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Understanding differential effectiveness of behavioral parent training from a family systems perspective: Families are greater than “some of their parts”

Behavioral parent training (BPT) is a theory-driven, evidence-based, and widely used intervention strategy for preventing and decreasing children’s disruptive behavior problems, indirectly via improved parenting behavior. However, not all families benefit equally from BPT. To date, our knowledge of who benefits (and who does not) and our understanding of why some families benefit more than others is limited. An important challenge for research and practice is finding ways

to tailor interventions to the needs of an individual family and increase their effectiveness. We put forward family systems theory as a tool to gain more insight into which families (do not) benefit from BPT and why. We synthesize the theoretical foundations and empirical support for the putative mechanisms through which the functioning of family systems may explain BPT effectiveness and propose ways in which family systems theory can help strengthen the design, implementation, and evaluation of BPT programs.

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Behavioral parent training (BPT) is a widely used, theory-driven, and evidence-based intervention strategy to prevent and decrease children’s disruptive behavior problems (Furlong et al., 2013; Leijten et al., 2017; McCart et al., 2006; Mouton et al., 2018). These parenting programs aim to positively change parenting behavior and, ultimately—through these changes in parenting—change child behavior. Although there is convincing evidence that these programs are effective, effects are modest, ranging from small effects in

prevention settings to moderate effects in treatment settings (Menting et al., 2013; Mouton et al., 2018; Piquero et al., 2016). Moreover, not all families benefit equally from BPT and some families do not seem to benefit at all (Bor et al., 2002; Pelham et al., 2017; Thijssen et al., 2017; Van Aar et al., 2019). To date, we have limited knowledge of who benefits (and who does not) and limited understanding of why some families benefit more than others.

Several scholars have argued that a family systems perspective, which places the caregiver and child within the larger family system may be a promising tool to tailor our intervention strategies to the needs of individual families (e.g., Cowan et al., 1998; Dishion & Stormshak, 2007; Griest & Forehand, 1983; Griest & Wells, 1983; Kitzman-Ulrich et al., 2010). Although BPT is specifically designed to target parenting behavior as a key risk factor for disruptive child behavior, and therefore inherently places child behavior in the context of the family system, BPT practice and research has a strong focus on one aspect of one subsystem (i.e., parenting behavior in the caregiver subsystem). A family, however, is greater than “some of its parts.” We would like to argue that family systems theory is a valuable framework to expand the exploration of how and why families do or do not benefit from current BPT programs. The added benefit of a family systems framework is that it can be applied to all family types and constellations and therefore offers an inclusive framework to assess family functioning and needs. Moreover, a call for applying family systems theory to BPT is timely since it extends the recent calls for father involvement in BPT practice and research (Fabiano & Caserta, 2018; Isaacs et al., 2015; Panter-Brick et al., 2014).

In the current manuscript we (a) explore how family systems theory may help us understand and explain differential effectiveness of BPT programs as an evidence-based intervention strategy for disruptive child behavior; (b) discuss the theoretical foundations and recent empirical evidence supporting the validity of a family systems perspective on BPT, and importantly; (c) explore possible implications of a family systems perspective for the design, implementations, and evaluation of BPT programs, aimed at tailoring their implementation to the needs of individual families and increasing their effectiveness.

BEHAVIORAL PARENT TRAINING

BPT programs aim to alter parenting behavior by training caregivers to use parenting behaviors and techniques that reinforce positive child behavior and decrease disruptive child behavior. The content of these programs is based on sound theoretical foundations, such as social learning theories (e.g., modeling theory by Bandura, 1977; coercive cycle theory by Patterson, 1976; and attachment theory by Bowlby, 1969). Learning theories describe that children learn from observations and respond to both positive and negative reinforcements from their caregivers (Bandura, 1977; Patterson, 1976). Caregivers model, for example, behavioral and emotional responses in conflict situations. Moreover, the coercive cycle theory (Patterson, 1976) argues that disruptive child behaviors that are (unwittingly) being reinforced, will increase. In BPT, caregivers are instructed on how to model positive behavior and emotion regulation, how to reinforce the positive behaviors of their children, and how to prevent the reinforcement of negative behaviors. Attachment theory describes the “affectionate bond” between a caregiver and a child. Attachment security is based on the child’s trust that his or her caregiver will serve as a “secure base” from which to explore the environment (Bowlby, 1969). When a caregiver does not form a secure base, this may lead to negative attention seeking behavior and low motivation to comply in children (Dadds & Hawes, 2006; Scott & Dadds, 2009; Shaw et al., 2000). In BPT, attachment theory is represented in techniques to create positive interactions between caregiver and child and to strengthen the caregiver–child relationship.

The translation from these theories to practice has resulted in several evidence-based BPT programs. The three most applied and studied BPT programs are the group-delivered programs: Positive Parenting Program (Triple P level 4, Sanders, 1999, there is also an individually delivered version available [standard Triple P]) and Incredible Years basic (IY: Webster-Stratton, 2008); and the individually administered program Parent–Child Interaction Therapy (PCIT: Eyberg & Boggs, 1989) (see for an overview of the most studied programs, Leijten, Gardner et al., 2018). Although the form and delivery of these (and other) programs varies somewhat, there is strong overlap in the parenting behaviors and techniques used (e.g.,

praise and time-out). All three programs aim to *increase* positive parenting behaviors theorized to decrease children's problem behavior, such as praising positive behavior and limit setting, and to *decrease* negative parenting behaviors theorized to increase children's problem behavior, such as threatening and harsh discipline. There is convincing evidence that these BPT programs are effective (Honeycutt et al., 2015; Leijten, Gardner, Landau, et al., 2018; Mouton et al., 2018).

However, BPT practice faces two important challenges. First, the average effects of most programs are modest (e.g., Menting et al., 2013), with not all families benefitting equally, and some families not benefitting at all (e.g., Pelham et al., 2017; Thijssen et al., 2017; Van Aar et al., 2019). To date, very few consistent moderators of BPT effectiveness have been identified (for a review see, Dedousis-Wallace et al., 2020). However, meta-analyses suggest that families with less severe problems may benefit less (Leijten et al., 2020), and maintenance of BPT effects have been shown to be harder for economically disadvantaged families (Leijten et al., 2013). Second, we have little insights in the mechanisms underlying differential BPT effectiveness. BPT directly targets parenting behavior of an individual caregiver. Parenting behavior is therefore theorized to be the most important mechanisms of change. However, empirical studies have *not* consistently demonstrated that parenting behavior is indeed the key mediator of BPT effectiveness (Forehand et al., 2014; Weeland et al., 2018; Weeland, Chhangur, Jaffee, et al., 2017). Theoretically this can be explained by the fact that the relation between parenting practices and child behavior is neither direct nor unidirectional (Pettit & Arsiwalla, 2008). The putative mechanisms of change underlying interventions targeting parenting and child behavior may therefore also be complex (Burke & Loeber, 2016; Kazdin, 2007; Rimestad et al., 2017; Weeland et al., 2018). Changes in parenting and child behavior after participation in BPT may partly be explained by third variables, which often may not be assessed in research on BPT effectiveness.

