Time-Out with Young Children

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Time-out is a component of many evidence-based parent training programmes for the treatment of childhood conduct problems. Existing comprehensive reviews suggest that time-out is both safe and effective when used predictably, infrequently, calmly and as one component of a collection of parenting strategies—i.e., when utilised in the manner advocated by most parent training programmes. However, this research evidence has been largely oriented towards the academic community and is often in conflict with the widespread misinformation about time-out within communities of parents, and within groups of treatment practitioners. This dissonance has the potential to undermine the dissemination and implementation of an effective suite of treatments for common and disabling childhood conditions. The parent-practitioner relationship is integral to the success of Parent-Child Interaction Therapy (PCIT), an evidence-based treatment which involves live coaching of parent(s) with their young child(ren). Yet this relationship, and practitioner perspectives, attitudes and values as they relate to time-out, are often overlooked. This practitioner review explores the dynamics of the parent-practitioner relationship as they apply to the teaching and coaching of time-out to parents. It also acknowledges factors within the clinical setting that impact on time-out's use, such as the views of administrators and professional colleagues. The paper is oriented toward practitioners of PCIT but is of relevance to all providers of parent training interventions for young children.

Keywords: time-out ; attachment ; practitioner review ; attributions ; parent training ; behavioral parent training ; parent management training ; PCIT

1. Introduction

Parent training—also known as Behavioural Parent Training or Parent Management Training—is a term used to describe an empirically sound suite of programmes for the treatment of childhood conduct problems and other childhood psychopathology [1]. Internationally, childhood conduct problems represent one of the most common mental disorders diagnosed in children under seven years [2] and if left untreated, may persist into adulthood with widespread social and economic consequences [3]. Parent training has a more extensive evidence base than any other psychosocial treatment for any disorder in the child mental health context [1]. Prominent examples include the Community Parent Education Program (COPE; [4]), Defiant Children [5], Helping the Noncompliant Child [6], The Incredible Years [7], Triple P [8], and Parent-Child Interaction Therapy ([PCIT; [9]). These programmes are drawn from the work of Constance Hanf and Gerald Patterson in the 1960s and involve two phases—initially strengthening the parent-child relationship through child-led play, and later providing parents with support to have developmentally appropriate expectations of children and manage their children's challenging behaviour safely and effectively [10][11]. Within Parent-Child Interaction Therapy (PCIT), these phases are known as Child Directed Interaction (CDI) and Parent Directed Interaction (PDI), respectively.

Time-out (technically, time-out from positive reinforcement) involves a brief pre-planned withdrawal of parental attention (typically while the parent remains in the room) and restriction of access to desirable items such as toys, in response to a child's defiance or non-compliance with a parent's clear and fair instruction. It is incorporated in the second phase of almost all of the prominent, evidence-based parent training interventions. The intention of these programmes is to equip parents with a range of techniques or strategies to respond to children's non-compliance or defiance in a safe and effective way. Within these parent training interventions, time-out is introduced alongside teaching parents how to give effective, developmentally sensitive commands; how to use planned ignoring in conjunction with praising the 'positive opposite' of an undesirable behaviour; using natural or logical consequences, and other developmentally appropriate ways of responding to a child's non-compliance or defiance [9]. As such, time-out is one component of a collection of behaviour management strategies, which are predicated on initially strengthening and consolidating the parent-child relationship [12].

Of all of the components that make up parent training programmes, time-out is perhaps the technique that is the most well studied [13]. It appears to be particularly important for parent training programmes that are treating emerging and/or

established child conduct problems (as opposed to general parenting advice aimed at preventing difficulties from occurring) [14]. Several recent reviews provide a useful and comprehensive overview of the empirical literature on time-out [12][15][16][17], including observation that "there is no empirical evidence for iatrogenic or harmful effects of time-out" [13].

Yet despite this empirical evidence of time-out's safety when used appropriately, the strategy remains one of the more divisive and technically challenging parenting techniques. In recent years there has been growing public concern around the safety and appropriateness of time-out [12][18], fuelled by articles in popular press publications and online material; these claims have been described as "wild and unsubstantiated, yet highly visible" [19].

