66).

avior, or enhanced family treatment (EFT), which combined SFT content with increased attention to other life concerns.

All 9 therapists (6 women, 3 men) had a master's degree or the equivalent in clinical or school psychology, 2 years of supervised family intervention experience, and high ratings by supervisors. The 60-hr protocol training emphasized a core treatment with two minor variations and avoided biasing the therapists, who were also uninformed of the study hypotheses.

SFT represented a conventional parent management approach that included core social-learning components for altering the family's social environment. Every family proceeded through a flexibly paced sequence of 12 modular content areas. Using a dialogue style of topic presentation, therapists helped parents apply the concepts to their own situations, used modeling and role play to teach the accompanying skill (and when appropriate, observed parent–child interactions in the clinic playroom to provide in vivo practice and feedback), assigned and reviewed homework assignments, and reinforced parents for effort. Parents were encouraged to focus on specific units of behavior (not general traits); attend to prosocial child behaviors that were incompatible with aggressive behavior; act as behavioral coaches through systematic use of reinforcement (social, activity, tangible, token), extinction, mild punishment, clear instructions, and shaping; and replace angry outbursts, self-defeating behaviors, and overreliance on physical punishment with teaching, skill building, and pleasant interchanges. Finally, token programs, home–school coordination, communication skills, and troubleshooting skills helped parents to maintain newly acquired skills and promote generalization of child prosocial behaviors across settings.

Therapists in EFT duplicated the SFT content but also elicited from parents various concerns and topics that were not directly connected to parent–child intervention (e.g., feelings about being in therapy, job stress, health problems, personal worries, family disputes, and external demands). We hypothesized that supportive discussions of such problems created opportunities for parents to make explicit and possibly resolve unspoken issues that, left unaddressed, may otherwise lead to parental disenchantment and treatment failure. EFT therapists followed an explicit plan to prompt discussion of parental expectations, feelings, and issues collateral to the parent training focus. During the first session, therapists solicited parents' feelings about seeking treatment, prepared for and normalized possible parental reactions during therapy (e.g., feeling overworked, feeling silly or awkward, discouragement, guilt or doubt about parenting, feeling frustrated by slow changes, etc.), probed for general concerns (e.g., health, work pressures, relatives, etc.), and set up a framework of openness between therapist and parents. In later sessions, therapists regularly elicited discussions about personal

concerns, collateral issues, and other feelings throughout therapy at 11 transition periods between modular units of social-learning content. EFT therapists also gave specific attention to any collateral issue (i.e., spontaneous concern) that was brought up during a modular unit (but the discussion was deferred to the end of the session), whereas SFT therapists acknowledged such issues and then diplomatically redirected the discussion. During enhancement discussions, therapists probed for feelings and created a framework for problem solving and collaboration to create an atmosphere that allowed explicit identification, discussion, and resolution of expectations and concerns held by the parents.

Treatment fidelity was promoted by a comprehensive intervention manual, detailed cueing checklists, strict record-keeping requirements, tape recording of all sessions, and close supervision. Fidelity was verified by independent (uninformed) observation of intended differences between EFT and SFT and the use of a detailed process–content matrix observation code. All 11 transition periods between modular units were coded in 20-min segments for each case (93% intercoder agreement). In contrast to SFT therapists, EFT therapists were expected to display markedly higher rates of problem solving, information seeking, explaining, and discussion of content outside of child behavior (i.e., personal states and beliefs unrelated to child, health issues, marital or extended familial issues, work or financial concerns, community and household matters). On the basis of an analysis of coded segments from 1,233 sessions, EFT and SFT were clearly distinguishable: EFT therapists produced EFT-specific behaviors at a rate of 27.5%, compared with the SFT therapists' rate of 4.2%,  $t(855) = 21.0, p < .0001$ . For child-focused and behavior management topics, EFT and SFT therapists exhibited comparable rates of facilitative listening (14.1% and 12.5%, respectively).

