Mindfulness-Based Parent Training: Strategies to Lessen the Grip of Automaticity in Families With Disruptive Children

Jean E. Dumas
Department of Psychological Sciences, Purdue University

Disagreements and conflicts in families with disruptive children often reflect rigid patterns of behavior that have become overlearned and automatized with repeated practice. These patterns are mindless: They are performed with little or no awareness and are highly resistant to change. This article introduces a new, mindfulness-based model of parent training and contrasts the model’s assumptions with those of behavioral (operant) parent training. The new model informs 3 strategies to lessen the grip of automaticity in families with disruptive children: facilitative listening, distancing, and motivated action plans. The article does not oppose mindfulness to mindlessness or suggest that the former is always better than the latter but instead proposes that each is most useful at different times in the parenting process. I conclude by calling for empirical investigations of mindfulness-based parent training and, if those are successful, for the development of an integrated model that blends behavioral and mindfulness-based principles to inform all facets of intervention.

Parent–child interactions play a major role in child development and socialization and have long been the focus of programmatic efforts to change them when they are dysfunctional. These efforts have led to the creation and refinement of a sophisticated psychosocial approach, known generically as behavioral parent training (BPT) or parent training for short. Since its inception in the 1960s, BPT has become one of the most widely used interventions for families with disruptive children. The methods of instruction and the two core techniques of BPT, differential reinforcement and time-out, have been developed into comprehensive, manualized programs for professionals (e.g., Barkley, 1997; Eyberg & Boggs, 1998; McMahon & Forehand, 2003) and the general public (e.g., Barkley & Benton, 1998; Webster-Stratton, 1992).

Applied successfully in diverse socioeconomic and ethnocultural contexts, BPT offers a time-limited, cost-effective means of fostering positive parent–child interactions in families with disruptive children or with children at risk of becoming disruptive (Eyberg et al., 2001; Gross et al., 2003; Serketich & Dumas, 1996; Webster-Stratton, 1998). For example, a meta-analysis of 26 outcome studies found that, on average, children whose parents participated in BPT were better adjusted at home after treatment than 80% of children whose parents did not participate. Similarly, participating parents were better adjusted themselves at the end of treatment than two thirds of nonparticipating parents (Serketich & Dumas, 1996). Though positive, these findings show that not all families benefit from BPT. Some parents are reluctant to become engaged in programs designed to change the ways they interact with their children. Others become engaged initially but participate minimally and often drop out early. Still others participate fully and make positive changes in their parenting but do not maintain them for any significant length of time.

Interventions work and fail for many reasons. One of them is that the processes through which an intervention achieves change can be expected to be relevant and beneficial to some but not all participants (see Kazdin, 1997, 2001). Fundamentally, the operant
model underlying most BPT programs assumes that human behavior is a function of the contingencies of reinforcement and punishment to which individuals are exposed in their daily lives and that changes in these contingencies are necessary to modify undesirable behavior (Dumas, 1989). There is no doubt that carefully planned changes in contingencies can help many families with disruptive children. However, research in cognitive, social, and clinical psychology since BPT was first developed has shown that its operant model cannot account for numerous facets of human behavior. Of particular relevance to processes of change is the growing literature on automaticity in the development and maintenance of adaptive and maladaptive behavior. This literature shows that, with practice under comparable learning conditions, many patterns of behavior become automatized, that is, under the control of largely unconscious rules that do not readily respond to changes in contingencies of reinforcement and punishment (Bargh & Chartrand, 1999; Bargh & Ferguson, 2000). In line with this evidence, I believe that some families do not benefit from BPT because, by the time they are offered intervention, they have engaged in ineffective patterns of interaction so often that those have become automatized and highly resistant to change.

There is growing awareness of the role of automaticity in family interactions (e.g., Milner, 2000), but researchers and clinicians have been slow to consider its implications for interventions for families with disruptive children. This is the purpose of this article. Following an overview of automaticity in everyday life and family relationships, I contrast the BPT model with a new, mindfulness-based parent training (MBPT) model. The fundamental assumptions underlying each model are presented in Table 1. The MBPT model informs three strategies to lessen the grip of automaticity in families with disruptive children. I present these strategies, along with indirect empirical support for each from research in other areas of psychology, compare these strategies with those used in BPT, and call for systematic evaluations of the new model. As should become apparent in the following, I am not advocating a rejection of the BPT model. Rather, this article calls for an integration of research on effective parenting with research on automaticity to bring parent training practice in line with current empirical knowledge. In that perspective, I use the labels behavioral and mindfulness-based to describe the two models only, not to suggest that a mindfulness approach is antibehavioral or that a behavioral approach never addresses mindfulness issues.

Automaticity

Much of what we do, we do automatically and mindlessly, without the guidance of explicit plans or the intervention of conscious acts of will. Everyday life would be impossible if it were not for a font of automatized patterns of thinking, feeling, and acting acquired in the course of countless exchanges with our social and physical world (Bargh & Ferguson, 2000).

