The impact of enhancing a behavioral program for children with severe behavioral disorders by promoting parents' coherent life story

Susan Kathryn Schiltz-Day

Iowa State University
INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps. Each original is also photographed in one exposure and is included in reduced form at the back of the book.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.
The impact of enhancing a behavioral program for children with severe behavioral disorders
by promoting parents' coherent life story

by

Susan Kathryn Schiltz-Day

A dissertation submitted to the graduate faculty
in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

Major: Education

Major Professor: Gordon C. Hopper

Iowa State University

Ames, Iowa

1996

Copyright © Susan Kathryn Schiltz-Day, 1996. All rights reserved.
This is to certify that the Doctoral dissertation of
Susan Kathryn Schiltz-Day
has met the dissertation requirements of Iowa State University

Signature was redacted for privacy.

Committee member
Signature was redacted for privacy.

Committee member
Signature was redacted for privacy.

Committee member
Signature was redacted for privacy.

Committee member
Signature was redacted for privacy.

Major Professor
Signature was redacted for privacy.

For the Major Program
Signature was redacted for privacy.

For the Graduate College
Dedication

I dedicate this dissertation with appreciation

to my husband, Tim Day who displayed ongoing support and encouragement,

to my major professor, Gordon Hopper, who has a remarkable skill of fostering
the student mind,

and to my friends of the FOCUS program who are willing to believe in families.
# TABLE OF CONTENTS

## CHAPTER 1. INTRODUCTION
- Statement of the Problem: 15
- Research Questions and Hypotheses: 17
- Definition of Terms: 18
- Overview: 19

## CHAPTER 2: REVIEW OF LITERATURE
- Introduction: 21
- Treatment Recommendations: 23
- Parental Involvement: 26
- Behavioral Parent Training: 29
- Behavioral Parent Training vs. Client Centered Approach: 32
- Enhanced Parent Training: 35
- Multimodal Approach: 38
- Parental Views of Parent Training: 40
- Summary: 42

## CHAPTER 3: METHODOLOGY
- Introduction: 44
- Subjects: 45
- Independent Variables: 46
- Dependent Variables: 48
Quantitative Instruments 48
Qualitative Instrument 50
Procedure 51
Collection of Data 52
Quantitative Design 53
Qualitative Design 54
Quantitative Analysis of Data 54
Qualitative Analysis of Data 55

CHAPTER 4: RESULTS 57

Quantitative Analysis 57

Differences between the groups 57
Parametric statistics 58
Graph of the means 58
Results of the ANOVA 59

Qualitative Analysis 60

Themes of how the parents' responses changed 61
Themes of the parents' evaluations 61
Theoretical themes 61

CHAPTER 5: DISCUSSION, SUMMARY, AND RECOMMENDATIONS 66

Introduction 66
Summary 73
Recommendations 73
| APPENDIX A. PARENT THERAPY GROUP AGENDA AND RATIONALE | 76 |
| APPENDIX B. CHILD BEHAVIOR CHECKLIST | 80 |
| APPENDIX C. PARENT ATTITUDE SURVEY | 84 |
| APPENDIX D. PERSONAL DATA SHEET | 89 |
| APPENDIX E. OPEN-ENDED QUESTIONS REGARDING PARENTING | 90 |
| APPENDIX F. GROUP EVALUATION FORM | 91 |
| APPENDIX G. INTRODUCTORY LETTER FOR ENHANCED CONDITION | 92 |
| APPENDIX H. INTRODUCTORY LETTER FOR REGULAR TREATMENT CONDITION | 93 |
| APPENDIX I. CONSENT TO PARTICIPATE IN GROUP FORM | 94 |
| APPENDIX J. APPROVAL FROM HUMAN SUBJECTS REVIEW BOARD | 95 |
| APPENDIX K. PARENTS MEANINGFUL UNIT RESPONSES FOR PARENTING GOALS AND HOPES AND FEARS FOR THEIR CHILD | 96 |
| APPENDIX L. PARENTS MEANINGFUL UNIT RESPONSES FOR GROUP EVALUATION | 99 |
| REFERENCES | 102 |
| ACKNOWLEDGMENTS | 114 |
ABSTRACT