Measures included the following: (a) parent and teacher reports on Achenbach's Child Behavior Checklist; (b) parental report of personal adjustment on the Symptom Distress Checklist–90 (SCL-90; Derogatis, Rickels, & Rock, 1976), marital adjustment on the Dyadic Adjustment Scale (DAS; Spanier & Thompson, 1982), and social support on the Arizona Social Support Interview Schedule (ASSIS; Sandler & Barrera, 1984); (c) Hollingshead four-factor socioeconomic status index. For all scheduled appointments, therapists recorded (a) family punctuality; (b) appointments kept, cancelled, or missed without cancellation ("no-showed"); (c) homework completion; and (d) a rating of the quality of each parent's in-session participation (1 = *very poor*, 2 = *poor*, 3 = *mixed*, 4 = *adequate*, 5 = *good*). To assess reasons for dropout, nontherapist staff interviewed dropouts by telephone, including an open-ended question about why the family stopped treatment and a standardized Parental Opinions Questionnaire (POQ) assessing events and attributions possibly linked to dropout.<sup>1</sup> Open-ended responses were reliably sorted (98% agreement) into four categories by two coders who were uninformed about family intervention type: intrapersonal concerns (e.g., affective states, physical illness, or lack of self-confidence), dissatisfaction with the therapist, dissatisfaction with the intervention, and situational concerns (e.g., marital separation, relocation, job loss, or transportation problems).

## Results and Discussion

The EFT and SFT groups were quite comparable with respect to pretreatment characteristics (see Table 2). EFT and

<sup>1</sup> The item pool for the POQ was developed from a survey of 18 clinical researchers actively engaged in the evaluation of behavioral family-based interventions. These experts generated a pool of actual and hypothesized reasons for family dropout noted in their own samples and then, at a later time, rank ordered the observed occurrence for each item contributed by the group. The resulting 32 items were then categorized into four nonoverlapping areas that contribute to dropout: intrapersonal, intervention, therapist, and situational concerns.

SFT completers averaged 22.0 ( $SD = 5.9$ ) and 21.0 ( $SD = 5.2$ ) sessions respectively,  $t(89) = 0.89$ ,  $ns$ . EFT discussion time varied widely from one family to another and accounted for approximately 5% additional time.

To address the major question of this study, we compared EFT and SFT groups with respect to dropout rate. Families who attended some treatment sessions but did not complete the entire protocol were classified as dropouts.<sup>2</sup> Of the 72 families beginning EFT, 21 (29.2%) dropped out before completing treatment, and 51 completed treatment. Of the 75 families beginning SFT, 35 (46.7%) dropped out before completing treatment, and 40 completed treatment. EFT yielded a significantly lower dropout rate than SFT,  $\chi^2(1, N = 147) = 4.1, p = .04$ . The treatment manipulation clearly affected dropout in that families whose treatment focused exclusively on parent training and child behavior dropped out more often than families who had many opportunities during treatment to discuss life concerns beyond child management. This finding emerged in the context of a strong design that included (a) multiple gating to include only severely aggressive children; (b) stratified random assignment to control for socioeconomic status, child age, and num-

Table 2  
Pretreatment Characteristics of EFT and SFT Families

Variable	EFT		SFT		$t$ or $\chi^2$
	$M$	$SD$	$M$	$SD$	$t$
Child aggression					
Parental CBCL score	80.2	7.2	79.4	7.5	0.65
Teacher CBCL score	74.6	7.7	75.1	8.2	0.40
% of child problems occurring longer than 1 year	83.8	20.4	77.8	25.0	1.59
Child's age (years)	6.9	1.8	6.6	1.9	0.92
Marital adjustment					
Maternal DAS score	106.5	18.9	107.4	17.6	0.24
Paternal DAS score	110.0	18.6	112.5	14.6	0.64
Depressive symptoms (parent)					
Maternal SCL-90 score	57.0	9.5	57.8	8.6	0.54
Paternal SCL-90 score	54.8	10.2	51.2	11.8	1.50
Family Adversity Index score	2.4	1.6	2.6	1.6	0.60
		%	%		$\chi^2$
Single-parent household		29.2	30.7		0.01
Socioeconomic status <sup>a</sup>					0.82
I		5.6	6.7		
II		12.5	9.3		
III		33.3	32.0		
IV		33.3	38.7		
V		15.3	13.3		
Referred by agency		54.2	57.3		0.05

Note. The group sizes were 72 for EFT and 75 for SFT for all measures except DAS and paternal SCL-90, which included 46 for EFT and 41 for SFT. None of the  $t$ -test or chi-square statistics were significant at the .05 level. EFT = enhanced family treatment; SFT = standard family treatment; CBCL = Child Behavior Check List; DAS = Dyadic Adjustment Scale; SCL-90 = Symptom Distress Checklist-90.

<sup>a</sup> The roman numerals refer to levels of socioeconomic status, ranging from the lowest (I) to the highest (V).