Automaticity is a double-edged sword. On the positive side, it provides us with essential “shortcuts” to manage our interactions with people and things and leads to major economies in attention and effort. Toddlers are aware, quite literally, of every step they take, consciously putting one foot in front of another in the difficult and tiresome task of learning to walk. Rapidly, however, practice enables them to smooth over their hesitations and makes them experts able to walk and

### Table 1. Fundamental Assumptions of the Behavioral and Mindfulness-Based Parent Training Models

<table>
<thead>
<tr>
<th>Behavioral Model</th>
<th>Mindfulness-Based Model</th>
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<tr>
<td>Human behavior is a function of the contingencies of reinforcement and punishment to which individuals are exposed in the course of their exchanges with the environment.</td>
<td>Much of human behavior is automatized. It reflects ATPs, that is, transactional, relationship-specific ways of coping that are performed with little conscious awareness, stable, and highly resistant to change.</td>
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<td>Disruptive behavior is learned and sustained by the positive and negative reinforcement (e.g., social attention, avoidance) children receive from social agents, parents in particular.</td>
<td>Conflict in families with disruptive children reflects ineffective ATPs that are maintained by strong negative emotions.</td>
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<td>Intervention relies on operant principles to teach parents to establish shifts in contingencies such that their children’s prosocial behaviors obtain positive parental reinforcement and their aversive behaviors are consistently punished or ignored.</td>
<td>Intervention relies on mindful practices to teach parents to consider their own and their child’s behavior nonjudgmentally, to distance themselves from negative emotions, and to develop parenting goals that are accompanied by motivated action plans.</td>
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<td>Maintenance and generalization of intervention gains rely on a process of positive reinforcement. As parents and children exchange reinforcers through their newly acquired patterns of interaction, these patterns are likely to maintain themselves and to generalize to new situations.</td>
<td>Maintenance and generalization of intervention gains rely on the development of effective ways of coping that become automatized with practice, that is, on new ATPs (until they themselves may need to be changed in mindful ways).</td>
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Automaticity in Family Relationships

Automaticity plays a major role in parenting and in the development of a child’s coping competence (Dumas, 1997). Clinical observation and research in cognitive and social psychology suggest that, with repeated practice under comparable learning conditions, everyday patterns of family interaction become integrated into what I call automatized transactional procedures (ATPs). ATPs consist of interrelated ways of thinking, feeling, and acting that have become characteristic of people who interact with each other often, such as parents and children (see Smith, 1994, for a discussion of procedural knowledge in the control of social behavior). ATPs have a number of important features. I emphasize four of them here, which are reflected in the first two assumptions of the MBPT model (see Table 1):

1. They are transactional, relationship-specific ways of coping.
2. They are performed with little or no conscious awareness.
3. They provide continuity and stability to the relationship by serving as guides to current and future exchanges.
4. They are highly resistant to change.

Consider each of these features in turn. First, ATPs are transactional in nature. They reflect the unique history of the parent–child relationship—a history in which each member has acquired relationship-specific ways of thinking, feeling, and acting (Dumas & LaFreniere, 1993; Milner, 1993; Patterson, Reid, & Dishion, 1992). When these ways of coping are generally positive, regular practice of effective communication skills leads parent and child to acquire a high level of proficiency in the use of prosocial methods of exchanging information, influencing each other, and solving mutual problems. Conversely, when they repeatedly practice dismissive, critical, or coercive ways of coping, parent and child become increasingly likely to engage in aversive interactions that run along well-practiced grooves of ill feelings, mutual recrimination and blame, or helplessness and withdrawal. Thus, a mother with a long history of conflict with her disruptive 10-year-old son may react to his latest temper outburst by feeling automatically angry (“Why can’t he just do what I ask without grumbling for once?”) and helpless (“What’s the point in trying? I can’t handle him”). Likewise, the boy may automatically say to himself that his mother is again unfair and that he has every right to protest. These thoughts and the feelings and actions that accompany them are relationship-specific, rather than ways of coping that both partners necessarily display with other people as well (Dumas & LaFreniere, 1993).

Second, ATPs are not the products of conscious decisions or choices, or of deliberate acts of will. Rather, ATPs become overlearned to such an extent that they give access to automatized thoughts, feelings, and actions. Two key characteristics of these automatized ways of coping are immediacy and efficiency. Immediacy refers to the fact that ATPs proceed rapidly in the presence of similar stimuli to those that led to their development and practice in the past; cognitive deliberation and planning are not required to set them off. Efficiency refers to the fact that, once set off, ATPs proceed without taxing cognitive resources; they require limited amounts of attention, leaving the protagonists cognitively free to engage in other, parallel activities (Bargh & Ferguson, 2000; Logan, 1992). I recently conducted an intake interview with the mother of a young disruptive boy. The child was sitting on the floor playing with blocks while we worked. At one point, his mother’s account of one of his violent temper tantrums led him to object loudly and rudely to what she was saying. Without looking at him or even turning toward him, his mother quickly replied just as loudly and rudely. Bickering back and forth continued for several minutes, often at a fast pace, but without interrupting the protagonists’ parallel activities. The mother remained focused on the interview and answered my questions in detail, while the child continued to build an elaborate structure that he proudly showed me later.

Another way of saying that ATPs are immediate and efficient is to say that they are mindless (Segal, Williams, & Teasdale, 2002). Parents and children are most likely to call on overlearned ways of coping when they are stressed or distracted (i.e., when their personal resources allow them to do little more than rely on what they know best because they have repeatedly practiced it in the past). This is a major issue for families with disruptive children and for those seeking to help them, as these families often face multiple stress-
ors and distracters in addition to parenting and child difficulties (Wahler & Dumas, 1989).

