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COVID-19 and the Acceleration of Behavioral Parent Training

Telehealth: Current Status and Future Directions

Alexandra D.W. Sullivan and Rex Forehand, University of Vermont
Juliana Acosta, Justin Parent and Jonathan S. Comer, Center for Children and Families, Florida International University
Raelyn Loiselle and Deborah J. Jones, University of North Carolina at Chapel Hill

The SARS-COV-2 (COVID-19) pandemic and associated social distancing guidelines have accelerated the telehealth transition in mental health. For those providing Behavioral Parent Training (BPT), this transition has called for moving sessions that are traditionally clinic-based, active, and directive to engaging, supporting, and treating families of children with behavior disorders remotely in their homes. Whereas many difficulties accompany this transition, the lessons learned during the current public health crisis have the potential to transform BPT service delivery on a large scale in ways that address many of its long-standing limitations. We describe both challenges and opportunities and consider the possibilities inherent in a large scale BPT service delivery model capable of increasing the reach and impact of evidence-based treatment for all families.

COVID-19 is a complex, multisystem stressor for children and families. Parents must cope with worries related to surges in infection rates, lingering side-effects among even the seemingly young and healthy after they recover, and COVID-related mortalities as well as compromised life functioning among the most vulnerable. As news on vaccine development and roll-out unfolds, caregivers must continue to navigate an unprecedented level of uncertainty in their families’ daily lives. Increases in isolation, joblessness, and underemployment are part and parcel of public health quarantine, stay-at-home, and social distancing efforts. Unsurprisingly, both parents and children report growing levels of psychological distress (Patrick et al., 2020), and risk of child maltreatment is on the rise (Humphreys et al., 2020; Lawson et al., 2020). Further, the most vulnerable children and families, including racial and ethnic minorities, those with limited financial resources, and those with preexisting medical conditions, are at even greater risk of contracting COVID-19 (Goyal et al., 2020) and pandemic-linked deteriorating psychological wellness (Gassman-Pines et al., 2020; Holman et al., 2020).

Considering such challenges, parents and other caregivers are reporting elevations in child misbehavior, highlighting a critical public health need to increase reach of, access to, and engagement in evidence-based treatment for disruptive behavior disorders (DBDs) and related issues (Fitzpatrick et al., 2020). Evidence-based treatment targeting parenting skills, called Behavioral Parent Training (BPT; also called Parent Management Training), may fulfill this need, mitigating stress for both children (Comer et al., 2013; Rothenberg et al., 2020; Stoll et al., 2020) and caregivers (Mehri et al., 2020; Sullivan et al., 2018; Tømmerås et al., 2018). Accordingly, BPT providers have risen to the challenge, rapidly transitioning to telehealth to support families at home, in the context of their daily lives as they balance work, homeschooling, and childcare (Gurwitch et al., 2020).

This article details challenges and opportunities arising from the swift transition to telehealth delivery of BPT. Although technology has transformed BPT service delivery in several ways, including technology-enhanced treatment, we focus on therapist-led, synchronous (i.e., real-time) care that leverages audio and video data (i.e., videoconference), given their unique relevance to treatment needs in the context
of COVID-19 social distancing guidelines. As such, we provide a brief review of the history and evidence base for BPT, including remotely delivered treatment. We then delineate long-standing challenges with traditional, clinic-based BPT, and how remote formats may overcome these obstacles. Next, we discuss issues clinicians might consider specific to the transition to remote BPT. We then highlight the potential to build upon this momentum to transform the field, as surveys indicate a large majority of psychologists intend to continue offering telehealth services post-pandemic (Sammons, VandenBos, & Martin, 2020; Sammons, VandenBos, Martin, et al., 2020). We conclude with future directions for subsequent research and practice, as we believe COVID-19 accelerated remote service delivery should continue as a treatment option long after the COVID-19 public health crisis passes.