Table 3  
Parental Opinions: Completer Versus Dropout Families

Category	Completers		Dropouts		$t$
	$M$	$SD$	$M$	$SD$	
Intrapersonal concerns	0.56	0.85	0.92	1.12	1.76
Dissatisfaction with the therapist	0.06	0.28	0.73	1.52	2.65*
Dissatisfaction with the intervention	0.23	0.55	1.14	1.72	3.11*
Situational obstacles	1.09	1.16	3.08	1.66	6.64**

Note. Parental opinions data are based on our findings with the Parental Opinions Questionnaire. Each category is scored from zero to 8, reflecting the number of items endorsed.

\*  $p < .01$ . \*\*  $p < .001$ .

ber of parents in the home; (c) implementation of both treatment conditions by the same 9 therapists; (d) careful promotion and evidence of treatment fidelity; and (e) a viable intervention.<sup>3</sup>

Of the 55 families who dropped out, 37 (25 of 34 SFT and 12 of 21 EFT dropout families) were debriefed by telephone. The remaining 18 dropouts could not be reached (i.e., disconnected telephone, no forwarding address or telephone number), which suggested that these families were suddenly faced with situational factors that forced them to relocate. Most (86%) of the reasons for dropout given by EFT and SFT families implicated environmental or logistical obstacles caused by their current life situation (i.e., "situational" reasons). Neither group implicated the therapist as the reason for dropping out, and intrapersonal reasons were similarly implicated by SFT (26%) and EFT (20%) dropouts. Compared with EFT dropouts, however, SFT dropouts indicated dissatisfaction with the intervention more often (26% versus 6%) and situational factors less often (47% versus 73%). Overall, SFT dropouts offered more reasons than EFT dropouts (44% of SFT dropouts gave more than one reason, compared with 25% of EFT dropouts). SFT and EFT dropouts did not differ significantly on endorsement of intrapersonal, therapist, or situational items on the POQ. However, SFT dropouts endorsed a significantly greater number of items reflecting dissatisfaction with the intervention,  $M_{SFT} = 1.52$  ( $SD = 1.96$ ),  $M_{EFT} = 0.33$  ( $SD = 0.49$ ),  $t(36) = 2.85, p < .01$ . Dropouts in general (SFT and EFT pooled) reported significantly greater dissatisfaction with the therapist, dissatisfaction with the intervention, and situational problems than did completers (see Table 3). These findings indicate that SFT dropouts were more dissatisfied with the intervention than EFT dropouts and were

<sup>2</sup> This definition of dropout is deliberately overinclusive (see Armbruster & Kazdin, 1994). Thirty percent of the dropout families completed half or more of the treatment protocol; that is, dropout families averaged 6.98 sessions ( $SD = 5.3$ ) and completed an average of 27.8% ( $SD = 19.3$ ) of the treatment protocol.

<sup>3</sup> Treatment outcome was not the focus of this article. However, completers (EFT and SFT combined) showed significantly greater improvement in parenting skills and reduction in child behavior problems, compared with available dropouts (controlling for pretreatment levels through covariate analysis).

more likely to attribute dropout to that dissatisfaction. Moreover, given the lower EFT dropout rate and the finding that dropouts generally were more dissatisfied with the therapist than completers, the EFT protocol may have promoted a stronger bond between therapist and parent.

Another plausible reason for EFT-SFT differential dropout is that EFT may have helped parents cope more effectively with stress associated with family adversity. To examine this issue, we constructed a family adversity index ranging from 0 to 7 from pretreatment data as a function of seven dichotomous indices: (a) alcohol or drug problem reported for either parent; (b) criminal record reported for either parent; (c) low socioeconomic status; (d) family referred by agency or school; (e) single-parent household or evidence of marital discord (DAS score < 100); (f) psychological distress in either parent (SCL-90 T score > 60); and (g) aversive social network ( $\geq 50\%$  aversive social network on the ASSIS). Families who ultimately dropped out reflected greater family adversity at pretreatment than completer families (see Table 4). Dividing the sample into low (0-2) and high (3-7) family adversity, the high-adversity families showed significant differential dropout as a function of treatment condition (SFT = 58.8%, EFT = 29.6%),  $\chi^2(1, N = 61) = 5.17, p = .02$ , whereas the low-adversity families did not (SFT = 36.6%, EFT = 28.9%),  $\chi^2(1, N = 86) = 0.58, p > .40$ . Given that family adversity and agency referral were comparably represented initially in EFT and SFT families, it follows that EFT helped more families, particularly those facing greater adversity, cope sufficiently with stress to continue in treatment.