The purpose of this study was to investigate the impact of enhancing an already existing day treatment program for youth with severe behavior disorders. The intervention consisted of a short-term parent therapy group which operationalized elements of attachment theory and narrative therapy and then compared this to the program's regular treatment. This group focused on assisting parents (1) to review their past for a coherent story, (2) to identify and utilize a parenting strength, and (3) to voice their hopes and fears to their child with an emphasis on the child's potential. The effectiveness of this group was assessed by both a quantitative and qualitative methodology. There were six clients in the enhanced treatment condition, and nine clients in the regular treatment condition.

For the quantitative aspect of this study, a repeated measures design (specifically a split-plot design) was utilized to evaluate the effectiveness of the parent therapy group. The instruments used in this study included the Child Behavior Checklist\(^1\) and the Parent Attitude Survey\(^2\). For the qualitative aspect of this study, written responses to several open-ended questions were analyzed by three raters. This process allowed the emergence of thematic and theoretical information regarding the clients' experience of the parent therapy group.

The results of the analysis of variance indicated no treatment effect and no treatment by time effect. There was a time effect which indicated that all of the parents reported an


improvement in their perception of their child’s behavior from pretest to posttest which likely supported the behavioral component of the program. The qualitative aspect to this study suggested the importance of this group for assisting the parents to gain an experience of cooperation, connection, and competency. The theoretical construct that was derived from the parental responses suggested that the group fulfilled deficit needs and was based on Maslow’s theory of the hierarchy of needs. It did seem that the group experience fostered a change in self-definition and may be a useful tool to combat resistance which is frequently identified with this population.

---

CHAPTER 1. INTRODUCTION

Children are the future. Recognizing this, it becomes imperative that we examine how well-equipped our youth will be to face the many and varied challenges of the future. The Carnegie Council (1989) noted "millions of American youth are at risk of reaching adulthood unable to meet adequately the requirements of the workplace, the commitments of relationships in families and with peers, and the responsibilities of participation in a multicultural society and of citizenship in a democracy" (p. 21). This concern would seem particularly evident for youth who have been removed from regular school programming due to severe behavior disorders. These youth have already displayed a difficulty with following societal rules and expectations. Hetherington and Parke (1986) defined socialization as "whereby an individual's standards, skills, motives, attitudes, and behaviors conform to those regarded as desirable and appropriate for his or her present or future role in society" (p. 481). Thus it would seem that these youth have not accepted this element of the childrearing or socialization process.

These youth are generally diagnosed with one of the several disruptive behavior disorders (i.e., attention-deficit disorder, oppositional defiant disorder, or conduct disorder) which are characterized by a variety of acting-out behaviors as their diagnostic criteria. These disruptive behavior disorders have a high degree of comorbidity, and this has resulted in disagreement among researchers who speculate whether these disorders represent distinct categories or are just varying levels of severity of the same disorder (Abikoff & Klein, 1992; Loeber, Keenan, Lahey, Green, & Thomas, 1993; Loeber, Lahey, & Thomas, 1991). These disorders are also described as having similar associated secondary problems which include impaired social functioning, depression, low self-esteem, and academic underachievement or failure (Grizenko, Papineau, & Sayegh, 1993; Webster-Stratton & Dahl, 1995). The hallmark of these disruptive disorders is the externalizing behaviors (American Psychological Association, Diagnostic and Statistical Manual of Mental Disorders, 4th edition, 1994) which
throw havoc into an already complex socialization process. Thus these youth are seen as not complying within the realm of societal expectations and they exhibit externalizing behaviors such as "aggressive and interpersonally alienated behaviors" (Caspi, Henry, McGee, Moffitt, & Silva, 1995). These aggressive behaviors are delineated by the Child Behavior Checklist (Achenbach, 1991a) and include lying, running away, setting fires, stealing, vandalism, arguing, destruction, jealousy, fighting, stubbornness, temper, and threatening behavior. Probably the greatest concern with these youth is the prevention of further development along an antisocial path into adulthood (Spitzer, Webster-Stratton, & Hollinsworth, 1991; Tolan, Guerra, & Kendall, 1995). As noted succinctly by Estrada and Pinsof (1995) "ameliorating today's childhood disorders prevents the adolescent and adult disorders of tomorrow" (p. 403).