Family systems theory can help us form hypotheses on alternative and/or additional mechanisms of change and ultimately provide ways to tailor the design and implementation of BPT programs. The functioning of, and (resistance to) change in, other family subsystems

may predict how much a specific family benefits from BPT (i.e., act as moderator) and/or may be part of the mechanisms underlying change (i.e., act as mediator). These factors could directly contribute to the etiology or maintenance of disruptive child behavior, interfere with change processes if left unattended (Dishion & Stormshak, 2007; Griest & Forehand, 1983; Griest & Wells, 1983; Scott & Dadds, 2009; Stormshak & Dishion, 2002), and/or be related to engagement (including enrollment, attendance of sessions, within-session engagement, and homework completion) of caregivers enrolled in BPT (Chacko et al., 2016; Kazdin & McWhinney, 2018).

A FAMILY SYSTEMS PERSPECTIVE ON BPT EFFECTIVENESS

Family systems theory

Family systems theory, also referred to as family process theory, stems from the general systems theory (GST). GST is both a transdisciplinary field of study and a theoretical framework in which various microlevel approaches are known as "systems theories" (i.e., the word system comes from the Latin word *systema*, literally meaning "composition"). It is used to explain behavior of complex, organized systems of all sorts (e.g., from thermostats to amoebas; Whitchurch & Constantine, 2009). The application of GST to the family originated from applied clinical practice in psychiatry and psychotherapy, and specifically family therapy. One of the first applications was an application to the origins of schizophrenia (Bateson et al., 1956; Bavelas, 1982). This switch from assessing maladaptive behavior in an (isolated) individual to assessing it in the context of the (dysfunctional) family system has been very influential in research and clinical practice (Friedman & Allen, 2011).

Family systems theory places the caregiver and child within the larger family system in which individual family members are necessarily interdependent (Cox & Paley, 1997; Kreppner & Lerner, 1989; Minuchin, 1988). All subsystems within the family are systems of their own, but are also interdependent, exerting continuous and reciprocal influences on one another. From a family systems perspective any individual family member can never be fully understood independent of the context of that system and

the interactions between the subsystems. Family systems theory can be applied to all family types and compositions, including families with single or multiple caregivers, blended families and LGBTQ families. The number of caregivers and the number of siblings determines the number of subsystems within the family. For example, in a family consisting of two caregivers raising one child, the family system consists of seven subsystems (see Figure 1): three individual subsystems (caregiver 1 [a], caregiver 2 [b], and the child [c]); three dyadic subsystems (caregiver relationship [ab], caregiver 1–child relationship [ac], and caregiver 2–child relationship [bc]); and the triadic relationship between caregiver 1, caregiver 2, and the child (i.e., the coparenting relationship: abc).

These subsystems are embedded in each other (e.g., the individual subsystems are embedded in the dyadic and triadic subsystems) and form a hierarchically organized system, which in turn is embedded within larger systems (e.g., the community). The functioning of the subsystems is determined by rules, boundaries, and interactions, which occur both within and across these various levels of systems. For example, individual family members have to function within separate subsystems (e.g., siblings must learn how to negotiate conflict without interference from their caregivers), but the larger family system is also an important resource for support (e.g., siblings in conflict need rules, boundaries and support from their caregivers when needed; Minuchin, 1985).

Family (re)organization and feedback loops

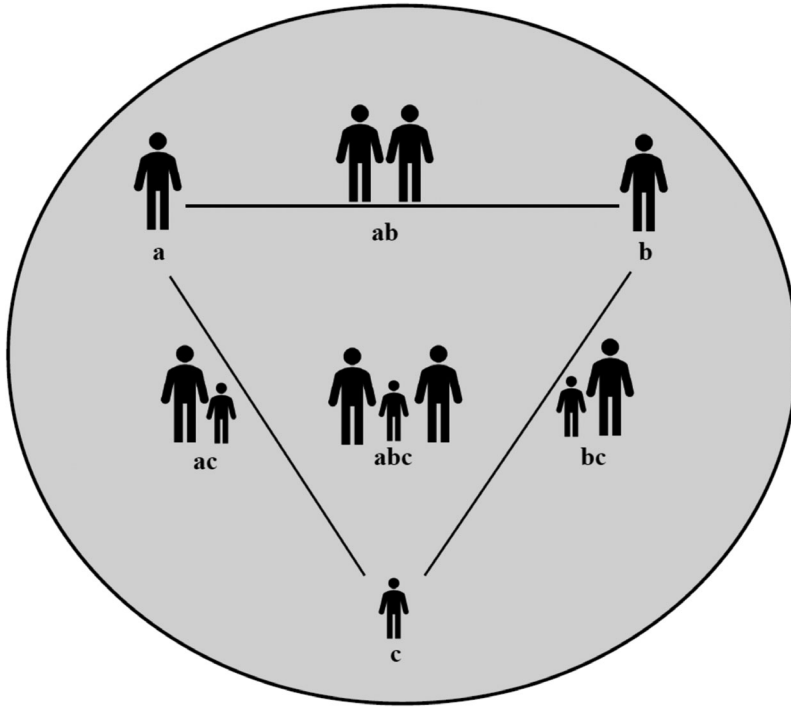
The family system has a self-organizing tendency through feedback loops: loops of causal links between different subsystems. Change in any of the subsystems could potentially cause change in the next subsystem in the loop and then the next and the next, in a ripple around the loop until the last element influences the original one. Some feedback loops may intensify problems (such as in coercive cycles). For example, if a child asks for a treat and the caregiver says no, the child may start to whine. A caregiver may try to stop the whining by reacting to this behavior in a negative way (e.g., raising his/her voice), which may increase the whining and causes the caregiver to eventually give in. This may start a negative feedback loop which eventually intensifies negative caregiver

and child behavior. Research has shown that the family system can indeed become disorganized when a child develops disruptive behavior (and possibly more so than, e.g., in case of internalizing problems; Green et al., 1992; Lindahl, 1998).