2. Broader Influences/Environment

> *"[My mother], she'd read a book and she had an idea that… putting Emma on the time-out chair wasn't a good idea… so there was a real… disorder between the PCIT and at home." [20].*

Outside of the therapy room, there are a number of influences that may shape the lens through which a parent views time-out. A parent is typically a member of a number of different systems or groups, which may have mixed or disparate views on time-out—for example, extended family, social groups, childcare centres or antenatal groups. Parental stress levels, socioeconomic factors, and the extent of wider family support (including the degree of unity or conflict between parents) are influential on engagement generally [21], and potentially on the acceptability of time-out specifically.

Cultural factors are also very relevant, as these may influence gender roles, parenting styles, and parent engagement in treatment programmes [22]. The research literature relating to the acceptability of time-out to parents (and children) of minority ethnicities is limited [23]. Reviews that have been published have tended to explore the interaction between majority cultural groups and parent training programmes generally [17], or the international transportability of programmes, i.e., whether the programme is still effective when introduced to a different country (e.g., [24]). Relevant to time-out is the extent to which particular cultural beliefs value interdependence, hold that a parent ought to or should assume control of/'take charge' of a child's behaviour, demonstrate affection, and the parent's level of comfort with limit setting [17].

Often, parent training approaches include techniques that have been developed and normed within an Anglo-American cultural context in the United States [17][23]. This somewhat individualistic (vs. collectivistic) cultural context often values parental control, but also allows for the child to negotiate or reason with their parent, i.e., also values the child's autonomy and individual freedom [17][23]. If this cultural group is assumed to be the "default", the advice drawn from parent training programmes may be viewed with distrust by parents from minority cultures, and there may be a dissonance with parent attitudes and beliefs in the diverse real world of service delivery [23]. Future research ought to consider the influence of more precise factors such as families' acculturation, immigration experiences, and socioeconomic status [23]. Ideally, practitioners ought to facilitate discussion around the family's religion, family traditions, parents' own experiences of having been parented [23], and explore how time-out 'sits with' the family in relation to their cultural values [17].

Media messaging and public and professional dialogue conspicuously feature two inter-related concerns about time-out, namely, that it (1) causes harm in otherwise healthy children, and that it (2) exacerbates existing difficulties in children who have experienced trauma, despite evidence to the contrary on both counts [12]. Parents are beginning to echo and amplify high-profile media criticisms of time-out, contributing to perception that it is ineffective and harmful [18]. In the clinical context, understanding and addressing parental concerns is essential, as—in terms of parent engagement—the empirical evidence relating to whether time-out causes harm *is perhaps less relevant than a parent's concern that it might*. Even where parents are weary or ambivalent, fearful of (or angry at) their child, they typically want to do what is best for their child. The therapist-parent relationship is an essential vehicle for validation of parents' emotion, and an opportunity to provide brief tailored support for the parent as they navigate the often-wide-ranging views and perspectives of the people in their world.

3. Therapist Cognitions, Emotions, Experiences and Behaviour

> *"I come from an attachment framework and struggle with some of the aspects of PCIT" (PCIT Practitioner) [25].*

Unless a treatment programme is delivered by way of pre-recorded material (for example, Triple P Online [26]), time-out is typically introduced in the context of a practitioner-parent relationship. A practitioner's experience with teaching and coaching time-out, the nature of their relationship with the parent and child, and their own level of comfort with client

discomfort (in the service of greater goals) may influence their willingness to implement time-out in PCIT. Factors such as the practitioner's own family of origin experiences (i.e., experience of having been parented) and their own parenting practice (i.e., use of, and attitudes toward time-out with their own children) may also be relevant. Practitioners may underestimate the influence of their own emotional state—perhaps ambivalence or wariness relating to time-out—on their behaviour in session. This is a cognitive bias known as the hot-cold empathy gap that is increasingly considered relevant to the implementation of psychosocial interventions [27]. This dynamic is apparent in another treatment, namely exposure-based tasks within Cognitive Behavioural Therapy for anxiety disorders. Relative to other techniques, exposure tasks tend to be infrequently used by clinicians, with Deacon and Farrell [28] suggesting that this cannot be explained by dissemination difficulties alone. Instead, they propose that "negative beliefs about exposure therapy (e.g., that it is unethical, intolerable and unsafe) impede the utilization of this treatment, even among therapists trained to administer it" [28].