Third, even though the content of parent–child interactions varies across time and place, ATPs give continuity and stability to these interactions. This is because they are not only relationship-specific products of past ways of coping but also essential guides to current and future coping (Bargh, Gollwitzer, Lee-Chai, Barndollar, & Trötschel, 2001). For example, the likelihood that a child will do what a mother asks depends not only on the circumstances surrounding the request but also on the interactional history that both partners have shared over the years. Children who have learned to love and respect their mother are likely to obey promptly without even thinking about it. This is less likely of children who have ambivalent feelings for their mother or who know from experience that their mother commands freely but rarely follows through. ATPs serve as guides to maternal coping as well. These guides are generally beneficial for mothers who have developed a positive, responsive relationship with their children, but they are not for mothers who regularly struggle with discipline and other childrearing issues (Kochanska & Murray, 2000).

Kochanska’s (2002) programmatic research shows that positive parent–child ATPs are part of what she refers to as a “mutually responsive orientation” characterized by responsiveness and shared positive affect.

Responsiveness refers to the parent’s and the child’s willing, sensitive, supportive, and developmentally appropriate response to one another’s signals of distress, unhappiness, needs, bids for attention, or attempts to exert influence. Shared positive affect refers to the “good times” shared by the parent and the child—pleasurable, harmonious, smoothly flowing interactions infused with positive emotions experienced by both. (p. 192)

Unfortunately, in families with disruptive children, mutual responsiveness is less sensitive and supportive than it is oppositional and confrontational, and “good times” are too rare to nurture healthy relationships and deal prosocially with unavoidable disagreements and conflicts (Dumas, LaFreniere, & Serketich, 1995; Patterson et al., 1992).

Finally, ATPs are highly resistant to change (Logan, 1989). This is positive for parents and children who trust and treat each other with respect and who enjoy each other’s love and support. However, it is a curse for family members who are repeatedly in conflict with each other or emotionally unavailable and distant. It is also a curse in parent training, as overlearned ways of coping often compete strongly against the most carefully crafted parenting program. Psychological research on mindfulness offers promising ways of overcoming this resistance and, more generally, of lessening the grip of automaticity in families in which ATPs are not serving parents or children well.

Mindfulness

Several definitions of mindfulness have been proposed. I give two of them here:

Mindfulness [is] a state of psychological freedom that occurs when attention remains quiet and limber, without attachment to any particular point of view. Mindfulness is a process of looking freshly, of observation that is essentially nonbiased and explorative. It brings about an interval of time within which habits of meaning, thought, behavior, or emotion are suspended, reconsidered. (Martin, 1997, pp. 291–292)

Or, more succinctly,

Mindfulness means paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally. (J. Kabat-Zinn, 1994, p. 4)

Mindfulness is both a state of mind and a varied set of practices. As a state of mind, it is characterized by careful, considerate, and compassionate attention, irrespective of the specific practices used to foster it. This attention is experiential and, for many mindfulness practitioners, spiritual rather than analytical. It is focused on being rather than on doing, on the present and on immediate experiences as they unfold, rather than on understanding or solving problems. This attention is also nonjudgmental in that it accepts immediate experiences as they are. It does not evaluate these experiences, identify with them, or attempt to prolong or change them.

Mindful practices are found in all spiritual and religious traditions and have repeatedly been associated with health and healing. However, it is only recently that they became a legitimate topic of inquiry in Western psychology, probably because spirituality and religion were dimensions of human functioning that mainstream psychology deliberately sought to ignore for much of the 20th century.

Experimental, social, and clinical psychologists interested in topics such as memory, decision making, learning, and behavior change are studying mindfulness and mindful practices (e.g., Langer, 1997). In the area of behavior change, mindful practices have become an integral part of a number of interventions to treat adults with psychological problems or disorders, such as mood and anxiety disorders (Hayes, Strosahl, & Wilson, 1999; Roemer & Orsillo, 2002; Segal et al., 2002; Teasdale et al., 2002), alcohol dependency...
Mindfulness has not yet received the same amount of attention from researchers and clinicians working with children and families, but it holds promise in this area also. Before I consider that promise, I must emphasize that I reject a simplistic opposition between mindfulness and mindlessness, and I do not see the former as always better than the latter. Rather, I believe that each is most useful at different times in the parenting process. Mindful practices provide time-tested ways of cultivating mutual care and respect in families and of attending to the different needs and preferences of parents and children. Mindful practices are also helpful for stepping back from unproductive ways of coping. Specifically, when they become an integral part of parent training, these practices offer tools to consider and set in motion alternate patterns of parent–child interaction and to practice them until they replace older, less effective patterns (i.e., until they become in turn mindless). In other words, I see mindful practices as a means for addressing family relationship problems and, ultimately, as a stepping stone to a different, more productive mindlessness between parents and children. In this perspective, MBPT is not only about learning new ways of coping. It is also about practicing them over and over again to create new automaticities—new ATPs that are more effective and harmonious than the ones that initially brought the family in for help (Bargh & Ferguson, 2000; Segal et al., 2002).

Fostering Everyday Mindfulness in Parent Training

There are different ways of fostering everyday mindfulness in parent training. I have found three of them useful in my work with families with disruptive children. They are

*Facilitative listening*—To encourage parents to share their experiences and concerns and to attend to their immediate thoughts and feelings nonjudgmentally.

*Distancing*—To help parents distance themselves from their overlearned ways of coping and the negative emotional states with which they have become associated.

*Motivated action plans* (MAPs)—To help parents choose effective goals for themselves and their children and devise and implement specific plans to reach those goals.

When used together, these ways of encouraging mindfulness reflect Assumptions 3 and 4 of the MBPT model. I describe them separately for ease of presentation, but they overlap to a considerable extent in intervention.