However, other feedback loops may resolve problems. In the case of children starting to whine after being refused a treat: If the caregiver ignores the whining and chooses to be consistent, the whining in reaction to a refusal will decrease over time and will eventually stop. This corrective feedback will reestablish the family equilibrium. Moreover, families also have the capacity to reorganize and adapt in response to external forces, such as input from an intervention. Interventions targeting one of the individual subsystems (i.e., the caregiver or child) may evoke changes in other (individual, dyadic, or triadic) subsystems (Patterson et al., 2004). Therefore, how an intervention affects a certain subsystem could be difficult to grasp when this subsystem is evaluated in isolation. For example, BPT participation has been shown to lead to a decrease in children's attention-deficit/hyperactivity disorder symptoms between the start of and mid-program, which in turn was associated with an increase in caregivers feelings of self-efficacy between mid- and post-program (Rimestad et al., 2017). This may theoretically lead to further changes in caregivers' well-being, their parenting behavior, and their child's behavior. BPT hands caregivers a toolbox to help them (re)establish rules and routines, positive limit settings, and respond to situations in which rules are broken by the child. The use of this toolbox within caregiver–child interactions challenges existing patterns of interactions in the caregiver-child, but also other subsystems, resulting in feedback loops that may lead to (further) change.

If all goes well, new positive patterns emerge as an adaptation to the to this external intervention (Cox & Paley, 1997; Minuchin, 1988). However, feedback loops may be discontinued because of differential rates of change in different subsystems or by a lack of overall change in one or more subsystems. For example, caregiver's stress or depression may impede the implementation of the new learned techniques in a consistent, positive and sensitive way. But even when the participating caregiver puts the BPT toolbox into practice, by the book, problems in other subsystems may prevent change. For

FIGURE 1. CONCEPTUAL OVERVIEW OF A FAMILY SYSTEM, IN THE CURRENT CASE REPRESENTING TWO CAREGIVERS WHO SHARE RESPONSIBILITIES FOR ONE CHILD



example, when the new parenting techniques are implemented by one caregiver but not by the other(s), the family may stay in previously ingrained interaction patterns. Furthermore, a reorganization may also lead to instability which may bring about new vulnerabilities in the family system. For example, it may be that changes in parenting behavior negatively affect the sibling relationship. Siblings may feel as if the target child of BPT “gets all the attention” because of his/her negative behavior, which leads to increased feelings of exclusion and sibling rivalry.

THEORETICAL FOUNDATIONS
FOR AND EMPIRICAL EVIDENCE
OF THE IMPORTANCE OF THE FAMILY SYSTEM
IN EVALUATING BPT EFFECTIVENESS

The functioning of, and interactions between, the different subsystems and the course and functioning of feedback loops herein are important for understanding which factors within the family system contribute to the

development and maintenance of child behavior. And, more importantly, for understanding if and how caregivers’ participation in BPT may lead to change, preferably lasting change, in child behavior. This crucial information is, however, missed if the effects of BPT on parenting and child behavior are assessed in isolation, without considering the larger family system. Considering possible mediating and moderating roles of other subsystems may be an important tool for improving our understanding of differential effectiveness of BPT and provides us insights needed for further tailoring the content and implementation of these programs. In case of BPT, it may thus be important to assess intervention effects on parenting and child behavior in context of the other family subsystems, more specifically in the context of caregivers’ cognitions and well-being (individual subsystems), the quality of caregiver–child, caregiver-caregiver, and sibling relationships (dyadic subsystems), and the coparenting relationships (triadic subsystems).

In the following paragraphs, for each of these subsystems we describe (a) the theoretical foundations for and recent empirical evidence of how the subsystem is related to parenting and child behavior, and (b) how the functioning of this subsystem may moderate and/or mediate BPT program effectiveness. Moderation is here explained as differential effectiveness: BPT is more effective for families with specific family characteristics compared to families without these characteristics (e.g., BPT is less effective for families in which caregivers have negative attributions about their child's behavior than for families in which caregivers do not). The transtheoretical model of change (Prochaska & DiClemente, 1983) explains such differences in intervention effectiveness by the relation between these characteristics and participants' readiness, willingness, and ability to change their behavior. Mediation is explained as the mechanisms through which BPT ultimately affects child behavior: changes in subsystems of the family contribute to BPT effectiveness on parenting and child behavior (e.g., BPT contributes to positive changes in caregiver attributions about child behavior, which in turn leads to improved parenting behavior and ultimately improved child behavior). Changes in one subsystem may thus start cascading changes in other subsystems.

We fully acknowledge that disentangling the family subsystems in this way is somewhat artificial as in reality they are nested and intertwined. However, we deem it necessary in order to discuss the theoretical validity and empirical evidence for the subsystems in an organized and systematic way. Different theories may underly the importance of the different subsystems in the development, maintenance and change of parenting and child behavior. Moreover, although there is an abundance of evidence on the importance of the separate family subsystems in the etiology and development of children's disruptive behavior, few studies have assessed how they relate to BPT effectiveness and fewer have assessed possible cascading effects (see for an overview of the effects of BPT components and add-on components, Leijten et al., 2019; Leijten, Gardner, Melendez-Torres, et al., 2018; Leijten, Melendez-Torres, Gardner, et al., 2018). We will therefore discuss the literature per individual subsystems, which are all valuable and unique pieces of information needed to understand the

value of the family system in BPT practice and research.

Individual subsystems within the family system

Caregivers: Theoretical foundations and empirical evidence. The functioning of caregivers as individual subsystems (represented in Figure 1 as *a* and *b*) and specifically caregivers' education, age, socio-economic status, cognitions (e.g., self-efficacy, expectations, and attributions), and (mental) health, drug use, and well-being (hereafter referred to as well-being) have been repeatedly related to parenting and child behavior (Bornstein, 2019; Carneiro et al., 2016; Jones & Prinz, 2005; Wilson & Durbin, 2010). We will focus on cognitions and well-being since these are central and malleable predictors of caregiver functioning in light of parenting. The complex links between caregiver cognitions and well-being, their parenting behavior, and child outcomes is described in different theoretical frameworks such as the multiple determinants of parenting (Belsky & Jaffee, 2006), family stress theory (Hill, 1958), and parental self-efficacy theory (Bandura & Adams, 1977). Cognitions guide parents' processing of information about their children, their children's behavior, and their role as parents to inform their decisions on how to act (Johnston et al., 2018). Indeed, negative cognitions have, for example, been found to predict coercive parenting behavior and subsequently disruptive child behavior (Smith et al., 2015). Caregiver well-being indirectly affects child behavior via multiple mechanisms, such as how sensitive caregivers are to their child's cues and how easy it is for them to get their child's attention, to be consistent, and to provide their child with adequate stimulation (Barnett, 2008; Leinonen et al., 2003; Tan et al., 2015). For example, economic distress has been associated with children's disruptive behavior via caregivers' emotional well-being and parenting behavior (Barnett, 2008; Bøe et al., 2014).