A particular transferential dynamic can evolve in the parent-therapist relationship when a parent raises concerns around time-out. Hawes and Dadds [29] describe this as "the spread of anxiety or pessimism from parent to therapist" (p. 6). Therapists themselves may be somewhat ambivalent about time-out [25], or perhaps anxious about their ability to successfully coach a parent through the early PDI sessions, which can be complex and demanding to facilitate. The therapist may inadvertently conceptualise the parent's position as resistant, or unconsciously form a rationale for omitting PDI from the PCIT protocol (e.g., that the child's behaviour has improved substantially in CDI, so PDI is unnecessary), thereby "inadvertently collud[ing] to avoid strategies that require parents to set limits on misbehaviour" [29]. Recognising and becoming aware of these dynamics is an essential step in addressing these common "signs of a struggle for change" [29].

The early attachment experiences of both the therapist and the parent may manifest in the therapeutic relationship during the course of a parent training intervention. Core sensitivities are internal working models, anxieties or considerations that an individual holds in relation to their role in connection with others [30][31]. While these dynamics are primarily conceptual rather than empirical, they can be useful in assisting with understanding a particular pattern of connection between therapist and parent. For example, an *esteem sensitive* parent may strive to demonstrate success or achievement (e.g., with homework completion) and may be very vigilant and sensitive around criticism (e.g., in coaching, which is typically more directive in PDI) [31]. A *separation sensitive* parent may experience limit setting as conflict, which is potentially associated with separation [30]—for this parent, taking charge during the PDI phase of PCIT may be particularly challenging and require additional therapist support. At its best, the parent-practitioner relationship can provide a safe haven and secure base for the parent, and a model of what "bigger, stronger, wiser and kind" looks and feels like to a child [31].

4. Parent Cognitions, Emotions, Experiences and Behaviour

> *"…while [PDI sessions] were horrible sessions, in many regards, they were the most valuable sessions because it taught me what I could do with him under many situations and recover the situation and not let my child ruin my life. And not let him have… parents that didn't like him"* [20].

In recent years, and in the context of increased media and public concerns relating to time-out, three studies have investigated parents' understanding of time-out [32][33][34]. Findings across all three studies demonstrated that parents' understanding of the purpose and procedure for time-out differed from the empirical literature. The majority of parents perceived time-out as a time for their children to "think" [33] "think about bad behavior" [34], or "think about what they had done" [32]. This is in contrast to the theoretical rationale for time-out, i.e., to remove the child from a reinforcing environment following misbehaviour [12]. Beyond their technical understanding of the time-out process, a parent's acceptance of a discipline technique such as time-out includes measures of their willingness to use it with their own child, anticipated disruption of implementing the discipline, perceived effectiveness of the technique, and expectation that using the discipline would lead to improvement in their child's behaviour [35]. Parents who reported using time-out with their 1-to 10-year-old children and rated it as being effective were significantly more likely to report using empirically supported time-out steps [34]. Also, expected relationships emerged between parents' understanding about time-out, their use of time-out with their own child, and their acceptance of the technique [32]. Parents who endorsed accurate knowledge about time-out rated an evidence-based description of time-out as more acceptable than parents who endorsed less accurate knowledge. In contrast, parents who endorsed more negative attitudes and beliefs about time-out perceived an evidence-based description of time-out as less acceptable than parents who endorsed fewer negative attitudes. Beyond ratings of acceptability, parents' accurate understanding as well as negative attitudes and beliefs about time-out were significantly associated with their use of empirically supported time-out steps. Parents who agreed with accurate beliefs about the

safety and effectiveness of time-out were more likely to report using a greater number of evidence-based time-out steps when using time-out with their children. In contrast, parents who indicated holding more negative attitudes toward time-out were more likely to report using fewer evidence-based time-out steps [32].