**BPT: History and Evidence Base**

BPT is a well-established family of treatment programs with common history, theory, and practice elements targeting childhood noncompliance, oppositionalism, aggression, and associated challenges (Chorpita et al., 2011; Comer et al., 2013; Daley et al., 2014; Evans et al., 2014; Eyberg et al., 2008; Kaehtler et al., 2016; Kaminski & Clauussen, 2017; Pelham & Fabiano, 2008). Parental use of behavioral skills intended to disrupt a coercive cycle of parent-child interaction implicated in early-onset DBDs constitutes BPT's mechanism of action (Forehand et al., 2014; Patterson, 1982). Practitioners teach parents to consistently (a) pay more attention to behaviors they want to increase (e.g., compliance, gentle hands, calm body), (b) decrease attention to non-safety-related attention-seeking behaviors (e.g., whining, tantrums), and (c) use effective consequences for noncompliance and unacceptable behaviors (e.g., aggression, property destruction). As caregivers master these new skills, their relationship with their child, and in turn, child behavior, improves with effect sizes that have been called "large" and "robust" (Comer et al., 2013; Eyberg et al., 2008; Kaminski & Clauussen, 2017; Kazdin, 2000). Extant BPT programs are numerous and diverse; a few contemporary examples include Community Parent Education Program (COPE; Cunningham et al., 1995), Defiant Children (DC; Barkley, 2013), Incredible Years (IY; Webster-Stratton et al., 2004), Helping the Noncompliant Child (HNC; McMahon & Forehand, 2003), and Parent-Child Interaction Therapy (PCIT; Schuhmann et al., 1998). Research on BPT constantly evolves, with frequent publications on BPT iterations tailored to specific groups of families (e.g., specific cultures; children with severe behavioral difficulties, intellectual disabilities, or developmental concerns) or integrating BPT into other established multi-system family treatments (Bagner et al., 2010; Bagner & Eyberg, 2007; McCabe et al., 2012; Parra-Cardona et al., 2017).

BPT programs are the most studied and efficacious psychosocial intervention approach for behavior disorders in preschool and school-aged children, and they are the recommended first-line treatment for children with behavioral difficulties in this age range (Kaminski & Clauussen, 2017; Kazdin, 2000; McCart et al., 2006; Mingebach et al., 2018; Nock, 2006). In addition to well-established reductions in externalizing behavior, there is increasing evidence that BPT also leads to reductions in comorbid childhood internalizing problems, including separation, social, and generalized anxiety, as well as depressive symptoms and general disinhibition (Carpenter et al., 2014; Comer et al., 2013, 2021; Higa-McMillan et al., 2016; Rothenberg et al., 2020). Critical in the context of the pandemic, BPT also has cascading effects for parental mental health and well-being, including reductions in parental stress and depressive symptoms, increases in perceived parental competence, and decreases in interpertarent conflict (Anastopoulous et al., 1993; Chacko et al., 2009; Daley et al., 2014; Gonzalez & Jones, 2016; Pisterman et al., 1992; Somuga-Barke et al., 2001; Sullivan et al., 2018). With families spending more time together in isolation, the parenting skills BPT promotes can offer marked relief and stress reduction for overwhelmed caregivers and underserved children.

**Telehealth Delivery of BPT (Tele-BPT)**

The well-established clinical efficacy of BPT, however, depends on a caregiver’s access to and engagement in services (Quetsch et al., 2020). Moreover, BPT does not work for everyone, and treatment effects tend to wane with time (Leijten et al., 2019; Noick & Ferrier, 2005; Overbeck et al., 2020; Ros et al., 2016). Scientists have tested many strategies to overcome these long-standing challenges, including technology-enhanced and virtual service delivery options (see Georgeson et al., 2020; Hall & Bierman, 2015; Jones et al., 2013; MacDonell & Prinz, 2017 for reviews). Amid the social distancing guidelines critical for pandemic-era public health, emerging data on the latter has been particularly timely and useful (Comer et al., 2015; Gurwitch et al., 2020).