There is a significant body of research which has explored the characteristics of this population of youth. This research has indicated that these children show more reactive antisocial behavior (Fraser, 1996; Matthys, VanLoo, et al., 1995), exhibit tendencies to escalate rather than neutralize conflict with peers (Matthys, DeVries, et al., 1995), have a higher incidence of adolescent behavior problems (Patterson, DeBaryshe, & Ramsey, 1989; Zaslow & Takanishi, 1993) and this is, unfortunately, followed by further continuity of difficulties (a developmental path) such as having a higher incidence of deviant or criminal behavior later in life (Chamberlain & Rosicky, 1995; Dishion & Andrews, 1995; Kazdin & Johnson, 1994; Patterson et al., 1989; Rutter, 1989; Tolan et al., 1995). There also seems to be a differential path depending on age of onset; the younger the age of onset for the behavioral difficulties, the more likely the chronicity (Tolan & Thomas, 1995). Therefore children with behavior or aggression difficulties exhibit a wide range of problems in their social development.

When viewing the multitude and accumulation of factors that identify or are associated with high risk children and families, one begins to realize the complexity of the situation as
researchers have cited a wide range of factors including poverty, economic difficulties, parental deviance or mental illness, impaired parenting and child rearing practices, abuse, family conflict, family change, deviant peer group association, prenatal influences, birth defects, complications and prematurity, hereditary influence, inadequate nutrition, and neglect (Conger, Ge, Elder Jr., Lorenz, & Simons, 1994; Dodge, Petit, & Bates, 1994; Fergusson & Lynskey, 1996; Wicks-Nelson & Israel, 1991). Although all of these avenues would likely be beneficial to explore, this study will focus on the area of the parent-child relationship or the family environment.

As can be expected of children with behavior disorders, there is a great deal of difficulty with the child’s compliance to adult authority (a benchmarker when making the diagnosis for oppositional-defiant or conduct disordered youth) and thus a concern regarding the use of discipline. Chamberlain and Patterson (1995) depict a rather grim picture of when there is chronic noncompliance in a family. They theorized that the frustrated parent typically would tend toward coercive measures which would lead to the youth resenting the parental authority and subsequently the youth would continue to act out. They noted a particular concern regarding the tendency of this cycle to escalate with intensity as well as severity. Therefore replacing the power assertive parenting stance with an inductive style would hopefully end the youth’s anger, hostility, and accompanying oppositional pattern (Hoffinan, 1970).

This concern with the coercive or power assertive environment of the family has prompted other researchers to identify a correlation between disruptive/bullying behavior displayed outside of the family and poor family functioning (Rigby, 1994). Thus coercive discipline is thought to impact the parent-child relationship directly as well as indirectly through modeling (Chamberlain & Patterson, 1995). Dumas’ (1996) study suggested “that relatively low levels of positiveness and compliance, coupled with high levels of aggression, especially in the child-mother relationship, may play an important role in determining whether
a family will seek professional services for disruptive child-behavior problems” (p. 106). Parents having high reactivity to child behavior problems are thought to have schemas that predispose them to automatically view behavior in a threat-oriented manner (Bugental, 1985). Thus the negative emotional climate of the family seems to be associated with elevated rates of disruptive behavior diagnoses in children (Stubbe, Zahner, Goldstein, & Leckman, 1993). And it seems that stressors such as economic hardship and depression, both of which impact negatively on parents, effect parenting negatively (Conger et al., 1994; Dodge et al., 1994; Geller & Johnston, 1995; Sampson & Laub, 1995; Whitbeck et al., 1992) which is then associated with a higher incidence of problem behaviors in their offspring.