This interplay of parents' experience using time-out with their children, their understanding about time-out, and their perceptions of the effectiveness of time-out are likely all coming into the treatment room when they meet with the therapist. The parent may also be experiencing feelings of inadequacy, overwhelm or anxiety, anger, guilt or shame from a 'history of 10,000 defeats' in disciplinary interactions with their child [36].

Time-out is first mentioned early in the course of PCIT in the intake assessment, where therapists are encouraged to "ask specifically" about a parent's use of timeout [9], p. 11. In our experience, parents often respond with words to the effect of "I've tried time-out, but it didn't work". A distinction may be drawn between a parent's *experience* of time-out having been ineffective, and their *perception* that it would be ineffective for their child. Each of these scenarios might require a tailored response from the PCIT therapist, as described below.

For example, prior to using time-out, a parent might form an *impression or perception* that time-out would be ineffective for their child, perhaps partly as a result of their child-referent attributions or cognitions around the cause of their child's disruptive behaviour. These causal explanations for a child's challenging behaviour and cognitions about their parenting role, that parents form implicitly or explicitly may influence how parents engage with parent training and may predict attrition from treatment [37][38][39]. For example, if a parent's attributions suggest that the cause of the child's difficulties is internal to the child and stable, this is likely to influence their willingness to consider changing their own behaviour and engaging with a technique such as time-out—stated plainly, there may be an immediate sense of "that won't work—he's a bad kid". The parent may form the impression that time-out is not novel, sophisticated or salient enough to change the behaviour of a child who is perceived to be manipulative, vindictive or deviant. In response, the PCIT therapist might name or describe the apparent dissonance between a parent's sense of what the child needs and what PCIT is advocating and spend more time explaining the rationale.

As outlined earlier, it is also possible that a parent has *experienced* time-out as ineffective in the past, as it can be difficult to implement correctly [13]. Time-out is not one technique, but a series of steps, that are ideally implemented sequentially and in a pre-determined order (refer to **Table 1** for these components and their associated evidence and the Supplementary Material for a case vignette). Omitting or substituting one or more components of the time-out process or applying time-out inconsistently, may inadvertently worsen a child's disruptive behaviour [40], potentially discouraging a parent from using time-out again, and fostering a perception that it is ineffective.

Often, the parent comes to PCIT having inadvertently established a pattern where aversive discipline interactions with their child are occurring regularly and are rich in content which relates to basic attachment needs in the child [41]. Positive parent-child interactions have become less frequent and typically have become "attachment neutral" [41]. If reward strategies such as star charts or labelled praise are infrequent and 'neutral', and discipline interactions are frequent and 'rich', it is easy to see why a parent might perceive that time-out is ineffective [41]. Time-out may remain "subtly infused with attachment-rich behaviours (e.g., hostility, rejection, ambivalence) that are highly salient and threatening to the child" [41]. Successful use of time-out depends on the parent shifting the balance, to ensure that positive or neutral time with their child is richer (from an attachment perspective) than disciplinary exchanges. Therapist coaching in PCIT is particularly well placed to ensure this occurs – the coach may encourage the parent to use positive voice tone, physical touch, eye contact, and expressions of enjoyment in both CDI and PDI.

5. Child-Related Considerations

The standard PCIT time-out procedure is indicated for children with a developmental age of approximately 2.5 years and above [9]. For developmental and relational reasons, time-out is not indicated for children younger than two [42] and for practical reasons, other strategies (such as incentive systems or removal of privileges) are typically used with older children [43]. A specific adaptation has been developed for toddlers younger than 2 years old, where the follow-up after a command involves a guided compliance procedure, i.e., the parent gently guides the child in following their instruction; [42]. The adaptation assumes that toddlers have not yet achieved the required language comprehension, ability to sustain attention, and social awareness to comply with parent instructions [42]. Studies have also described adaptations to the PCIT protocol—typically for younger children—that do not involve the use of time-out, including Parent-Child Attunement Therapy [44].

Similarly, an adaptation to the standard procedure has been developed for children on the Autism Spectrum [45]. It includes a time-out readiness phase where there are concerns around the child's language comprehension, extreme behaviours (e.g., self-injury, extreme aggression), or relating to parent reluctance to use time-out with their child with special needs [45]. The adaptation also includes a physical guidance contingency for rapidly and effectively concluding the time-out process where necessary, which the authors describe as the Big Red Stop Button [45]. These examples of adaptations acknowledge the importance of considering factors such as the child's age, cognitive abilities, and adaptive skills.