How may caregiver cognitions and well-being affect BPT effectiveness?. Caregiver's cognitions and well-being have both been found to moderate BPT effectiveness (Beauchaine et al., 2005; Leijten et al., 2013, 2020; Reyno & McGrath, 2006). Cognitions and well-being may affect caregivers' readiness, willingness, and ability to change their behavior. Caregiver

cognitions, specifically how caregivers perceive the influence they have over what they do and how their child reacts, may affect parents' expectations of the usefulness of BPT and if and how they will implement the learned strategies (Mah & Johnston, 2008). Indeed, it was found that of caregivers who enrolled in BPT, those who reported maladaptive attributions about their child's behavior were most likely to never show up for a session (Chacko et al., 2017). Moreover, maladaptive cognitions about parenting and child behavior may make it difficult to implement the learned techniques in a positive, consistent and sensitive way, reducing their effects on child behavior. Larger BPT effects were indeed found for caregivers with high parenting self-efficacy than for caregivers with low parenting self-efficacy (Van den Hoofdakker et al., 2010).

Caregiver well-being possibly affects BPT effectiveness both ways. On the one hand, it was found that caregivers who perceived more stress and lower quality of life reported more barriers to participate in BPT (e.g., because participation seems overwhelming), formed poorer therapeutic alliances with BPT practitioners, and in turn showed worse outcomes (Kazdin & McWhinney, 2018; Kjøbli et al., 2013; Rostad et al., 2018). On the other hand, it has been argued that caregivers who experience problems may perceive a greater need for support and may be more motivated to participate in an intervention and change their behavior (Beauchaine et al., 2005; Pereira et al., 2014). Indeed, parents who experienced high levels of stress were more likely to complete the program (Rostad et al., 2018) and showed stronger decreases in harsh discipline after participation (Pereira et al., 2014). Moreover, stronger effects of BPT on disruptive child behavior were found in families with a history of drug abuse (Beauchaine et al., 2005) or maternal depression (Leijten et al., 2020, but for conflicting results see Dedousis-Wallace et al., 2021).

Theoretically, participation in BPT may indirectly affect caregivers' cognitions and well-being—for example, via an initial decrease in disruptive child behavior, an increase in feelings of self-efficacy, or their perceptions of their child's behavior—and thus mediate BPT effectiveness (Forehand et al., 1984; Rimestad et al., 2017). Several studies found that BPT programs indeed have “collateral effects” on caregiver cognitions and well-being (Booker

et al., 2018; Colalillo & Johnston, 2016; Feldman & Werner, 2002; Hutchings et al., 2007; Rimestad et al., 2017; Whittingham et al., 2009). However, an individual participant data meta-analysis found no evidence for a general effect of BPT on caregiver outcomes beyond parenting behavior (Leijten, Gardner, Landau, et al., 2018). This suggests that the content of current BPT programs does not structurally improve caregiver well-being.

Dyadic subsystems within the family system

The caregiver–child relationship: Theoretical foundations and empirical evidence. Although caregiver–child attachment is not a synonym of the caregiver–child relationship, attachment theory forms the theoretical fundament of the importance of the caregiver–child relationship (represented as *ac* and *bc* in Figure 1) in child development (Bowlby, 1969). The affectionate bond between caregiver and child is activated in times of distress and becomes visible in the child's preferential desire for proximity and contact with the caregiver. Attachment security is based on the child's trust that the caregiver will serve as a “secure base” from which to explore the environment (Bowlby, 1969). Extensive literature indicates that securely attached children are able to develop and maintain more positive relationships with their caregivers and display less disruptive behavior compared to insecurely attached children (e.g., Fearon et al., 2010; Theule et al., 2016; Thompson, 2016). Caregiver sensitivity—defined as a caregivers' ability to perceive and to accurately interpret the child's signals and needs, and as such, to respond appropriately and promptly—plays a crucial role in shaping the caregiver–child attachment relationship (Ainsworth et al., 1978; De Wolff & van IJzendoorn, 1997).

How may the caregiver–child relationship affect BPT effectiveness? The caregiver–child relationship may moderate BPT effectiveness because it affects how effective the implemented parenting strategies are in changing child behavior. Parenting strategies based on conditioning and social learning theories, such as praising children's prosocial behavior or punishing disruptive behavior, may be less effective in decreasing disruptive child behavior in cases of poor caregiver–child relationships (Bakermans-Kranenburg et al., 2003; Scott &

Dadds, 2009). This may be explained by the fact that the caregiver–child relation affects how caregivers deliver these strategies. For example, praise may not be effective if delivered in an “attachment neutral” (i.e., without enthusiasm and affection) or insensitive (i.e., not in a timely and appropriate) way (Dadds & Hawes, 2006). However, to our knowledge the caregiver–child relationship has seldom been tested as a moderator of BPT effectiveness. A recent review found three studies that have measured different aspects of the caregiver–child relationship in the context of BPT, with mixed results (Dedousis-Wallace et al., 2021). For example, caregiver-reported dysfunction in the caregiver–child relation predicted BPT effects, where children of reporting lower levels of parent–child dysfunction showed a larger decrease in disruptive behavior (Lavigne et al., 2008). However, in the same study observed caregiver warmth, respect for autonomy and quality of assistance to the child did not.

If the caregiver–child relationship is positively impacted when caregivers participate in BPT, it could also be a mediator of BPT effectiveness. Positive caregiver–child interactions may strengthen the caregiver–child relationship and, in turn, the effectiveness of the learned techniques to reinforce positive behavior. All three of the most studied BPT programs (Triple P, IY, and PCIT) contain content that is specifically aimed at strengthening the caregiver–child relationship. However, the caregiver–child relationship has been seldomly assessed as mediator of BPT (with an exception of programs specifically targeting caregiver sensitivity, such as Video-feedback Intervention to Promote Positive Parenting and Sensitive Discipline [VIPP-SD]; Juffer et al., 2012, 2017). A meta-analysis did show that combining both components of behavior management and relationship building techniques leads to larger effects of BPT programs in clinical settings (but not in prevention settings) than a sole focus on behavior management (Leijten, Melendez-Torres, Gardner, et al., 2018).