Research which does not focus specifically on youth with behavior disorders, but has explored the developmental and socialization process, has continued to identify the importance of the parent-child relationship. Kochanska, Aksan, and Koenig (1995) conceptualized child compliance as a developmental process, fostered in the long-term qualities of the cooperative parent-child relationship which leads to the acceptance of adult authority. Further they proposed that “a long-term pattern of parent discipline, based on negotiation rather than power...may increase the likelihood of committed compliance” (p. 1767). In terms of describing helpful parenting styles, Steinberg, Lamborn, Darling, Mounts, and Dornbusch (1994) suggested “it appears that the combination of parental aloofness and disciplinary laxity appears universally harmful to adolescents. Conversely, parental authoritativeness - the combination of responsiveness and demandingness - carries many benefits and few disadvantages for adolescents from different walks of life” (p. 769). Smetana (1995) proposed the need for negotiation between parent and adolescent so that healthy development can occur, and that with either too permissive or too rigid of a parenting style this is less likely to occur. Kazdin & Johnson (1994) advocated that “parent-child relationships are central to social competence in children and adolescents” (p. 227). Thus parenting has certainly been considered to play a central role in the development of children.
However, it is important to recognize that the parent-child relationship is bi-directional with both the parent and the child each influencing one another. A study by Slee (1996) found that mothers with conduct disordered children described their family climate as less relationship oriented, more conflictual, less cohesive, and less organized than mothers without conduct disordered children. However, Slee introduced the concept that perhaps this was due to an adaptive reaction to the stress of having a conduct disordered child in the family rather than a condition of these families. Similarly, Chamberlain and Patterson (1995) noted that “the coercive child has a strong role in training his parents to be more distant, less involved, and in a very real sense less loving” (p.16). Therefore as suggested by Martin (1994):

The behavior of the child causes those in the environment to react in a specific manner that strengthens the disposition. For example, the child who exhibits high levels of negative emotion tends to elicit high levels of negative emotion in return, which may in turn cause others to avoid the child....In this way, children tend to create their own environments - environments that are consistent with their predispositions. (p. 125)

Thus both the child and the parent have a role in defining the parent-child relationship. The simplistic notion of the parenting style being the sole determinant of child outcome is particularly lacking when “it is not the case that all children raised in adverse circumstances experience mental health or adjustment problems” (Fergusson & Lynskey, 1996, p. 281). There is a strong suggestion that the child’s temperament plays a crucial role in the outcome of the parent-child relationship and the outcome of a behavior disorder (Caspi, et al., 1995; Kochanska, 1995; Kochanska, DeVet, Goldman, Murray, & Putnam, 1994; Sanson & Rothbart, 1995).

This can also be described in terms of “goodness of fit” (Chess & Thomas, 1989) whereby if the demands of the environment and the disposition of the child combine in a “bad fit”, the result may be in the production of problematic or abnormal behavior. Kochanska (1995) has attempted to blend the two aspects of the child’s temperament with the parental
discipline mode in an effort to promote internalization and self-regulatory behavior. Her results suggested that there may not be one type of preferred parenting style, but instead that the style may need to take into consideration the child's temperament, particularly when dealing with relatively fearless children (a parent may need to utilize some appropriate amount of power assertion to catch the attention of the fearless child).

Other researchers have postulated the role of children's cognitions with accepting adult authority (Braine, Pomerantz, Lorber, & Krantz, 1991; Fraser, 1996; Grusec & Goodnow, 1994). Overall as Sanson and Rothbart (1995) considered the impact of the child's temperament, the "best" parenting style, and the parent-child relationship, they noted "it becomes more difficult to give any universal prescription for 'good parenting', other than perhaps specifying the need for parental sensitivity and flexibility" (p. 312). "Families ... are confronted with a difficult problem: providing an environment that changes in the right way and at the right time" (Eccles et al., 1993, p. 99) and providing for not only individualized needs, but also for the developmental needs as the youth matures. Thus creating the optimal family environment for the socialization of youth clearly becomes rather complicated. And this all directly impacts clinicians since conduct disorders, school-related behavior problems, and other features of antisocial behaviors are the most common reasons for treatment referrals in childhood and adolescence (Chamberlain & Rosicky, 1995; Kazdin & Johnson, 1994; Rubin, Stewart, & Chen, 1995). Thus it becomes necessary for clinicians to more fully understand the factors linked to behavior disorders so that they will be better able to develop interventions which will assist with decreasing the occurrence of childhood and adolescent antisocial behavior (Fraser, 1996; Tolan et al., 1995).