**Facilitative Listening**

Facilitative listening is a form of communication fostering understanding and nonjudgmental acceptance of thoughts, feelings, and actions—our own and those of others. It stands in contrast to an expert or prescriptive mode of communication. In MBPT, facilitative listening must occur throughout intervention and has two broad aims. The first is to obtain detailed information about parental concerns, while conveying to the parents that the clinician is attentive, nonjudgmental, and sincerely interested in the challenges they face. As is true of effective clinicians in general, professionals who rely on facilitative listening solicit parental opinions and preferences on repeated occasions, avoid criticism and premature advice giving, and provide frequent positive feedback that shows acceptance and understanding. In MBPT, they often do so successfully by inviting parents to tell stories about themselves and their children and about the challenges they face in their daily interactions.

Through questions that move from general to specific, clinicians can obtain information necessary for a complete understanding of a critical issue, clarify the information received with respect to details (when, where, how), find out how the parent feels about the issue, and understand what the parent has already done about it. With time, clinicians who elicit and listen attentively to stories about child care, relationships with family and friends, and other personal or family issues (a) convey respect and genuine empathy, (b) help parents distinguish between things they can change (e.g., a child’s oppositional behavior) and things they cannot (e.g., a failed relationship and the painful divorce that followed), and (c) encourage parents to set themselves realistic and enhancing goals that they will be motivated to implement.

The second aim of facilitative listening is to help parents take a progressively more accepting stance toward the challenges they face and a less critical one toward themselves and others. This stance “involves replacing the old mode of fixing and repairing problems with a new mode of allowing things to be just as they are, in order to see more clearly how best to respond” (Segal et al., 2002, p. 95). It contrasts with many psychological approaches, including BPT, which, once it has established when, where, and how problems occur, uses that information to attempt to solve those problems. In other words, through facilitative listening MBPT clinicians convey an attitude of acceptance in
the face of problems and invite parents to adopt a similar attitude. Parents who learn to do so are best able to decide how they want the intervention to proceed and how they will implement the goals they set themselves. More important, these parents learn to accept that life is difficult, that rearing children is challenging, that some things cannot be changed, and that the intervention does not promise to solve all parent–child problems but only offers some help along the way.

In MBPT, facilitative listening is a form of communication that runs counter to the commonly held view that interpersonal problems are best addressed through behavior influence (getting another person to comply with one’s requests) and problem solving (arriving at an agreement with another person to reduce or eliminate a problem). More fundamentally, facilitative listening runs counter to Western culture’s strong emphasis on doing rather than contemplating and on reducing, solving, or eliminating problems rather than accepting them as an integral part of life and pausing to see what (if anything) can be done (Hanh, 1995). With practice, facilitative listening teaches parents to “be with” their problems, to accept them instead of repeatedly engaging in unproductive attempts to fix, ignore, or run away from them. And it teaches clinicians to let go of the urge to immediately “do something” to make things better for the family. This does not replace the need to modify ineffective parenting strategies. Rather, as the issues facing the family are being clarified, facilitative listening helps parents decide what they can and cannot change in their family life, in their own behavior, or in their relationship with their children. This enables them to develop workable goals for themselves and their children and to specify carefully designed action plans that they have a realistic chance of implementing successfully.

A facilitative listening stance should not be mistaken for an attitude of confusion or resignation in the face of overwhelming challenges. To the contrary, stepping back and acceptance break the hold of automaticity by enabling parents to see more clearly how best to proceed before they do and by reducing the negative thoughts and feelings that are always associated with the conflicts that bring them to seek help. In other words, facilitative listening is empowering. Parents who are genuinely listened to in MBPT often report that they are better able to deal with daily challenges, even before any action plan has been set up. In large part, this is because facilitative listening sets the stage for distancing by helping parents to assert their authority without being critical or angry or feeling incompetent or helpless.

Distancing

“We practice anxiety. We practice getting angry. And the more we practice, through repeating these patterns in our lives, the ‘better’ we get at them, and the harder they are to break out of” (M. Kabat-Zinn & Kabat-Zinn, 1997, p. 107). This is true of other negative emotions and ruminations as well. Patterns of strong negative thoughts and feelings are frequent stumbling blocks to acceptance and change in individuals and families. They can sap the effectiveness of experienced clinicians by preventing them from listening nonjudgmentally.

Facilitative listening is relevant not only to interpersonal dialogues but also to the dialogues we have as we talk to ourselves and observe our own behavior. Distancing is key in these personal dialogues. Distancing is a form of communication with selves designed to put some psychological separation between our thoughts and feelings about a particular situation and the ways in which we act in that situation. This self-imposed separation is obvious whenever a mother says to herself, “I am mad but I will remain calm not to make matters worse.” It is also a major goal of socialization, as young children must learn to distance themselves from their negative feelings to be able to express them in nondestructive ways.

Distancing is used to promote mindfulness in MBPT by encouraging parents to see their negative thoughts and feelings, no matter how strong, as only a part of themselves, rather than as a complete and accurate account of reality. This can be done effectively by teaching parents to give those thoughts and feelings proper names and to talk about them in the third person, as in

Anger is sitting beside me. It is so hot that it could set me on fire.

Sadness is that dark cloud I see moving closer. If it is all I look at, I will be drenched.

Resentment is that trip wire just in front. If I am not careful, I will set off a huge explosion with my child.