Comer and colleagues’ Internet-delivered version of the BPT program, PCIT (Comer et al., 2015), helpfully illustrates the transition to tele-BPT. iP CIT (Comer et al., 2017) uses videoconferencing to stream parent-child interactions in real-time from families’ homes to a remote therapist who synchronously provides live coaching via a Bluetooth earpiece the parent wears.
Efficacy data suggest iPCIT results in meaningful reductions in child problem behaviors, as well as improvements in parent-child interactions and overall family functioning. Comer and colleagues (2017) found the rate of “excellent responders” as assessed by independent evaluators masked to treatment condition was significantly higher among families treated with iPCIT relative to clinic-based PCIT. Such findings suggest that in addition to overcoming traditional barriers to care, synchronous therapist-led BPT may offer improved ecological validity of care by treating families in their natural settings. Moreover, families participating in iPCIT, relative to those treated with clinic-based PCIT, report significantly fewer barriers to receiving care (e.g., transportation obstacles, scheduling sessions, competing time commitments). Finally, early results suggest iPCIT is associated with comparable treatment acceptance and satisfaction relative to in-clinic/person BPT (e.g., Comer et al., 2017), and it may even yield improved treatment engagement among traditionally underserved populations (Sanchez et al., 2021). In addition to iPCIT, synchronous group-based parent programs such as Triple P (Reese et al., 2012, 2015), Defiant Child (Xie et al., 2013), and Bootcamp for ADHD (Fogler et al., 2020), as well as asynchronous models (e.g., Tantrum Tool; Diaz-Stransky et al., 2020), are accumulating evidence favoring their effectiveness in reducing child behavior challenges (for a review of existing telehealth behavioral interventions, see Monzon et al., 2021; Ros-DeMarize et al., 2021). Accordingly, iPCIT and other virtual iterations are the linchpins in many pandemic-era child mental health practitioners’ array of evidence-based treatments, and we hope remote tele-BPT will remain a central offering going forward.

**BPT Obstacles and Telehealth Solutions**

For decades before the COVID-19 pandemic, broad limitations in the accessibility and acceptability of office-based care models have hampered the public health impact of well-established BPT programs (Comer & Barlow, 2014). Person-power issues in mental health care have rendered the mental health workforce insufficient to address the overwhelming demand and need for children’s services (American Psychological Association, 2020; Kazdin & Blase, 2011). The increasing concentration of mental health providers in metropolitan regions and academic hubs further compounds these problems, resulting in widening geographic disparities in care (American Psychological Association, 2018). As a result, children in remote geographic regions and rural areas are more than 20% less likely to receive mental health care, despite comparable rates of mental health problems (Fehr et al., 2020). Children with moderate levels of impairment are particularly underserved, as they are 50% less likely to receive mental health services than children in urban and suburban regions (Fehr et al., 2020).

To address these disparities, telehealth uses audio and visual data (e.g., videoconferencing) to provide synchronous clinician-led BPT services to more families in need (Comer et al., 2015; Doss et al., 2017). There has been a steep uptake in technology use and household internet in the past decade, especially among underserved families (e.g., rural- and low-income; Horrigan, 2009). Current estimates suggest that 85% of Americans own a smartphone, a share that is up from just 35% in 2011 (Pew Research Center, 2021b). Additionally, initiatives such as the Psychology Interjurisdictional Compact (PSYPACT), an interstate legislative effort designed to facilitate telepsychology and temporary in-person, face-to-face practice across state boundaries, offer opportunities for BPT providers in many states to provide tele-BPT services to underserved families living in areas outside of state lacking BPT providers. For families who have access to the necessary technology, such policy shifts allow large numbers of historically underserved populations to receive concrete parenting skills supporting an overall improved family milieu.

Beyond issues with access to providers, difficulties with engagement are another challenge in children’s mental health, including BPT (Chacko et al., 2016; Nock & Ferriter, 2005). Studies indicate approximately 50% of families with children diagnosed with DBDs and referred for BPT never enroll in treatment, enroll but never attend, drop out prematurely, or struggle with engaging in treatment tasks (e.g., between-session skill practice; Chacko et al., 2012; Fernandez et al., 2011; Peters et al., 2005). BPT engagement is particularly challenging for families experiencing adversity (e.g., low income, parental psychopathology) and thus could likely benefit from services the most (e.g., Chacko et al., 2008, 2009, 2016; Chronis et al., 2004; Kazdin, 1993; Miller & Prinz, 1990; Shaw & Taraban, 2017). Financial strain increases the likelihood of the coercive cycle of parent-child interactions implicated in the etiology and maintenance of early-onset DBDs and decreases the likelihood that low-income families can effectively engage in BPT (see Conger & Donnellan, 2007 for review; Santiago et al., 2011; Sullivan et al., 2019; Sullivan et al., 2021). Further, parenting stress, stemming from financial strain and other psychosocial factors, is linked to parental depression and children’s behavior disorders (Goodman et al., 2020; Peverill et al., 2021; Sullivan, Wright, et al., 2021), and there is substantial evidence that both stress
and depression may impede parents’ motivation to effectively and consistently use BPT skills at the level necessary to achieve durable child behavior change (Chacko et al., 2016; Chronis et al., 2004; Kazdin, 1997; Nock & Ferriter, 2005; Webster-Stratton, 1985). Accordingly, many factors contribute to difficulties retaining families in BPT.