On a critical note, these relationship building techniques solely focus on positive interactions and involvement (e.g., playing with your child) but do not necessarily teach caregivers *how* to build a high-quality caregiver–child relationship while spending time together. The combined effect of parental behavior management and relationship building techniques may be further

strengthened by specifically addressing sensitivity in BPT programs (Ainsworth et al., 1978; Bakermans-Kranenburg et al., 2003; De Wolff & van IJzendoorn, 1997). Several BPT programs have successfully done this, by including real-time coaching or video feedback components (e.g., in parent–child interaction therapy, Eyberg & Boggs, 1989, or VIPP-SD, Juffer et al., 2012, 2017).

The caregiver–caregiver relationship: Theoretical foundations and empirical evidence. Building on attachment theory, the emotional security theory suggests that children’s and caregivers’ emotional security in the context of the family is partly derived from both the quality of the partner relationship (i.e., the caregiver–caregiver relationship, represented in Figure 1 as *ab*) (Cummings et al., 2006; Davies & Cummings, 1994). The quality of the relationship between caregivers may affect all subsystems within the family system. Indeed, meta-analytic reviews have shown that the quality of the romantic partner relationship between caregivers is important for their personal well-being (Proulx et al., 2007), for the caregiver–child relationship quality (Erel & Burman, 1995), their parenting behaviors (Krishnakumar & Buehler, 2000), and child behavior (Van Eldik et al., 2020). Independent of the status of the relationship (e.g., married or cohabiting), the quality of this relationship may directly affect parenting behavior such as caregiver sensitivity and involvement with the child (Adler-Baeder et al., 2013; Glade et al., 2005). In addition, social learning theory suggests that children use the interactions between their caregivers as a model for their own interactions, informing their behavior (Bandura, 1977).

How may the caregiver–caregiver relationship affect BPT effectiveness? The relationship quality between caregivers has been found a moderator of BPT effectiveness, in which caregivers with high-quality partner relationships may benefit more than caregivers with poor-quality partner relationships (Dadds et al., 1987; Kazdin & McWhinney, 2018; Reid et al., 2003; Wymbs, 2011). Caregivers with a better partner relation may form better relations with their BPT practioners, and have better communication with their partner about parenting, both increasing BPT effects on parenting and, in turn, child behavior. Indeed, caregivers who have

stronger relationships with others (among which their partner) were found to encompass fewer barriers to participate in BPT and show a better quality therapeutic alliance with practitioners, which is an important predictor of intervention effectiveness (Kazdin & McWhinney, 2018). Moreover, in a mixed-methods study caregivers with high relationship satisfaction reported that BPT influenced both caregivers' parenting practices, even when only one attended BPT sessions, whereas couples with low relationship satisfaction reported that caregivers did not gain from BPT when they did not attend sessions (Huntington & Vetere, 2016).

If the caregiver-caregiver relationship is positively impacted by participation in a BPT program, it may also be a mediator of BPT effectiveness. It has been argued that involving the romantic partner in parenting practices positively impacts both the romantic and the coparenting relationship (Feldman, 2000). There is some (although mixed) evidence that BPT programs affect the partner relationship quality (Bodenmann et al., 2008; Zemp et al., 2016). For example, it was found that for mothers BPT positively impacted their marital relationship processes and relationship satisfaction, but not for stepfathers (Bullard et al., 2010). However, to our knowledge, the caregiver-caregiver relationship has not been assessed as a mediator of BPT effects on parenting or child behavior.

The child-sibling relationship: Theoretical foundations and empirical evidence. The child-sibling relationship is generally characterized by both love and warmth as well as by conflict and rivalry, which is explained by three theoretical principles (outlined by Buist et al., 2013): First, *attachment theory* may be used to frame sibling *warmth* (positive aspects of the relationship, such as intimacy, affection, and support) as a secure child-sibling attachment relationship can act as a protective factor against maladjustment. Indeed, low conflict between siblings and sibling companionship possibly buffer negative effects of poor caregiver well-being on child development (Keeton et al., 2015). Second, *social learning theory* may be used to frame sibling *conflict* (e.g., arguing and fighting) in which the sibling relationship may be used as a training ground for hostile and aggressive interactions, increasing the risk for disruptive problem behavior of the focal child. Correlational data suggests that siblings in

clinically referred families display higher levels of conflict and lower levels of warmth compared to not referred families for disruptive behavior (Dumas, 1996). Finally, *social comparison theory* may be used to describe the link between sibling *rivalry* and *problem behavior*. Sibling rivalry, or differential treatment, indicates that siblings perceive their caregivers to show more affection towards, have stricter rules for, or have more conflicts with one child compared to the sibling, which may relate increase maladjustment. Meta-analytic evidence showed that more warmth, less conflict, and less differential treatment were related to less disruptive behavior in children (Buist et al., 2013).

How may the sibling relationship affect BPT effectiveness?. The sibling relationship may moderate BPT effectiveness: BPT may be less effective for families in which sibling conflict is high compared to families in which sibling conflict is low. This may be explained in different ways. First, sibling conflict and violence may be closely related to other known moderators of BPT, such as parenting stress and caregiver's feelings of self-efficacy, which negatively affect caregivers' ability to implement the learned techniques (Feinberg et al., 2012; Shadik et al., 2013). Second, implemented techniques may be less effective in changing child behavior when they are applied to the problem child alone, since sibling conflict may maintain the disruptive behavior of the child (Scott & Dadds, 2009). However, to our knowledge sibling relationships have not been assessed as potential moderator of BPT effectiveness.

The sibling relationship may also be a mediator of BPT effectiveness, in such that when BPT affects the sibling relationship this leads to (further) changes in parenting and child behavior (Stormshak et al., 2009). On the one hand, BPT may increase sibling conflict and rivalry, due to increased (perceived) parental differential treatment and in turn prevents change. For example, the target child may feel that he/she is more strictly disciplined than his/her sibling(s) or the sibling(s) may feel the target child gets "all the attention". On the other hand, the parenting techniques taught in BPT may help caregivers monitor sibling interactions and mediate child conflict (see suggestions by Webster-Stratton, 2000). The implementation of these techniques may thus also affect how children interact with their siblings, which in turn

may lead to better sibling relationships, less parenting stress, more positive parenting and less disruptive child behavior. Although there are indications of a “spill-over” effect of BPT to siblings of the child for which families are referred to BPT (Brestan et al., 1997)—suggesting that caregivers generalize the skills they learn in BPT to their other children—to our knowledge, there is no data available on the sibling relationship as potential mediator of BPT effects on parenting or child behavior.