With practice, such self-statements enable parents to acknowledge what they think and feel, without identifying completely with their inner experience or allowing it to control what they say and do. More generally, distancing is incompatible with mindless responding because it imposes a separation between the situation in which parents find themselves and their reaction to it. This separation encourages awareness and promotes reasoned action (or inaction) by enabling parents to control their thoughts and feelings instead of responding to them immediately and thus to consider alternatives instead of doing what they have done repeatedly in the past in similar circumstances. Also, by helping parents regulate their level of arousal, distancing allows them to undertake tasks that require sustained efforts and in which rewards are delayed—such
as completing a parenting program or, more important, bringing children up.

Practically, clinicians who want to promote their own and their clients’ mindfulness must learn personally and teach their clients to listen attentively and nonjudgmentally to what they think and feel. This takes time and requires practice and is best achieved through regular quiet times or time-outs. Advocates of mindfulness training use meditation, relaxation, and breathing exercises to practice and teach attentive acceptance and nonjudgmental self-observation and self-talk (Segal et al., 2002). In MBPT, I ask parents to set regular, if possible daily, times aside to pause and reflect on their lives and those of their loved ones. I emphasize the importance of accepting and letting go of their thoughts and feelings without judging them as good or bad (or true or false) and of resisting the urge to immediately change what they or others do.

Whenever possible, I build opportunities for self-reflection and meditation in each MBPT session as well. This is not to replace the times set aside at home but to help parents who often feel overwhelmed and find it difficult to practice at home. I do that by teaching parents simple meditation techniques that we practice in session. The issue on which parents focus during each meditation exercise varies, although it is always one that the parent brought up or that I observed in session. Clinicians must resist the urge to talk during these reflective pauses. After each pause, they ask parents what came to their mind as they meditated. When these exercises have been preceded by genuine listening, parents often report thinking about critical or judgmental words or phrases that prevent them from altering the ATPs that are maintaining their parenting problems. This then sets the stage for the further practice of distancing, through dialogue or meditation—always with the aim of helping parents see their thoughts and feelings as just that, thoughts and feelings, rather than as objective accounts of who they or others are.

The purpose of distancing is not to modify negative thoughts or feelings as in many cognitively oriented therapies. Rather, it is to learn to accept them by developing a decentered relation to them. This is not designed to suppress or deny our negative mental life but to learn to see it only as a facet of who we are—not as our center or core. In this pragmatic perspective, thoughts and feelings are accepted as mental events that are more or less useful, instead of unchangeable statements of fact that define our identity (Breslin, Zack, & McMain, 2002). A father who regularly says to himself, “I am a bad parent” or “My child will never learn to take ‘no’ for an answer,” is likely to face many more challenges if he believes that these statements are literally true than if he is able to acknowledge them as disturbing thoughts and accept them as such.

As I emphasized already when talking about facilitative listening, an “attitude of acceptance does not refer to passivity or resignation in the face of strong affective states. Rather, it refers to being fully present with, but not preoccupied with, these states as they happen” (Breslin et al., 2002, p. 281). In other words, distancing is designed to reduce emotional turmoil by focusing attention away from the perceived nature of the problem and toward effective, practical solutions—away from negative emotional states and toward reasoned action (or inaction).

Parents find it much easier to practice distancing in a clinical setting than to engage in it in the midst of family conflict, when they are often blindsided by habitual negative thoughts and feelings. This is true, more generally, of most new ways of coping taught in BPT or MBPT. MAPs are designed to address that issue.

MAPs

Giving parents tools to change their own and their children’s behavior is central to all parent-training approaches. However, many parents find it difficult to use these tools on a consistent basis and give up more or less quickly, particularly when their children are slow to respond to the intervention or actively resist it. In the MBPT model, this is so in large part because parents and children who genuinely want to see their relationship improve often struggle to overcome the ATPs that control much of their aversive interactions or, more generally, because a desire to see behavior change is often not enough to bring about actual change.

Clinicians are well aware of this gap between motivation and action. Clinical and social psychological research shows that behavior change is a function of a person’s goals (where the person wants to get) and of the steps to be taken to reach those goals (what the person intends to do to get there). Generally speaking, people are able to reach goals that (a) are specific rather than vague, (b) are proximal rather than distal, and (c) promote rather than prevent (i.e., goals that are focused on attaining positive outcomes instead of avoiding negative ones; e.g., Gollwitzer, 1999). Typically, parent training helps parents teach their children to follow specific commands rather than to be obedient, to complete homework daily rather than to get good grades, or to wait until people have finished talking rather than to stop interrupting.

People are also more likely to reach their goals if they can specify clearly what they intend to do to reach them, that is, if they have a “cognitive map” to take them from their present to the desired goal state. These maps are behavioral strategies that specify when, where, and how the person will act to reach a particular goal. For example, a MAP such as, “Next time he yells, I will walk away, sit on the couch, and ignore him for three minutes” is likely to be much more
effective than a self-exhortation such as, “Next time he yells, I will try very hard not to lose my temper.”

In MBPT as in BPT, clinicians set aside time in each session to map out with parents how they will implement the goals they set for themselves and their children. In MBPT, this is done through facilitative listening that invites parents to set themselves specific, proximal, and promotion goals based on the session and to specify when, where, and how they will act to reach them. Once developed, MAPs are rehearsed by combining role playing and visualization with discussion. Role playing enables parents to practice the actual words and actions they intend to use with their children instead of merely talking about them. Visualization consists of asking parents to close their eyes, breathe regularly, and imagine themselves and their children interacting according to the new action plan.1

MAPs are designed to provide parents with alternative responses that they can make in situations that have repeatedly been controlled by negative ATPs in the past and thus to lessen the grip of automaticity on such situations. I encourage parents to see the words and actions they choose and practice in session as their “road maps” to parenting successfully. To emphasize this point, parents complete and take home homework assignment sheets that look like actual road maps. These maps are used to specify the goal or goals parents set themselves, as well as to summarize what they will say and do everyday to attain those goals.