There is little published research on the acceptability of time-out to the child, and the child's experience of time-out. During a time-out process, children may shout, scream, hit, kick or cry, and it is often assumed that this represents a time of distress for the child—a frequently cited critique of the technique. Another possibility is that—rather than distress—the child is protesting the implementation of new limits and consequences. Learning to stay on a time-out chair as a pre-explained consequence for non-compliance with a calm, fair and reasonable command, represents a series of small and repeated challenges for the child, and this may be conceptualised as an opportunity to develop resilience and self-regulation. Also, experiencing mild or moderate, short-lived anger, frustration or anxiety may be important in helping children develop emotion and behaviour regulation skills [19]. Importantly, the child learns

> *"no matter how upset I am, no matter how much I cry, scream, kick, or shout curse words, I will be safe. No one will yell at me or hit me. My parents will remain regulated" [19].*

For the child, time-out may represent a safer alternative than physical discipline, as a disciplinary exchange can represent a period of higher risk of physical harm for the child [39]. Unlike spanking, brief time-outs can be used several times per day initially (their required frequency would be expected to decrease rapidly if implemented correctly), which allows the parent to be more consistent in their response [43].

There are certainly situations where time-out is not indicated and may indeed be ineffective or contraindicated. The PCIT protocol recommends time-out as a response to a child's non-compliance with an effective command (i.e., a direct, necessary, developmentally appropriate parental instruction), and suggests that commands are to be used sparingly [9]. When a child is distressed or overwhelmed (perhaps due to an injury, tiredness or hunger), choosing not to give a command, but rather attending to the primary need, is a more suitable response than time-out. Likewise, behaviour such as whining or complaining ought to ideally be responded to with brief planned ignoring, rather than time-out [9]. Time-out is not indicated as a response to a child having a tantrum. Where a young child is struggling to regulate their emotions outside of the parent giving directions, or the child is tired or hungry, a parent providing a "time-in" (as described below) is likely to be the most appropriate response. **Table 2** provides examples of how these scenarios may be differentiated. Lieneman and McNeil [17] also present a useful table to assist parents to determine whether it is an appropriate time to use a command (which may go on to require time-out if the child is non-compliant), along with a summary of alternatives to commands. They suggest that in order for a direct command to be used, a child must be well-rested, not be too hungry or thirsty, be alert, have recently used the toilet, and be ready to learn [17].

Time-In

Time-in is inconsistently defined in the academic literature and popular press. One understanding of time-in is aligned with a parent providing the PRIDE skills (Praise, Reflection, Imitation, behavioural Description, and Enjoyment) in the Child Directed Interaction phase of PCIT. Use of these skills is recommended any time the child is not in time-out. When a child experiences intense disappointment, anger or frustration that is not necessarily associated with aggression or destructive behaviour, sitting alongside the child and describing their experience can aid the development of their emotion regulation abilities [46]. Paired with differential attention, the parent models calmness through their tone of voice and attends to their child's appropriate behaviour. Recognising a child's emotion, labelling this, and validating their experience (not necessarily their actions) can enhance children's social and emotional functioning [47].

6. Conclusions

Time-out is not intended to be used as a stand-alone technique in the management of children's challenging behaviour, but rather as one component of a multi-faceted approach which includes parent-child relationship enhancement as its foundation [17][19][48]. The behaviour management phase of parent training interventions such as PCIT typically includes a variety of components, of which the correct and appropriate use of time-out is but one [17]. Parents are supported to give effective instructions, which are developmentally appropriate, calmly stated, clear, and given one at a time [9]. Importantly,

parents are encouraged to use such direct commands sparingly, and to be consistent and fair both in their expectations of their child, and in their use of consequences [9].

This practitioner review, while not an exhaustive or systematic summary of the literature, has identified areas that warrant future research attention. These include a better understanding of professionals' knowledge of, and attitudes toward time-out, and how this influences the implementation of PCIT in clinical settings. There is also a need for a careful examination of the practitioner-related factors (e.g., education, training, experience, or context) that are associated with effective and sustained implementation of parent training approaches that include time-out. And, importantly, more research into a child's experience of time-out is also necessary.