In addition to psychosocial stressors, logistical and psychological obstacles can further challenge motivation. BPT services are often offered at inconvenient locations for families who experience transportation challenges, limited flexibility in work schedules, and lack of childcare for siblings (Feil et al., 2008; Harris et al., 2020; Jones, 2014; Tarver et al., 2014). Even if families do enroll in BPT, perceptions of stigma and concerns about confidentiality are also barriers to seeking and engaging in clinic-based BPT services (Love et al., 2016; Tarver et al., 2014; Weisenmueller & Hilton, 2021). Moreover, these challenges each disproportionately impact communities of color and those living in rural regions (Dixon De Silva et al., 2020; Fehr et al., 2020; Planey et al., 2019), further widening disparities in care.

Finally, poor ecological validity of clinic-based therapy sessions may also be complicit in parents’ limited skill use (e.g., Fabiano et al., 2012). Clinic-based BPT uses therapist modeling and role-plays as contexts for parents to practice their new skills; however, largely contrived and well-controlled sessions can rarely create the circumstances parents and children actually experience in the home and context of their daily lives. When parents must generalize these skills to the stressors and uniqueness of the home environment and other natural settings, clinic-based learning may fail to prepare them for the particulars of parenting in real life.

The provision of BPT via telehealth responds to many of these barriers, presuming families have access to reliable internet and devices. First, remote, real-time services increase flexibility for multiply stressed families and the clinicians who serve them. Greater flexibility with scheduling due to reduced logistical challenges with schedules, transportation, and childcare can reduce parental stress and increase motivation to engage in services (e.g., Boggs et al., 2004; Heinrichs et al., 2005). Indeed, no-show rates appear to be dropping in the context of widespread telehealth usage (Chen et al., 2020). Tele-BPT services also provide the unique opportunity to shape caregivers’ behavior in natural day-to-day routines during which children’s problem behavior tends to occur (e.g., bedtime, morning routines; Comer et al., 2017), enhancing the ecological validity of care. For example, if mealtimes are particularly challenging for a family, clinicians can intentionally schedule a session so that they can observe and coach a parent through the dinner hour. As such, parents can learn and implement skills in natural contexts, which may enhance maintenance of treatment effects, while clinicians also have the added benefit of evaluating behaviors and family functioning as they occur naturally. Therapists can also better observe treatment-interfering circumstances and collaboratively problem-solve home-based barriers when they are providing remote services to the home (e.g., helping identify an optimal timeout spot after examining the home environment). Such formats can even afford therapist opportunities for improved/augmented empathy, as they can greater appreciate stressful circumstances in the home setting (e.g., sirens in the background, crying sibling, phones ringing, household disorder, an unhelpful spouse; Comer & Timmons, 2019). Further, conducting treatment sessions in families’ natural environments rather than a community-based setting may mitigate concerns regarding stigma (Owens et al., 2002). Taken together, tele-BPT may be easier for families to access, engage in, and benefit from, ameliorating many of BPT’s longstanding limitations.

Tele-BPT has the potential to afford a more cost- and resource-efficient approach for reducing child problem behavior, given lowered costs associated with reduced office space and minimizing the need for clinicians to travel for home visits. Indeed, compared to traditional, face-to-face in-office care, costs associated with telemedicine efforts have been shown to be reduced by as much as one-third (e.g., Khanna et al., 2007). As childhood disruptive and externalizing disorders come at high societal cost (Chorozoglou et al., 2015; Romeo et al., 2006), reduced costs of remote BPT are particularly attractive.