MAPs promote mindfulness by training parents to anticipate and be ready to give careful, immediate, and nonjudgmental attention to childhood challenges as they arise—instead of ignoring them and wishing them away, resenting them and becoming angry, or blaming their children or themselves. Specifically, MAPs facilitate goal attainment by

- Transferring control from overlearned ATPs to environmental stimuli and promoting specific actions in response to those stimuli.
- Promoting immediate, efficient actions under low and high attentional demands.
- Promoting immediate, efficient actions when opportunities to act are only present for a short time.
- Promoting distancing in emotionally charged situations.

Transferring control to environmental stimuli. MAPs help transfer control of goal-directed stimuli from vague, internal appeals for change to environmental stimuli that can be anticipated in light of experience. This transfer provides the person with readily available self-regulatory strategies because, by committing in advance to respond to a situation in a specific manner and rehearsing how, effortful cognitive processing and decision making in context are reduced or unnecessary. This is supported by evidence showing that goals that are accompanied by action plans are more easily attained than goals that are not, even when these plans are deceptively simple. Much of this evidence comes from social and health psychology research on implementation intentions (see Gollwitzer, 1999; Gollwitzer & Schaal, 2001, for reviews).

Programmatic studies demonstrate that action plans greatly facilitate the crucial passage between formulating goals and implementing them. For example, Gollwitzer and Brandstätter (1997, Study 1) asked students to specify two goals they wanted to achieve during winter vacation. One of these goals had to be easy to implement and the other difficult. Typical goals included reading a novel, writing to a friend, settling a family conflict, and writing a course paper. Participants were also asked if they had action plans, that is, if they knew when, where, and how they intended to implement their goals. Participants were contacted again when they returned to the university to find out how successful they had actually been. Results showed that action plans significantly affected the implementation of difficult but not of easy goals. Approximately 80% of easy goals were implemented, whether students had a plan or not. However, only 22% of difficult goals were met without a plan, in contrast to 62% with a plan. This difference could not be accounted for by other variables assessed in the study.

Comparable results were found in an experimental variant of that study. Gollwitzer and Brandstätter (1997, Study 2) asked students to implement a difficult goal during winter vacation, namely to write a report describing how they spent Christmas eve. They were instructed to complete the task and to mail their report within 48 hr of the event. Half of the participants were also asked to devise action plans that specified when and where they would complete the task and to visualize and silently commit themselves to carry out their intentions. As anticipated, 71% of students who had a plan wrote their report within the prescribed timeframe, compared to 32% of students without a plan. These results, which have been independently replicated (Koole & Spijker, 2000), demonstrate that MAPs help people reach their more challenging goals.

Research on the implementation of health goals similarly supports the effectiveness of MAPs. For example, Milne, Orbell, and Sheeran (2002) compared the likelihood that students would exercise under three conditions: a control condition in which individuals did not receive any intervention and two experimental conditions, one in which they participated in a motivational intervention to encourage them to exercise and the other in which they participated in the same inter-

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1Visualization should not be confounded with wishful imagination of child behavior change. Visualization is only used once an action plan has been developed and instructions are clearly given to focus on implementation of that plan.
vention and developed an action plan. Results showed that 91% of students who were motivated and had a plan exercised the following week. This compares very favorably to 39% of students who were equally motivated but had no plan and to 29% of control students. MAPs have also been found to be beneficial in other health areas, such as cervical cancer screening (Sheeran & Orbell, 2000), regular vitamin intake (Sheeran & Orbell, 1999), and breast self-examination (Orbell, Hodgkins, & Sheeran, 1997). In the last study, 100% of women who indicated that they strongly intended to perform a breast self-examination did so in the next month when they had an action plan, compared to 53% of women with equally strong intentions but no plan.

This evidence shows that MAPs bring action initiation under environmental control and facilitate adaptive, automatized responses (Chasteen, Park, & Schwarz, 2001; Gollwitzer, 1999). However, to establish that MAPs promote automaticity requires a demonstration that they give rise to immediate and efficient action under low and high attentional demands and when opportunities to act are present only for a short time (Bargh & Ferguson, 2000).

**Promoting immediate, efficient actions under low and high attentional demands.** As we just saw, and contrary to what may seem intuitive, MAPs are most effective in attaining difficult goals and goals that are often perceived as unpleasant (such as breast self-examination). There is also evidence that MAPs are equally effective under low and high attentional demands. For example, in the context of a workshop on finding a job, Brandstätter, Lengfelder, and Gollwitzer (2001, Study 1) invited hospitalized patients undergoing withdrawal treatment for opiate abuse to compose a résumé. Participants were shown a model of what was expected and instructed to turn in their résumé by a specified time, before being randomly assigned to one of two conditions: an irrelevant implementation-intention condition, in which they planned when they intended to have lunch, where they would sit, and how they would start their lunch; and a relevant implementation-intention condition, in which they decided when and where they would write their résumé and how they would start composing it. Twelve out of 20 participants (60%) in the relevant condition completed the task on time, compared to zero out of 21 participants in the irrelevant condition. More important, within the relevant condition, 8 out of 10 patients who were experiencing high levels of distress because of severe symptoms of drug withdrawal (e.g., freezing, diarrhea, muscle pains, and cramps) completed the task successfully. This compared favorably with 4 out of 10 patients who had been hospitalized longer on average and who were not experiencing withdrawal symptoms anymore. This suggests that action plans facilitate goal attainment and, contrary to what might be expected, may actually be most effective when individuals are faced with significant competing demands for their attention (such as withdrawal symptoms).