In summary, the parent-practitioner relationship is integral to the success of Parent-Child Interaction Therapy (PCIT) yet this relationship, and practitioner perspectives, attitudes and values as they relate to time-out, are often overlooked. Delivering parent training interventions that include time-out can be challenging for practitioners. Misinformation abounds, the technique involves a number of steps, and coaching time-out processes in the clinic can be challenging for practitioners—both practically, and emotionally. Yet, given the effectiveness and established safety of time-out, and the potential harm associated with untreated or ineffectively treated childhood conduct problems, persisting with the delivery of evidence-based parent training programmes which include time-out is likely to result in parents being better equipped to respond to their child's challenging behaviour effectively, sensitively and safely.

References

1. Scott, S.; Gardner, F. Parenting programs. In Rutter's Child and Adolescent Psychiatry; Thapar, A., Pine, D.S., Leckman, J.F., Scott, S., Snowling, M.J., Taylor, E., Eds.; John Wiley & Sons, Ltd.: Chichester, UK, 2015.
2. Vasileva, M.; Graf, R.K.; Reinelt, T.; Petermann, U.; Petermann, F. Research review: A meta-analysis of the international prevalence and comorbidity of mental disorders in children between 1 and 7 years. J. Child Psychol. Psychiatry 2020, 62, 372–381.
3. Rivenbark, J.G.; Odgers, C.L.; Caspi, A.; Harrington, H.; Hogan, S.; Houts, R.M.; Poulton, R.; Moffitt, T.E. The high societal costs of childhood conduct problems: Evidence from administrative records up to age 38 in a longitudinal birth cohort. J. Child Psychol. Psychiatry 2017, 59, 703–710.
4. Cunningham, C.; Bremner, R.; Secord-Gilbert, M. The community parent education (COPE) program: A school-based family systems oriented course for parents of children with disruptive behavior disorders. Unpublished manual. 1998.
5. Barkley, R.A. Defiant Children: A Clinician's Manual for Assessment and Parent Training; Guilford Press: New York, NY, USA, 2013.
6. McMahon, R.J.; Forehand, R.L. Helping the Noncompliant Child: Family-Based Treatment for Oppositional Behavior; Guilford Press: New York, NY, USA, 2005.
7. Webster-Stratton, C. The Incredible Years: Parents, Teachers, and Children Training Series; Office of Juveline Justice and Delinquency Prevention: Washington, DC, USA, 2001; Volume 18, pp. 31–45.
8. Sanders, M.R.; Markie-Dadds, C. Triple P: A multilevel family intervention program for children with disruptive behaviour disorders. In Early Intervention & Prevention in Mental Health; Cotton, P., Jackson, H., Eds.; Australian Psychological Society: Carlton South, Australia, 1996; pp. 59–85.
9. Eyberg, S.M.; Funderburk, B. Parent-Child Interaction Therapy Protocol; PCIT International, Inc.: Gainesville, FL, USA, 2011.
10. Kaehler, L.A.; Jacobs, M.; Jones, D.J. Distilling Common History and Practice Elements to Inform Dissemination: Hanf-Model BPT Programs as an Example. Clin. Child Fam. Psychol. Rev. 2016, 19, 236–258.
11. Reitman, D.; McMahon, R.J. Constance "Connie" Hanf (1917–2002): The Mentor and the Model. Cogn. Behav. Pract. 2013, 20, 106–116.
12. Dadds, M.; Tully, L.A. What is it to discipline a child: What should it be? A reanalysis of time-out from the perspective of child mental health, attachment, and trauma. Am. Psychol. 2019, 74, 794–808.
13. Leijten, P. Effective Components of Parenting Programmes for Children's Conduct Problems. In Family-Based Intervention for Child and Adolescent Mental Health: A Core Competencies Approach; Essau, C.A., Hawes, D.J., Allen, J.L., Eds.; Cambridge University Press: Cambridge, UK, 2021; pp. 40–52.
14. Leijten, P.; Gardner, F.; Melendez-Torres, G.J.; van Aar, J.; Hutchings, J.; Schulz, S.; Knerr, W.; Overbeek, G. Meta-Analyses: Key Parenting Program Components for Disruptive Child Behavior. J. Am. Acad. Child Adolesc. Psychiatry

2019, 58, 180–190.