Pooling across EFT and SFT, dropout and completer families reflected significant pretreatment differences: Dropouts showed higher severity of child aggression at school but not home, higher family adversity, lower socioeconomic status, greater likelihood of being referred by an agency, and slightly greater child age. Participation before treatment termination also reflected dropout-completer differences: Dropouts missed significantly more appointments without prior cancellation (i.e., "no-shows"), had a much lower rate of kept appointments (52.7% versus 82.2%), and completed homework at a significantly lower rate. Therapists also rated the quality of in-session participation by dropout parents as significantly lower than their completer counterparts, which did not interact with treatment condition (see Table 4).

A final goal of our study was to formulate an initial working model of drop-out risk. Using termination status (0 = completer, 1 = dropout) as the criterion, we conducted discriminant analyses with pretreatment characteristics, adversity status, participation variables, and the combination as predictors. As found in Table 5, participation variables were stronger predictors than pretreatment variables, and the latter did not add to the prediction when the two predictor sets were combined. However, the contextual variable of family adversity, as well as socioeconomic status by itself, discriminated dropouts from completers, which is consistent with other studies of therapy attrition (Kazdin, 1990; McMahon et al., 1981; Weisz et al., 1987) and with research on family context (Dumas, 1989; Dumas & Wahler, 1985; Patterson, Reid, & Dishion, 1992; Wahler & Dumas, 1987).

The main finding has serious implications for the treatment of childhood antisocial behavior by means of social-learning-

Table 4  
*Pretreatment Characteristics and Participation While in Treatment for Completer and Dropout Families*

Variable	Completers		Dropouts		<i>t</i> or $\chi^2$
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	
Pretreatment characteristics					
Child aggression					
Parental CBCL score	80.0	7.4	79.4	7.5	0.46
Teacher CBCL score	73.7	7.3	76.6	8.6	2.20*
Percentage of child problems occurring longer than 1 year	82.3	22.8	78.3	23.3	1.01
Child's age (years)	6.5	1.8	7.2	1.8	2.09*
Marital adjustment					
Maternal DAS score	106.6	19.0	107.4	16.9	0.21
Paternal DAS score	110.3	16.2	113.3	18.3	0.75
Depressive symptoms (parent)					
Maternal SCL-90 score	57.2	9.3	57.6	8.7	0.22
Paternal SCL-90 score	54.3	9.7	50.2	13.7	1.34
Family Adversity Index score	2.3	1.5	2.8	1.7	1.83*
		%	%		$\chi^2$
Single-parent household	26.4		35.7		1.03
Socioeconomic status					12.7**
I	2.2		12.5		
II	8.8		14.3		
III	30.8		35.7		
IV	38.5		32.1		
V	19.8		5.4		
Referred by agency	46.2		71.4		7.98**
Participation while in treatment					
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>t</i>
Punctuality (%)	81.9	17.7	73.4	27.0	2.31*
No. of "no-shows"	1.1	2.2	2.8	2.4	4.36***
Appointments kept (%)	82.2	14.1	52.7	17.9	10.50***
Quality of in-session participation (rated by therapist)					
Mothers	4.8	0.2	4.6	0.5	3.23**
Fathers	4.7	0.4	4.2	1.2	2.84**
Homework (%)	89.7	13.8	81.4	31.1	2.11*

Note. CBCL = Child Behavior Check List; DAS = Dyadic Adjustment Scale; SCL-90 = Symptom Distress Checklist-90.

\* The roman numerals refer to levels of socioeconomic status, ranging from the lowest (I) to the highest (V).

\*  $p < .05$ . \*\*  $p < .01$ . \*\*\*  $p < .001$ .

based family interventions with multiproblem families. Focusing on parenting to the exclusion of other family and adult concerns can drive some families out of treatment and prevent the children from receiving help. Given this conclusion, one may ask why all parent training studies with the same population have not uniformly reflected high dropout. The potential answer is twofold. First, studies of parent training for childhood antisocial behavior (a) often include children with milder behavior problems (cf. Dumas, 1992) who present less clinical challenge and lower associated family pathology and (b) implement shorter treatments (cf. Kazdin, 1987) that make it easier to sustain participation. Second, it is possible that parent train-