**Promoting immediate, efficient actions when opportunities to act are only present for a short time.** In three other studies, Brandstätter et al. (2001) showed further that MAPs promote immediate, efficient actions when individuals have to complete tasks on which they have only a limited time to respond accurately. Specifically, implementation intentions led to faster reaction times to a target number presented on a computer screen than prior familiarization with the target in patients with schizophrenia and average controls (Study 2) and in students (Studies 3 and 4). More important, this acceleration effect was observed (a) only when participants encountered the environmental stimulus they had anticipated in their action plan (i.e., the target number, rather than other numbers) and (b) in Studies 3 and 4, when a parallel competing task made either low or high demands on participants’ attention.

These findings demonstrate that deciding in advance how to respond in a specific situation leads to immediate and efficient action when the situation occurs. As this is true even when opportunities to act are only present for a limited time and one’s attention must be allocated to other competing demands, this indicates that “forming an implementation intention is a conscious mental act that has automatic consequences” (Brandstätter et al., 2001, p. 957).

There are no published reports on the effectiveness of MAPs in MBPT. However, the evidence just reviewed suggests that placing goal-directed behavior under the control of clearly defined environmental stimuli should increase the likelihood that parents will initiate immediate, efficient actions in the presence of those stimuli. MAPs are thus good candidates to help break the emotionally charged cycles of automaticity that maintain parent–child conflicts. Mindfully planning how to act in conflictual situations should reduce the need for effortful cognitive processing and decision making in context. This is likely to have a double advantage. In the short term, it should facilitate rapid and competent initiation of positive parenting practices in situations that have traditionally triggered conflict. In the long term, it should provide parents with repeated practice under similar learning conditions and lead to the development of new ATPs to replace ineffective modes of functioning with more beneficial ones.2

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2I believe that the same applies to children. I will not consider here the use of MAPs with children, but this is an approach that will need to be evaluated with them also, both clinically and experimentally.
Promoting distancing in emotionally charged situations. Finally, maps are of little use to travelers who refuse to journey from where they are. This is obvious but by no means accepted by all parents early in intervention. In MBPT, I find that helping parents implement effective parenting strategies is often hampered by a long history of emotional turmoil, resentment, and hurt. This “baggage” can be so heavy that some parents appear, at least initially, to be stuck—complaining loudly about their circumstances but unable or unwilling to get motivated to take action. This experience is confirmed by clinical and observational evidence showing that interactions in families with disruptive children are regularly rocked by negative verbalizations and emotions and that cognitive and affective negativity can interfere with the most carefully planned parenting program (Dadds, Barrett, Rapee, & Ryan, 1996; Patterson et al., 1992).

Together with facilitative listening and distancing, MAPs can be used to foster an attitude of acceptance by offering practical solutions in circumstances in which parents have often struggled for a long time, not only with legitimate childrearing concerns but also with feelings of resentment and resignation. This is again done by helping parents specify when, where, and how they will respond to reach their goal. For example, facilitative listening may reveal that parents are easily angered and raise their voice quickly when their child procrastinates or refuses to do homework and then often aggravate matters by labeling the child as “just plain lazy” or “doing it on purpose.” Parents can implement their goal of remaining calm and noncritical in such situations by role playing and visualizing a MAP that will facilitate appropriate distancing, such as, “When my child complains about homework, I will tell myself not to raise my voice or label my child.” In other words, by giving parents straightforward, practical solutions, MAPs can help introduce some psychological distance between parents’ childrearing concerns and the negative emotional baggage with which they have become associated. This distance increases the likelihood that parents will acknowledge and accept where they are at with their children as the point from which to proceed.

Evidence demonstrates the effectiveness of MAPs in the control of habitual thoughts and feelings. For example, in one study, implementation intentions suppressed the automatized activation of stereotypical beliefs and prejudicial feelings toward women and the elderly (Moskowitz, Gollwitzer, Wasel, & Schaal, 1999). This shows that MAPs can be used not only to promote immediate, efficient action but also inaction, in the sense of controlling unwanted negativity. It remains to be established experimentally whether such control results in clinically significant changes in observable behavior in the parenting area. However, clinical experience confirms that parents who learn to control their automatized tendency to raise their voice and criticize their children when they misbehave are better able to handle conflict than parents who do not.

Comparing MBPT With ACT and MBCT

There are important similarities and differences between MBPT and a number of mindfulness-based interventions to treat adults with psychological problems or disorders, especially ACT (Hayes et al., 1999) and MBCT for depression (Segal et al., 2002). All three interventions share two fundamental assumptions: that problems and challenges, sometimes major, are a healthy part of human life and that acceptance is pivotal to change because it opens novel perspectives on problematic situations and suggests solutions to those situations that can actually be changed. MBPT and MBCT trace many of their clients’ difficulties to “bad habits.” These habits are automatized ways of thinking, feeling, and acting that tend to worsen difficulties instead of lessening them. In contrast, ACT accounts for psychological difficulties in terms of “the domination of analytical language over experience” (Hayes et al., 1999, p. 10). Specifically, culturally mediated and individually acquired verbal rules are assumed to make clients relatively insensitive to the direct consequences of their actions and, therefore, more likely to “follow the rule” than to adapt to the ever-changing contingencies to which they are exposed. The therapeutic techniques used in each intervention reflect these assumptions. All three approaches emphasize the importance of encouraging clients to be with their thoughts, experiences, and difficulties, instead of identifying with them or avoiding, ignoring, or wishing them away. ACT seeks to reduce the “verbal noose” of language on behavior through a variety of techniques designed to disrupt troublesome language practices. MBPT and MBCT recognize the importance of language in maintaining the client’s difficulties and include techniques such as distancing to reduce the impact of negative self-talk on behavior. However, the overall goal of these two approaches is to help clients develop new automaticities of thoughts, feelings, and actions through repeated practice of alternative ways of coping, both in and out of session. MBPT and MBCT put particular emphasis on meditation and re-