15. Larzelere, R.E.; Gunnoe, M.L.; Roberts, M.W.; Lin, H.; Ferguson, C.J. Causal Evidence for Exclusively Positive Parenting and for Timeout: Rejoinder to Holden, Grogan-Kaylor, Durrant, and Gershoff (2017). Marriage Fam. Rev. 2020, 56, 287–319.
16. Quetsch, L.B.; Wallace, N.M.; Herschell, A.D.; McNeil, C.B. Weighing in on the Time-Out Controversy: An empirical perspective. Clin. Psychol. 2015, 68, 4–19.
17. Lieneman, C.; McNeil, C.B. Time-Out for Child Behavior Management; Volume 52, in press.
18. Canning, M.G.; Jugovac, S.; Pasalich, D.S. An Updated Account on Parents' Use of and Attitudes Towards Time-Out. Child Psychiatry Hum. Dev. 2021, 1–14.
19. Niec, L.N. When negative emotion is a positive experience: Healthy limit-setting in the parent-child relationship. In Strengthening the Parent-Child Relationship in Therapy: Laying the Foundation for Healthy Development; in press.
20. Woodfield, M.J.; Cartwright, C. Parent-Child Interaction Therapy from the Parents' Perspective. J. Child Fam. Stud. 2020, 29, 632–647.
21. Lieneman, C.C.; Quetsch, L.B.; Theodorou, L.L.; Newton, K.A.; McNeil, C.B. Reconceptualizing attrition in Parent-Child Interaction Therapy: "dropouts" demonstrate impressive improvements. Psychol. Res. Behav. Manag. 2019, 12, 543–555.
22. Forehand, R.; Kotchick, B.A. Cultural diversity: A wake-up call for parent training. Behav. Ther. 1996, 27, 187–206.
23. Weisenmuller, C.; Hilton, D. Barriers to access, implementation, and utilization of parenting interventions: Considerations for research and clinical applications. Am. Psychol. 2021, 76, 104–115.
24. Gardner, F.; Montgomery, P.; Knerr, W. Transporting Evidence-Based Parenting Programs for Child Problem Behavior (Age 3–10) Between Countries: Systematic Review and Meta-Analysis. J. Clin. Child Adolesc. Psychol. 2016, 45, 749–762.
25. Woodfield, M.J.; Cargo, T.; Barnett, D.; Lambie, I. Understanding New Zealand therapist experiences of Parent-Child Interaction Therapy (PCIT) training and implementation, and how these compare internationally. Child. Youth Serv. Rev. 2020, 119, 105681.
26. Sanders, M.R.; Baker, S.; Turner, K.M. A randomized controlled trial evaluating the efficacy of Triple P Online with parents of children with early-onset conduct problems. Behav. Res. Ther. 2012, 50, 675–684.
27. Beidas, R.S.; Buttenheim, A.M.; Mandell, D.S. Transforming Mental Health Care Delivery Through Implementation Science and Behavioral Economics. JAMA Psychiatry 2021, 78, 941.
28. Deacon, B.J.; Farrell, N.R. Therapist Barriers to the Dissemination of Exposure Therapy. In Handbook of Treating Variants and Complications in Anxiety Disorders; Storch, E.A., McKay, D., Eds.; Springer: New York, NY, USA, 2013; pp. 363–373.
29. Hawes, D.J.; Dadds, M. Practitioner Review: Parenting interventions for child conduct problems: Reconceptualising resistance to change. J. Child Psychol. Psychiatry 2021, 62, 1166–1174.
30. Poulsen, B.; Coyne, J. The core sensitivities: A clinical evolution of Masterson's disorders of self. Psychother. Couns. J. Aust. 2017, 5, 1–19.
31. Powell, B.; Cooper, G.; Hoffman, K.; Marvin, B. The Circle of Security Intervention: Enhancing Attachment in Early Parent-Child Relationships; Guilford Press: New York, NY, USA, 2014; p. 396.
32. Brodd, I.; Niec, L.N. Parents' Attitudes Toward Time-Out; Central Michigan University: Mount Pleasant, MI, USA, 2018.
33. Drayton, A.K.; Byrd, M.R.; Albright, J.J.; Nelson, E.M.; Andersen, M.N.; Morris, N.K. Deconstructing the time-out: What do mothers understand about a common disciplinary procedure? Child Fam. Behav. Ther. 2017, 39, 91–107.
34. Riley, A.R.; Wagner, D.V.; Tudor, M.E.; Zuckerman, K.E.; Freeman, K.A. A survey of parents' perceptions and use of time-out compared to empirical evidence. Acad. Pediatr. 2017, 17, 168–175.
35. Kelley, M.L.; Heffer, R.W.; Gresham, F.M.; Elliott, S.N. Development of a modified treatment evaluation inventory. J. Psychopathol. Behav. Assess. 1989, 11, 235–247.
36. Patterson, G.R.; Chamberlain, P. A functional analysis of resistance during parent training therapy. Clin. Psychol. Sci. Pract. 1994, 1, 53–70.
37. Johnston, C.; Park, J.L.; Miller, N.V. Parental Cognitions: Relations to Parenting and Child Behavior. In Handbook of Parenting and Child Development Across the Lifespan; Sanders, M.R., Morawska, A., Eds.; Springer International Publishing: Cham, Switzerland, 2018; pp. 395–414.