*Triadic subsystems within the family system:
The caregiver–caregiver–child triad*

Coparenting relationships: Theoretical foundations and empirical evidence. Coparenting (represented in Figure 1 as *abc*) refers to collaboration in childrearing of caregivers who share responsibilities for a child and consist of different dimensions such as communication, agreement, cooperation, alliance, undermining, and solidarity (Belsky et al., 1995; Feinberg, 2003; Teubert & Pinquart, 2010). Theoretically, coparenting is often viewed as a mediating mechanism between the dyadic systems of the caregiver–caregiver relationship and the caregiver–child relationship (Margolin et al., 2001) and child adjustment (Baril et al., 2007). Consistency in parenting behavior across caregivers and supporting each other’s parenting efforts is deemed to be important for positive child outcomes and specifically could be important when dealing with difficult child behavior. This may become increasingly complex in the coparenting of multiple children in the same family or coparenting in family systems in which caregivers do not live together and/or multiple caregivers are involved (e.g., separated caregivers, step-, adoptive-, or blended families) (Adamsons & Pasley, 2013; Farr et al., 2019; Lavoie & Saint-Jacques, 2020). A meta-analysis showed that coparenting predicts caregiver–child attachment and child problem behavior above and beyond the relationship quality between caregivers and individual parenting of caregivers (Teubert & Pinquart, 2010). Some studies even suggest that the coparenting relationship is a stronger predictor of child development than caregivers’ relationship functioning (Camisasca et al., 2019; Stroud et al., 2015). Specifically, parenting alliance and discipline similarity between caregivers has been found to predict less parenting stress and

less disruptive child behavior (Harvey, 2000; Mikolajczak et al., 2018).

How may the coparenting relationship affect BPT effectiveness?. Important aspects of coparenting relationships, such as problems in the communication between caregivers, have been found to moderate BPT effectiveness: BPT has been found to be less effective in families in which coparenting relationships are poor (Dadds et al., 1987; Kazdin & McWhinney, 2018; Reid et al., 2003; Wymbs, 2011). In cases where only one caregiver participates in BPT and implements the learned techniques, problems in coparenting relationships (such as an undermining second caregiver) might prevent the implemented techniques from having an impact on child behavior (Scott & Dadds, 2009). Moreover, the coparenting relationship quality may predict communication about program content. When caregivers do not share program information this may increase the create a knowledge-, skill-, and confidence gap between participating and nonparticipating caregivers, which may further decrease coparenting relationships and prevent changes in parenting and child behavior (Huntington & Vetere, 2016).

If coparenting relationships are affected by BPT participation, they may also mediate BPT effectiveness. Theoretically, BPT may positively affect coparenting behavior because caregivers are forced to evaluate their parenting, plan the implementation of new parenting techniques which are taught in BPT, and align their behavior. Better communication and alignment between caregivers may positively impact parenting behavior, and in turn child behavior (Feinberg et al., 2009; Roskam, 2015). However, BPT could also negatively affect the quality of coparenting relationships, because it brings to light, or even magnifies, differences in parenting behavior between caregivers. This may be specifically the case when only one caregiver participates in BPT (Huntington & Vetere, 2016). Moreover, the importance of addressing coparenting relationships may increase with the complexity of the family system and the number of co-caregivers involved, such as in the involvement of grandparents, or in adoptive-, step-, or blended families (e.g., Adamsons & Pasley, 2013; Barnett, 2008; Lavoie & Saint-Jacques, 2020). To our knowledge there is little data on the potential mediating effect of the coparenting relationship.

IMPLICATIONS FOR RESEARCH ON BPT

Although using family systems theory to understand differential effectiveness of BPT seems theoretically sound, the empirical evidence for the role of the family system is modest. There simply is little data on possible moderators and mediators beyond parenting behavior and little data on the functioning of members of the family system other than the child and the mother. In almost 96% of the cases mothers are used as the informants in BPT research (Panter-Brick et al., 2014). This overrepresentation of mothers is not unique to BPT research and can be historically explained by the traditional focus on mothers being the primary caregiver of the children (Cabrera et al., 2018) and the focus on heterosexual, married, nuclear families in research on parenting (Leticq, 2019). Moreover, how we design studies to evaluate BPT effectiveness may affect the available resources for extensive, multi-method, and multi-informant assessment of mechanisms of change (Hein & Weeland, 2019). Randomized controlled trials (RCTs) are the gold standard for evaluating intervention effects. In an RCT design families are randomized over different treatment conditions (intervention and control), with (at least) a pre- and postintervention assessment. RCTs are very costly which might limit available resources (Hein & Weeland, 2019). Most RCT studies on BPT effectiveness therefore limit assessments to validated questionnaires on parenting and child behavior.

Although previous studies have given us valuable information on whether mothers who participated in BPT indeed experienced improvements in parenting and child behavior and on the overall effectiveness of BPT programs on a macro timescale, they provide us with little insights on the role of the family system. Family systems theory may provide us with an exciting new research agenda, exploring new mediators and moderators of BPT effectiveness. Increasing our knowledge on the role of the family system in BPT effectiveness will require (a) data on all subsystems of the family system, before, during, and after the intervention, (b) data from all individuals that are part of the family system, and (c) data on within-family (rather than between-family) processes. Using family systems theory to understand for whom BPT works and why thus has important implications for our research designs. First, in order to assess the effectiveness of BPT on the functioning of

the family as a system, we need data beyond parenting and child behavior (Colalillo & Johnston, 2016). Data should include information on family structure (e.g., number of caregivers and children involved) and on all members of the family system, as well as their relations: data on the well-being of all caregivers, the quality of the relationship between child and caregivers, between siblings, and between caregivers, and coparenting relationships. Structurally including data on the family structure of participating families may also be important to assess the generalizability of the research findings to all families (i.e., specifically whether they are generalizable to families who are not white, heterosexual, and do not have two caregivers). Currently, about three quarters of studies on BPT only report data on and from mothers (Panter-Brick et al., 2014).

Second and related, in order to assess how BPT affects the family as a system, we need to know how it affects its members (and the subsystems they are part of). This cannot be assessed with only one caregiver as an informant, but for this we need multiple family members as informants. Moreover, some aspects of the family system functioning, including rules, boundaries, family processes, and feedback loops herein, may be difficult to assess with traditional questionnaires. Bamberger (2016) has advocated combining RCT designs with intensive longitudinal methods, which assess family functioning and processes repeatedly with short time intervals and capturing momentary experiences. There are promising methodological and technological innovations that make it possible to assess dynamic change processes on appropriate timescales (Bamberger, 2016), such as daily diaries, experience sampling (ESM), micro-coded observations, and momentary assessments using electronically activated audio recordings (see, e.g., Aunola et al., 2017; Bastiaansen et al., 2018; Geukes et al., 2017; Granic et al., 2007; Mehl, 2017).