Table 5  
Discriminant Analyses Predicting Dropout From  
Family-Based Treatment

Family	N	No. (and %) correctly classified	Predictor variable (weight)
Pretreatment variables as predictors			
Dropouts	56	13 (23.2)	Family Adversity Index (0.683); child's age (0.737); aggression at school (0.543)
Completers	91	81 (89.0)	
All	147	94 (63.9)	
Participation variables as predictors			
Dropouts	56	42 (75.0)	Punctuality (0.199); no. of no- shows (-0.376); % appointments kept (0.960); in-session ratings (0.321)
Completers	91	82 (90.1)	
All	147	124 (84.4)	
Pretreatment and participation variables as predictors			
Dropouts	56	43 (76.8)	Family Adversity Index (-.162); child's age (-.175); aggression at school (-.129); punctuality (0.193); no. of no-shows (-0.365); % appointments kept (0.931); in-session ratings (0.312)
Completers	91	81 (89.0)	
All	147	124 (84.4)	

ers or therapists in other studies implicitly followed an EFT-type regimen although the intervention manuals and published treatment descriptions did not include this element in the protocol. Nonetheless, it is clearly the case that addressing the broader contextual issues, as we have done in EFT, is necessary to inoculate some families against premature departure and to promote greater consumer satisfaction.

Addressing the wide range of personal and emotional concerns that parents may be experiencing in addition to the out-of-control behavior of their child should obviously be an essential component in treatment. This recommendation complements recent advances in the study and integration of various roles for parents in child treatment (Fauber & Kendall, 1992; Kendall & Morris, 1991). Further optimization of engagement may also be attained through expanded and more flexible treatment models (Miller & Prinz, 1990), which may mean home-based implementation, provision of transportation, flexible hours including weekends, and greater sensitivity to cultural variation (Prinz & Miller, 1991).

### References

- Armbruster, P., & Kazdin, A. E. (1994). Attrition in child psychotherapy. In T. H. Ollendick & R. J. Prinz (Eds.), *Advances in clinical child psychology* (Vol. 16, pp. 81-108). New York: Plenum.
- Dadds, M. R., Schwartz, S., & Sanders, M. R. (1987). Marital discord and treatment outcome in behavioral treatment of child conduct disorders. *Journal of Consulting and Clinical Psychology, 55*, 396-403.
- Derogatis, L. R., Rickels, K., & Rock, A. (1976). The SCL-90 and the MMPI: Validation of a new self-report scale. *British Journal of Psychiatry, 128*, 280-289.
- Dumas, J. E. (1989). Let's not forget context in behavioral assessment. *Behavioral Assessment, 11*, 231-247.
- Dumas, J. E. (1992). Conduct disorder. In S. M. Turner, K. S. Calhoun, & H. E. Adams (Eds.), *Handbook of clinical behavior therapy* (2nd ed., pp. 285-316). New York: Wiley.
- Dumas, J. E., & Wahler, R. E. (1985). Indiscriminate mothering as a contextual aggressive-oppositional child behavior: "Damned if you do, damned if you don't." *Journal of Abnormal Child Psychology, 13*, 1-17.
- Eyberg, S. M., & Johnson, S. M. (1974). Assessment of behavior modification with families: Contingency contracting and order of treated problems. *Journal of Consulting and Clinical Psychology, 42*, 594-606.
- Fauber, R., & Kendall, P. C. (1992). Children and families: Integrating the focus of interventions. *Journal of Psychotherapy Integration, 2*, 107-124.
- Firestone, P., Kelly, M. J., & Fike, S. (1980). Are fathers necessary in parent training groups? *Journal of Clinical Child Psychology, 9*, 44-47.
- Firestone, P., & Witt, J. E. (1982). Characteristics of families completing and prematurely discontinuing a behavioral parent-training program. *Journal of Pediatric Psychology, 7*, 209-222.
- Forehand, R., Middlebrook, J., Rogers, T., & Steffe, M. (1983). Dropping out of parent training. *Behavior Research and Therapy, 21*, 663-668.
- Gould, M. S., Shaffer, D., & Kaplan, D. (1985). The characteristics of dropouts from a child psychiatry clinic. *Journal of the American Academy of Child Psychiatry, 24*, 316-328.
- Horne, A. M., & Patterson, G. R. (1980). Working with parents of aggressive children. In R. R. Abidin (Ed.), *Parent education and intervention handbook*. Springfield, IL: Charles C Thomas.
- Kazdin, A. E. (1987). Treatment of antisocial behavior in children: Current status and future directions. *Psychological Bulletin, 102*, 187-203.
- Kazdin, A. E. (1990). Premature termination from treatment among children referred for antisocial behavior. *Journal of Child Psychology and Psychiatry, 31*, 415-425.
- Kazdin, A. E., Siegel, T. C., & Bass, D. (1992). Cognitive problem-solving skills training and parent management training in the treatment of antisocial behavior in children. *Journal of Consulting and Clinical Psychology, 60*, 733-747.
- Kendall, P. C., & Morris, R. (1991). Child therapy: Issues and recommendations. *Journal of Consulting and Clinical Psychology, 59*, 777-784.
- Loeber, R. (1990). Development and risk factors of juvenile antisocial behavior and delinquency. *Clinical Psychology Review, 10*, 1-42.
- McMahon, R., Forehand, R., Griest, D., & Wells, K. (1981). Who drops out of therapy during parent behavioral training? *Behavioral Counseling Quarterly, 1*, 79-85.
- Miller, G. E., & Prinz, R. J. (1990). The enhancement of social learning family interventions for childhood conduct disorder. *Psychological Bulletin, 108*, 291-307.
- Patterson, G. R. (1986). Performance models for antisocial boys. *American Psychologist, 41*, 432-444.
- Patterson, G. R., Reid, J. B., & Dishion, T. J. (1992). *Antisocial boys*. Eugene, OR: Castalia.
- Prinz, R. J., & Miller, G. E. (1991). Issues in understanding and treating childhood conduct problems in disadvantaged populations. *Journal of Clinical Child Psychology, 20*, 379-385.
- Sandler, I. N., & Barrera, M. (1984). Toward a multimethod approach to assessing the effects of social support. *American Journal of Community Psychology, 12*, 37-52.
- Spanier, G. B., & Thompson, L. (1982). A confirmatory analysis of the Dyadic Adjustment Scale. *Journal of Marriage and the Family, 44*, 731-738.
- Wahler, R. G., & Dumas, J. E. (1987). Stimulus class determinants of