3One calls on the concept of rule-governed behavior to explain the lack of sensitivity to environmental contingencies that is characteristic of automaticity (MBPT and MBCT) and of rule-following (ACT; Hayes et al., 1999).
laxation to help clients be fully aware of their current experiences and, whenever necessary, step back from their overlearned but ineffective ways of coping. Consequently, the techniques they privilege are less verbal and more experiential than those of ACT. Finally, the use of MAPs is unique to MBPT. The other interventions both emphasize the importance of helping clients follow a committed course of action (ACT) or develop an action plan to prevent future episodes of depression (MBCT). However, MBPT is the only approach to offer clients a step-by-step tool to anticipate and practice how they intend to respond to problems and challenges in novel ways.

Future Directions

The MBPT model is built on what I see as reasonable parallels and extensions between established findings in cognitive and social psychology and parent-training practice and seeks to bring that practice in line with current empirical knowledge. However, this article is limited by the fact that these parallels and extensions are largely speculative. They need to be thoroughly tested and modified or discarded in light of research evidence. The challenge is significant, as research will need to establish not simply that parents benefit from MBPT but that this new approach “adds value” to a more traditional BPT perspective. Evidence of added value would come from data showing, among other things, that the MBPT model facilitates engagement and retention of families in intervention, helps families with long histories of parent-child conflict, and reduces relapse (i.e., return to preintervention problems after significant gains). The model is being tested in a universal preventive intervention designed to reduce risk of maltreatment in preschool children (Dumas, 2002). This group-based intervention follows current practice in program evaluation, including random assignment of groups to MBPT or BPT, manualization and fidelity monitoring of both conditions, and use of multiple process and outcome measures.

Research also needs to show that MBPT can help different families. The intervention just described targets comparable numbers of European and African American parents of diverse socioeconomic backgrounds and addresses this issue. In the meantime, it should again be stressed that mindfulness is not a culturally bound concept. Mindful practices invariably reflect the culture of those who adopt and teach them, but those practices cut across spiritual and religious traditions and have repeatedly been associated with health and healing in different cultures. This is particularly true of an attitude of acceptance, which has long been seen as essential to careful, considerate, and compassionate attention to self and others, and ultimately to living in harmony with oneself and others.

Summary and Conclusion

Clinicians who seek to help families with disruptive children know that even reasonable requests and minor disagreements can be enough to trigger well-practiced patterns of thinking, feeling, and acting that mindlessly result in conflicts, angry outbursts, and hurt feelings. This article argues that mindful practices that foster facilitative listening, distancing, and MAPs can help reduce the grip of automaticity in families with disruptive children and proposes a mindfulness-based model of parent training. The MBPT model is not designed to replace the behavioral model that has dominated the field for the past three decades but rather to challenge its assumptions in light of research from other areas of psychology. If this challenge is successful, I envisage the development of an integrated model that will blend behavioral and mindfulness-based principles to inform all facets of intervention.

Fundamentally, the article may seem contradictory. On the one hand, I claim that to lessen the grip of automaticity requires effort, in the form of mindful practices that bring attention to bear on habitual but ineffective ways of interacting. However on the other, I argue that this is effectively done with action plans that are designed to reduce the need for effortful cognitive processing and decision making in context. This contradiction is more apparent than real. It stems from the timing of the effort needed to develop new ways of coping. Deliberate and sustained (i.e., effortful) attention is needed to learn to accept that habitual ways of coping have become automatized and, when they are dysfunctional, to consider alternatives. This is central to MBPT and is best done through facilitative listening and distancing. However, at the end of each session, parents have to return to their usual interacting grounds, where “old habits die hard.” Hence the rationale for action plans have been carefully thought out and rehearsed. MAPs are designed to bring parental behavior under environmental control but without overtaxing cognitive and emotional resources in context. When this is successful, it replaces old, mindless habits with more effective ways of coping that should become just as mindless with practice.

As I emphasized earlier, this is another way of saying that mindlessness and mindfulness should not be pitted against each other. Rather, each is most useful at different times. Automaticity is an integral part of our social and emotional functioning and a major guide to our interactions (Bargh & Chartrand, 1999). However, mindful practices are essential to take stock regularly of who we are and how we live, to avoid passing by life
in the groove of habit. To strive for mindful family interactions at all times would not only be futile but also unhealthy. However, families with disruptive children come asking for better ways of interacting, and mindfulness offers them tools to consider carefully what they want to change, what they can change, and how they will do it. With time, any change they implement will have to become mindless to be effective. It will have to lead to a new automaticity, but only until it is itself challenged by further mindfulness—hopefully in a never-ending process of continuity and change in which parents and children learn to interact with mutual consideration and respect, even in the midst of unavoidable disagreements and conflicts.

References


MINDFULNESS-BASED PARENT TRAINING


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