**Clinical Considerations for Tele-BPT**

Transitioning to and expanding the availability of remote delivery options comes with its own obstacles, including technological difficulties (e.g., poor internet connectivity, equipment failure, videoconferencing application failure) that may interfere with treatment delivery, effect, fidelity, and length (Comer et al., 2015). As a result, treatment may last longer given session time being devoted to solving technological and logistical dilemmas (e.g., where to set up toys for child-centered play). Additionally, therapists may need to support emergent technological challenges and consider alternatives when the internet fails (e.g., rapidly shifting to a phone session). Rapport building may be more challenging given technological difficulties and obstacles related to distractions and interruptions in the treatment environment. At the same time, Comer and Timmons (2019) discuss how using video-
conferencing to provide services directly in homes can offer some opportunities for improved alliance, empathy, and engagement.

“Strategic flexibility” (Georgiadis et al., 2020) and “flexibility within fidelity” (Kendall et al., 2008) is particularly critical when remotely delivering BPT. Namely, clinicians must be prepared to flexibly adapt and tailor treatment protocols to respond to the specific clinical and technological needs and challenges of individual families (Georgiadis et al., 2020). Relative to traditional BPT, in which skill practice occurs in contrived laboratory tasks, treating families in their natural environments enhances the ecological validity of BPT. For example, clinicians may consider offering session times during particularly difficult aspects of a family routine (e.g., early morning for morning routine, later evening for bedtime routine), deviating from the traditional model of meeting once weekly at the same time. Therapists have more opportunities to capitalize upon behaviors that crop up naturally in the home context. For example, if siblings begin fighting in the other room, clinicians might consider immediately walking a caregiver through an effective timeout. Such flexibility is difficult, for trainees and seasoned clinicians alike; however, leveraging advantages unique to tele-BPT offers the opportunity to intervene in ecologically valid ways that may translate to more impactful change.

In addition to practical considerations, clinicians must give serious consideration to how best to cultivate cultural competence. Tele-BPT presents opportunities to work with diverse, underserved families; however, effective clinicians require targeted training, experience, and supervision to support these communities with cultural sensitivity and humility. Historically, BPT promotes an authoritative parenting style aligned with individualistic and Anglo-American cultural values, groups upon which BPT was developed (Rudy & Grusce, 2001; Weisenmuller & Hilton, 2021), suggesting that dissemination into cultures with differing histories and values may benefit from culturally-sensitive adaptations. Broadly, research on global and multicultural dissemination of psychological treatments suggests implementing treatments that feature cultural adaptations can be advantageous over implementing those without (Benish et al., 2011; Hall et al., 2016). In contrast, findings on the effect of culturally-tailored parenting interventions are mixed (Gardner et al., 2016; Kachler et al., 2016; Masiran et al., 2019; Ortiz & Del Vecchio, 2013; van Mourik et al., 2017), resulting in ongoing consideration regarding what constitutes best practice when implementing evidence-based parenting interventions with underserved families (e.g., Baumann et al., 2019; Mejia et al., 2017). In addition to potentially bolstering widespread implementation, increased use of remote technology may allow program developers to consult liberally with community stakeholders and local providers. Such collaboration aligns with expert recommendations in how best to culturally adapt evidence-based interventions (e.g., Krown et al., 2018; Murray et al., 2011). While such research on providing culturally relevant BPT to underserved groups continues, there is consensus that an increased emphasis on culturally-informed conceptualization (e.g., Gardner et al., 2016), treatment planning, and supervision is important to engage and retain individual families and, in turn, optimize tele-BPT outcomes for all families.

Further considerations include the need to develop telehealth-specific emergency plans given the potential for increased exposure to domestic violence and child abuse (Mazza et al., 2020; Pereda & Díaz-Faes, 2020) and associated elevated dangerous child internalizing problems (e.g., nonsuicidal self-injury, suicide attempts; [Carosella et al., 2021; Hill et al., 2021; Krass et al., 2021]) and externalizing problems (e.g., aggression, property destruction, child running from home), particularly among the most distressed families (Achterberg et al., 2021). As such, increased emphasis should be placed on proactively identifying safety procedures and enhancing therapist-parent coaching to ensure environment and family safety (e.g., Humphreys et al., 2020; Laxton et al., 2010; Racine et al., 2020). In a recent report, Humphreys and colleagues (2020) provide recommendations to prevent and protect children from such outcomes, including frequent assessment for violence risk factors (e.g., parental stress and irritability, substance use increases, harsh responses to child behaviors), supporting parent coping, and maintaining structure and consistency in schedules in the home. Depending on parents’ comfort, severe abuse presentations may benefit more from in-person intervention, particularly early in treatment, to allow the provider to have more control over the treatment environment. Additionally, families with a maltreatment history require careful consideration, weighing the pros and cons of in-person versus remotely delivered treatment, as well as careful safety planning (e.g., identifying triggers for dysregulation and developing a coping plan) and informed consent efforts, to ensure parents understand clinician mandated reporter responsibilities (Comer & Myers, 2016). Across families, in times of distress, prioritizing parent coping may support improved parent-child interactions and family environments.