Third, BPT effectiveness is mostly examined using designs testing *between*-family differences (i.e., differences between families receiving an intervention and those who do not). However, differences between families may not always translate to processes within families (Molenaar, 2004). It may therefore be equally important to study the *within*-family processes by using family-centered or family-specific methods (Howard & Hoffman, 2018). Such

detailed data on family functioning—not only before and after, but also throughout the intervention period—may provide valuable insights in processes and changes that may explain differential effectiveness of BPT programs.

We do not claim the application of family systems theory in BPT research will be easy. It will come with methodological, statistical, and translational challenges: Such as challenges in balancing data richness and participant burden, dealing with measurement error and nested data, and translating empirical results to intervention targets (Bamberger, 2016; Bastiaansen et al., 2020; Schuurman & Hamaker, 2019). For example, intensive data collection may be perceived as intrusive and as a burden by participants, which may lead to missing data and drop-outs. Moreover, intensive data collection may also be an intervention in itself, since the frequency and intensity of assessments in these intensive repeated measures are likely to increase attention to and evaluation of behaviors and interactions that are being assessed, which in turn may cause change (Bamberger, 2016). This could be both an advantage (e.g., data can be used in clinical practice to provide participants with feedback) as well as a limitation (e.g., it may muddle interpretation of results) of this design.

An additional benefit of applying family systems theory to BPT may be that it forms an opportunity to enhance integration of science and practice (Bastiaansen et al., 2020; Howe, 2019; Stormshak & Dishion, 2002). An important challenge for BPT practice and research is not only to understand differential effects, but also find ways to tailor interventions to the needs of individual families in order to increase effectiveness. Family systems theory could be used to explore ways to tailor the implementation of BPT programs to the needs of individual families. Knowledge stemming from this research could in turn be used to decide on the needed form, focus, and intensity of the intervention (Dishion & Stormshak, 2007; Forehand & Kotchick, 2002). For example, because it shows us that when there are problems in the coparenting subsystem BPT is less effective or that it is more effective to treat caregiver depression prior to their participation in BPT. In the next sections we outline suggestions on how to implement a family systems perspective to BPT practice.

IMPLICATIONS FOR BPT PRACTICE

Program content and implementation

Family systems theory may provide us with a tool to implement our existing BPT programs as (cost)effective as possible. Importantly, this does not necessarily mean that all BPT programs should include content on all subsystems of the family system, for all participating families. We need to balance a family's needs with the intensity and cost-effectiveness of the programs. Previous studies indicated that “less is more” when it comes to interventions: briefer interventions often outperform longer interventions (for a meta-analysis see Bakermans-Kranenburg et al., 2003). Our intervention strategies should thus be as short and generic as possible, and as long and tailored to the individual family as necessary.

One way to use family systems theory in practice is by using it as a screening instrument to decide in which family subsystem(s) we should intervene, with what intensity, and in which order, to effectively prevent or decrease disruptive child behavior. For example, by systematically assessing how children and caregivers function; what the quality of the caregiver-child, caregiver-caregiver, and sibling relationships are; who the caregivers in the family system are and how they coparent. In some families, such a screening may indicate that parenting behavior should indeed be the key target in order to decrease disruptive child behavior and BPT programs in their current form and implementation are a good fit for these families.

For other families such a screening may indicate problems beyond and above parenting behavior. In these cases it might be important to specifically address these problems either before, during, or parallel to BPT, because problems in the family system could form barriers to enroll, actively participate in, and complete the program or to successfully implement the learned techniques (Kazdin & McWhinney, 2018; Rostad et al., 2018; Scott & Dadds, 2009). Discussing these problems before the start of the program may enhance caregiver engagement and indirectly BPT effectiveness (Chacko et al., 2017; Mah & Johnston, 2008; Weeland, Chhangur, van der Giessen, et al., 2017). Discussing these problems during BPT may boost effective implementation of the learned techniques. Most BPT programs

include content on the well-being of the individual caregiver, and on the caregiver–child, caregiver–caregiver, and coparenting relationships. Because these subsystems have been shown to be related to parenting behavior, we would expect that targeting both these subsystems and parenting leads to a “double whammy” effect. However, evidence for the effectiveness of including content beyond parenting is mixed. A meta-analysis showed that including content aiming to improve caregiver–caregiver or coparenting relationships in BPT programs does not necessarily lead to larger effects on parenting or child behavior (Leijten et al., 2019). In clinical treatment settings including techniques to improve the caregiver–child relationship and caregiver well-being were found to enhance BPT effectiveness (Leijten et al., 2019; Leijten, Melendez-Torres, Gardner, et al., 2018). In prevention settings, the opposite was found: programs including techniques to improve caregiver well-being were found less effective than programs that do not include these techniques (Leijten et al., 2019). Whether targeting problems beyond parenting behavior is an effective strategy to increase BPT effectiveness, may thus depend on the severity of these problems.

Targeting problems in family subsystems beyond parenting behavior within BPT may thus specifically be effective for families in which there are indeed problems in these areas. This may emphasize the importance of assessing family system functioning before deciding on the most appropriate intervention strategy. A modular or matching approach could be used to decide on which additional problems should be targeted and how (Chorpita et al., 2005, 2007; Colalillo & Johnston, 2016). Some program already offer additional modules. Triple P, for example, offers modules on techniques for mood management, stress coping, and the relationship between caregivers (Enhanced Triple P; Sanders, Markie-Dadds, Tully, & Bor, 2000), and developed a module on managing sibling conflict, of which the effectiveness is still being assessed (see the preregistration, Pickering & Sanders, 2016). IY offers an Advanced Program (building on IY Preschool) which includes content on parental relationships and conflict. However, a prerequisite for effectively addressing relationships between family members within BPT sessions may be that multiple family members actively participate in BPT.

When the screening indicates that problems in certain family systems are severe, such as in cases of caregiver psychopathology or conflict separations, it might be necessary to deal with these problems independently of BPT. Meta-analytic evidence suggests that offering families additional services (such as substance abuse treatment or stress management training) may actually decrease the effectiveness of BPT (Kaminski et al., 2008). These additional services may overwhelm or burden caregivers. In these cases, families may first need to address problems in other subsystems, before they can benefit from BPT. Sequential treatment (i.e., stepped care) instead of parallel treatment may be a better fit for these families. Moreover, sometimes a holistic approach may be needed. There are programs available that target the family system as a whole, such as functional family therapy (Hartnett et al., 2017) and multi-systemic therapy (Henggeler & Schaeffer, 2016) for families of adolescents, and the universal prevention program Family Foundations (Feinberg et al., 2010). In sum, family systems theory could be used to systematically screen family functioning to decide the best intervention strategy for an individual family. Whether such a stepwise approach to BPT is feasible and effective will need careful evaluation. This requires a renewed research agenda and close collaboration between research, practice, and participating families.