38. Sawrikar, V.; Hawes, D.J.; Moul, C.; Dadds, M. The role of parental attributions in predicting parenting intervention outcomes in the treatment of child conduct problems. Behav. Res. Ther. 2018, 111, 64–71.
39. Skoranski, A.M.; Skowron, E.A.; Nekkanti, A.K.; Scholtes, C.M.; Lyons, E.R.; DeGarmo, D.S. PCIT engagement and persistence among child welfare-involved families: Associations with harsh parenting, physiological reactivity, and social cognitive processes at intake. Dev. Psychopathol. 2021, 1–18.
40. Everett, G.E.; Hupp, S.D.; Olmi, D.J. Time-out with parents: A descriptive analysis of 30 years of research. Educ. Treat. Child. 2010, 33, 235–259.
41. Scott, S.; Dadds, M. Practitioner review: When parent training doesn't work: Theory-driven clinical strategies. J. Child Psychol. Psychiatry 2009, 50, 1441–1450.
42. Girard, E.I.; Wallace, N.M.; Kohlhoff, J.R.; Morgan, S.S.J.; McNeil, C.B. Parent-Child Interaction Therapy with Toddlers: Improving Attachment and Emotion Regulation; Springer International Publishing: Cham, Switzerland, 2018.
43. McNeil, C.B.; Hembree-Kigin, T.L. Parent-Child Interaction Therapy, 2nd ed.; Springer: New York, NY, USA, 2011.
44. Dombrowski, S.C.; Timmer, S.G.; Blacker, D.M.; Urquiza, A.J. A positive behavioural intervention for toddlers: Parent-child attunement therapy. Child Abus. Rev. 2005, 14, 132–151.
45. McNeil, C.B.; Quetsch, L.B.; Anderson, C.M. Handbook of Parent-Child Interaction Therapy for Children on the Autism Spectrum; Springer: Cham, Switzerland, 2019.
46. Duncombe, M.E.; Havighurst, S.S.; Holland, K.A.; Frankling, E.J. The contribution of parenting practices and parent emotion factors in children at risk for disruptive behavior disorders. Child Psychiatry Hum. Dev. 2012, 43, 715–733.
47. Havighurst, S.; Kehoe, C. The role of parental emotion regulation in parent emotion socialization: Implications for intervention. In Parental Stress and Early Child Development; Deater-Deckard, K., Panneton, R., Eds.; Springer: Cham, Switzerland, 2017; pp. 285–307.
48. Troutman, B. Integrating Behaviorism and Attachment Theory in Parent Coaching; Springer International Publishing: Cham, Switzerland, 2015; p. 126.