- mother-child coercive interchanges in multidistressed families: Assessment and intervention. In J. D. Burchard & S. N. Burchard (Eds.), *Prevention of delinquent behavior* (pp. 190-219). Beverly Hills, CA: Sage.
- Wahler, R. G., & Dumas, J. E. (1989). Attentional problems in dysfunctional mother-child interactions: An inter-behavioral model. *Psychological Bulletin*, 105, 116-130.
- Weisz, J. R., Weiss, B., & Langmeyer, D. B. (1987). Giving up on child psychotherapy: Who drops out? *Journal of Consulting and Clinical Psychology*, 55, 916-918.

Received August 31, 1992  
 Revision received April 1, 1993  
 Accepted June 16, 1993 ■

### Call for Papers

Beginning in 1995, there will be a new peer-reviewed journal in the emerging interdisciplinary specialty area devoted to work and well-being. Its mission statement is as follows.

The *Journal of Occupational Health Psychology* publishes research, theory and public policy articles in occupational health psychology (OHP), an interdisciplinary field representing a broad range of backgrounds, interests, and specializations. OHP concerns the application of psychology to improving the quality of worklife and to protecting and promoting the safety, health, and well-being of workers. The *Journal* has a threefold focus on the work environment, the individual, and the work-family interface. The *Journal* seeks scholarly articles, from both researchers and practitioners, concerning psychological factors in relationship to all aspects of occupational health. Included in this broad domain of interest are articles in which work-related psychological factors play a role in the etiology of health problems, articles examining the psychological and associated health consequences of work, and articles concerned with the use of psychological approaches to prevent or mitigate occupational health problems. Special attention is given to articles with a prevention emphasis. Manuscripts dealing with issues of contemporary relevance to the workplace, especially with regard to minority, cultural, or occupationally underrepresented groups, or topics at the interface of the family and the workplace are encouraged. Each article should represent an addition to knowledge and understanding of OHP.

Manuscripts should be prepared according to the *Publication Manual of the American Psychological Association* and should be submitted in quadruplicate to:

James Campbell Quick, Editor  
*Journal of Occupational Health Psychology*  
 University of Texas at Arlington  
 P.O. Box 19313  
 Arlington, Texas 76019  
 Phone number: (817) 273-3514  
 FAX number: (817) 273-3515  
 E-mail Internet address: JOHP@willard.uta.edu

Express mail: 701 South West Street  
 Room 514  
 Arlington, Texas 76010

The *Journal of Occupational Health Psychology (JOHP)* will be published quarterly by the Educational Publishing Foundation (EPF), an imprint of the American Psychological Association devoted to the quality publication of interdisciplinary journals.