Recruitment, inclusion, and engagement of caregivers in BPT practice and research

Family systems theory could also be used to critically evaluate and improve how current BPT are implemented in their current form. One specific problem is that in most cases only one caregiver participates in BPT practice and research, which is mostly the mother (Panter-Brick et al., 2014). Cultural diversity and societal changes (e.g., legislation of same-sex caregiver couples) have led to increasing heterogeneity in family structures (Cabrera & Tamis-LeMonda, 2013; Erdem & Safi, 2018; Lamb, 2010; Pearce et al., 2018). It is therefore imperative that all members of the family are identified, structurally and actively approached, informed on, and invited to participate in, BPT practice and research (Ramchandani & Iles, 2014). This is necessary to enhance generalizability of research findings to different families and improve BPT effectiveness. Indeed,

participation of multiple caregivers per family in BPT has shown to lead to better outcomes (Bagner, 2013; May et al., 2013; Rienks et al., 2011). Moreover, involvement of all caregivers in BPT research and practice is a prerequisite for assessing and addressing functioning of the family system, specifically the caregiver–caregiver and coparenting relationship.

We acknowledge that in general practitioners put in a lot of effort to engage caregivers in BPT and that recruitment and engagement of multiple caregivers in BPT practice and research may be easier said than done. For example, when both fathers and mothers are invited to participate, fathers have generally been found to be more hesitant to participate than mothers (McBride et al., 2017; Niec et al., 2015) and fathers more frequently drop out the program (Helfenbaum-Kun & Ortiz, 2007; Fletcher et al., 2011). The literature on parenting practice suggests different ways to improve recruitment materials and inclusion procedures. First, recruitment and inclusion procedures should be inclusive. For example, flexibility in scheduling sessions (so that sessions do not interfere with work of any of the caregivers), accessibility of and transportation to the training location, and availability of childcare could encourage and enable multiple caregivers to participate (National Academies of Science, Engineering and Medicine, 2016; Ramchandani & Iles, 2014). Second, the used media, materials (e.g., posters, websites), and content (e.g., video vignettes or used examples) should be inclusive. They currently might be experienced as mother-oriented (Sicouri et al., 2018) and heteronormative (Phares et al., 2010). In general, LGBTQ individuals report feelings of discrimination and a lack of LGBTQ sensitivity in mental health services (McNair & Bush, 2016).

Third, we need to explicitly express to all caregivers within the family system that all caregivers are *important* for the development of their child, even (more) in the cases of families in which caregivers are separated and of blended families. Although professionals do affirm the importance of involvement of, for example, fathers in child development, they might not necessarily see them as effective agents in changing child behavior (McBride et al., 2017). In training our practitioners, we may therefore need to address stereotypes of family composition and gender roles, as well as (unintended and/or unconscious) bias based

on sexual orientation or cultural background (Leticq, 2019; National Academies of Science, Engineering and Medicine, 2016). Already during pregnancy, expectant fathers and non-biological mothers in mother–mother families report feeling invisible and secondary because they are not treated as equal caregivers (Pruett et al., 2017; Wells & Lang, 2016; Widarsson et al., 2015). Moreover, some caregivers may need a little more convincing to participate than others. For example, compared to mothers, fathers report being more defensive about the need for treatment (Niec et al., 2015). Spending time on building a therapeutic alliance with all caregivers may be important (Kazdin & McWhinney, 2018; Scott & Dadds, 2009). For some caregivers it may help to use a more collaborative approach, for example by referring to BPT as coaching instead of treatment and by emphasizing the importance of teamwork (Dadds & Hawes, 2006).

Some of these issues may be strongly intertwined with law and policy. Policy has a strong influence on how families and society organize work and family in daily practice (Gregory & Milner, 2008; Rush, 2015). For example, through policy on, and length of, paternity leave. Moreover, the growing group of families with a large diversity of family structures faces many challenges, such as limited possibilities for the involvement of extended family or limited possibilities for multiple caregivers to have legal guardianship (Abraham, 2017; Gash & Raiskin, 2018). Such laws and policies have implications for the ability of different caregivers to be involved in and make decisions in the child's (mental) health care. Therefore, our suggestions for practitioners may also be relevant for policymakers.

CONCLUSION

In concluding, BPT is an evidence-based intervention strategy to prevent and decrease child disruptive behavior. However, currently not all families benefit equally from these interventions and some do not benefit at all. Understanding why some families benefit and others do not, and how we can best tailor our existing interventions to the needs of individual families, might be the biggest upcoming challenges for BPT practice and research. We argued that family systems theory could be a tool to assess differential effectiveness, help us form

(new) hypotheses on moderators and mediators explaining differential effectiveness, and provide ways to tailor the design and implementation of BPT programs. The subsystems of the family system may be important moderators of BPT effectiveness because they may negatively affect caregivers' and children's readiness, willingness, and ability to change. Moreover, changes in the family subsystems and feedback loops within the family may be important for understanding if and how caregiver's participation in BPT leads to change, and most importantly to lasting change, in parenting and child behavior. A family systems perspective on BPT may help us to approach the complexity of parenting and child behavior in a systematic and organized way (Stormshak & Dishion, 2002).

The notion that the family systems theory might be a valuable tool for the design, implementation, and evaluation of any child and family intervention has been previously put forward (e.g., by Cowan et al., 1998; Griest & Wells, 1983; Kitzman-Ulrich et al., 2010). However, to date, it has seldom been applied to BPT practice and research. Although the idea is theoretically sound, there is still little direct evidence of the feasibility and added benefit of using the family systems theory in BPT practice. We therefore deem a renewed call for a family systems perspective on BPT, in research and practice, important.

We offered suggestions on how the family system could increase our understanding on differential effectiveness, and ultimately strengthen the design, content and implementation of existing BPT programs. We realize that these suggestions require investments from program developers, practitioners, and researchers. However, it may provide us with an exciting new research agenda for the evaluation of BPT effectiveness and the potential gains of applying a family system perspective to the design and implementation of BPT programs may be large compared to the (possibly small) changes in practice (Ramchandani & Iles, 2014). In time it could potentially increase cost-effectiveness of existing programs by improving effective implementation, making our intervention strategies as short and generic as possible, and as long and tailored to the individual family as necessary. Moreover, family systems theory provides us with a holistic and inclusive framework on family functioning and may enhance the integration of BPT research and practice.

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