Amidst the current public health crisis, several emergency practice and policy changes have been implemented to facilitate immediate access to telehealth services (e.g., Centers for Medicare & Medicaid...
For example, in 2020, the U.S. federal government announced an emergency policy shift that providers would not be subjected to penalties for any unintended HIPAA violations occurring in the context of good faith telehealth practices during the pandemic. This announcement also allowed providers to use consumer-grade videoconferencing platforms rather than expensive HIPAA secure platforms. Accordingly, throughout the pandemic, most mental health providers have been able to feel comfortable, from a liability perspective, to practice telehealth without fear of professional or financial ruin in the event of an unintended technology-related confidentiality breach (e.g., hacking). In addition, although telehealth was rarely reimbursed for before 2020, during the pandemic, payers have adjusted their policies to ensure telehealth services are reimbursable. These emergency policy shifts have enabled a considerable proportion of mental health services to occur remotely during the pandemic, abruptly transforming the mainstream nature of outpatient mental health services. That said, it is unlikely that all of these policy shifts are permanent—particularly those related to patient confidentiality and HIPAA. Providers will need to keep abreast of evolving policies to be able to provide continuous services that are compliant with current policies.

**Future Directions for Tele-BPT in a Postpandemic World**

Reliance on telemental health during the COVID-19 pandemic has presented a unique opportunity to engage more families in BPT. That said, remote formats are nascent relative to a centuries-old practice, and more research, development, and infrastructure is required to serve all families who need support. First, despite the offline population shrinking (Perrin & Atske, 2021), disparities in internet access and technological literacy exist, and much room for improvement remains if a goal of remote services is to increase access for all families. Younger, more affluent, urban, and higher-educated families are still more likely to access broadband internet at home (Pew Research Center, 2021a, 2021b; Swenson & Ghertner, 2020), whereas rural communities and counties with higher densities of older populations contend with slower connections speeds associated with mobile data (e.g., LTE) dependence (Dempsey & Sun, 2020). Accordingly, clinicians who are comfortable offering tele-BPT on different technological platforms (e.g., smartphone, tablet, computer) will be able to better serve families with limited access to technology. Additionally, clinicians should consider carefully educating and verifying understanding regarding the technology necessary to engage in tele-BPT to empower patient engagement. Finally, using existing technology in schools and integrated care contexts may further close the digital divide, increasing reach to children lacking internet access. While some of these steps may ease the individual burden of inequitable technology and internet access, system-level intervention is necessary to fully address widespread access to high-speed internet.

As such, many families, particularly those with lower incomes, lower levels of educational attainment, or those living in more rural environments, may lack access to personal electronic devices with webcams or have the broadband internet connectivity (e.g., internet deserts) needed to conduct treatment sessions. For example, in 2021, only 86% of individuals whose income is less than $30,000 use the internet, relative to 99% of those who make $50,000 or more.

Geographic disparities also exist. As another example, 86% of urban families have a subscription for broadband internet access, but that rate falls to 81% in rural communities, with the lowest subscription internet rates in the rural South (Martin, 2021). COVID-19 has highlighted the impact of these digital disparities on underserved families, which can thus benefit less from the rapid telemedicine expansion in response to the pandemic (Ortega et al., 2020; Wosik et al., 2020). That said, the Broadband Data Act (Public Law 116-130), signed into law in March 2020, should facilitate the allocation of broadband resources to underserved areas and, in turn, the reality of remote BPT service delivery for all families. As a field, we must be cautious that the promise of telehealth methods for meaningfully expanding the reach of treatment is not squandered on simply providing more delivery options to the very same populations traditional brick-and-mortar services serve. Indeed, at present, many of the populations with reduced access to technology and the internet are among the same populations disproportionately experiencing barriers to office-based care (Chou et al., 2017).

Expanding the virtual reach of BPT services to underserved, economically disadvantaged, and rural families increases the likelihood of matching families and clinicians based on language of preference, race, and ethnicity, which can be a benefit given data on matching and engagement (e.g., McCabe et al., 2012). However, diverse providers are underrepresented in children’s mental health, underscoring the need for recruiting and retaining diverse candidates to training programs that represent the backgrounds of the families in need, and bolstering instruction and clinical supervision in multicultural competency, exploration, and humility.

As remote technologies allow BPT’s reach to expand to different cultures and geographic regions, services
must be thoughtfully tailored to address the diverse needs of low-income, racial, and ethnic minority families. Previous research has shown that these families traditionally benefit the least from BPT interventions (e.g., Lundahl et al., 2006; Reyno & McGrath, 2006), primarily due to poor engagement and disproportionately high dropout (e.g., Lavigne et al., 2010). One way to tailor internet-delivered BPT may be to conduct treatment using a modularized, family-centered approach that flexibly adapts to a diverse range of presenting problems. The opportunity to offer a modular approach to BPT may prove significantly advantageous during and following the COVID-19 pandemic as families face uniquely distressing and uncertain events (e.g., job loss, a family member contracting the virus or dying) that impact family functioning and, consequently, child behavior problems. In turn, delivering BPT in a modularized approach may more feasibly allow clinicians to target important areas of family functioning, such as parental well-being and co-parenting conflict, which closely relate to child behavior problems, but exist outside of parent-child interactions. For example, emergent research explicitly discusses the importance of directly targeting parent coping (e.g., parental psychological flexibility; Coyne et al., 2020), particularly for parents of children with DBDs and comorbid challenges (e.g., Supporting Caregivers of Children with ADHD: Chronis-Tuscano et al., 2020). Directly addressing these facets of caregiving in the context of remotely delivered BPT may prove critical in better serving families with culturally and socioeconomically diverse backgrounds.

If families can access, engage in, and complete BPT services, evidence still suggests that treatment gains wane over time (Leijten et al., 2019; Overbeck et al., 2020). Declining treatment effects are largely attributed to parents decreasing or discontinuing altogether using their new skills (Overbeck et al., 2020). Parents revert to focusing their attention on the child’s non-compliance and other problematic behavior without the ongoing support and coaching of the therapist and in the context of the family’s daily routine. Such regression is likely even more predictable in the context of public health crises like the COVID-19 pandemic, which has exacerbated all challenges known to limit BPT engagement, including parental financial strain, mental health challenges, and practical barriers (i.e., working at home/search for employment, homeschooling, childcare). It may be the case that targeting parent stress directly in the context of remote BPT enhances long-term outcomes. Additionally, families are better able to access booster sessions when offered remotely, potentially protecting against potential treatment regression. However, follow-up data on remotely and flexibly delivered BPT is limited, and further research is necessary.

Conclusions

The transition to tele-BPT in response to the COVID-19 pandemic has been challenging; however, work with families of children with DBDs has yielded unexpected benefits. Providing treatment in the home affords valuable flexibility, including connecting with underserved families most in need of BPT and adapting BPT to target routines with which families need the most support. Much research is needed to solidly ground these experiences in evidence; in addition, policy, insurance, and tradition will need to flex accordingly. Going forward, clinicians are urged to continue leveraging the unique advantages remote BPT confers, even as face-to-face treatment again becomes safe.

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This research was supported by the National Institutes of Child Health and Human Development (F31HD099825 to A. D. W.; F31HD101257 to J. A.; R01HD084447 to J. S. C.; T32HD007376 to R. L.) and Mental Health (R21MH11387 to D. J. J.). The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health. The authors declare no conflicts of interest.

Address correspondence to Rex Forehand, Ph.D., 2 Colchester Ave., University of Vermont, Burlington, VT 05405 e-mail: Rex.Forehand@uvm.edu.

Accepted: June 19, 2021
Available online 09 September 2021