Currently the recommended treatment is multimodal (Borduin, 1994; Grizenko et al., 1993; Zigler, Taussig, & Black, 1992) with strong support for family therapy (Borduin, 1994; Chamberlain & Rosicky, 1995; Liddle, 1996) and parent management training (also described as parent training and behavioral family training) (Dadds & McHugh, 1992; Estrada & Pinsof,
The parent management training is particularly advocated due to research identifying a concern regarding the family environment of these children which has often been associated with a coercive family process, negative and critical attribution process, conflictual interactions, and parental depression (Dadds & McHugh, 1992; Grizenko & Pawliuk, 1994; Haddad, Barocas, & Hollenbeck, 1991; Herbert, 1989; Kazdin, 1987; Patterson, 1986; Patterson, 1982; Patterson et al., 1992; Webster-Stratton & Dahl, 1995). Thus the treatment of youth with behavior disorders has had a strong emphasis on providing parent management training (Patterson, 1982) based on the belief that “changes in parenting are related to changes in child-adolescent problem behaviors” (Liddle, 1996, p. 7). The focus of this training is to assist the parents with the interactional pattern away from a coercive process to “building parental skills in reinforcement, delivering mild forms of discipline, and negotiating compromises” (Chamberlain & Rosicky, 1995, p. 443).

This behavioral focus is frequently combined with family and group therapy. This would suggest the importance of targeting the parent-child relationship, assisting parents to utilize parenting which is consistent, firm, and responsive to these children. It would be important for these parents to understand that their child’s temperament certainly plays a part in their need for an individualized parenting style. It would be useful to assist the youth from a cognitive behavioral stance which would include challenging unrealistic expectations and developing social skills. Group treatment has been encouraged with these youth as a method to foster a sense of belonging and attempt to block the youth’s selection of an inappropriate peer group. Finding ways to assist the family to learn to negotiate through conflict would begin to forge new avenues of interaction. All of these are elements of the recommended treatment for families with a youth who have a behavior disorder (Carlin, 1996; Estrada & Pinsof, 1995; Grizenko, et al., 1993; Liddle, 1996; Richard & Sullivan, 1996).

However, even though there has been some success with treatment, Fraser (1996) identified the hard work ahead as the “prognosis for change is often poor even with
treatment" (p. 19) for aggressive children and their families. And Greenberg and Speltz (1988) note that:

Although initial reports and enthusiasm by researchers and clinicians alike appeared to validate the operant parent training approach, it has been criticized on both philosophical and empirical grounds. First, despite the number of parent training studies showing short-term improvements in parent skills (with corresponding reduction in child deviance), a careful examination of long-term maintenance of immediate and subsequent generalizations of child behavior change reveals a less optimistic assessment of efficacy. (p. 178)

Greenberg and Speltz (1988) also suggested operant parent training is lacking as it is based on a reductionist view of personality. Emery, Fincham, and Cummings (1992) indicated that when interpreting risk factors correlated with parenting, "caution must be exercised in making the leap from demonstrations of risk or correlation to assertions of causality. The need for caution is particularly keen when addressing problems that are multidetermined" (p. 909). Thus it is important to remember that the findings of a coercive family process is not causal, but rather of a correlational nature. Hinshaw (1992) also addressed this issue noting that "because of the rapid development of children and because of the plethora of individual, familial, and school variables that could enter into causal equations, ... complex models may be especially pertinent for developmental psychopathology" (p. 135).

Therefore to assist the families of behavior disorder youth, there is a need to balance one's knowledge of risk factors with the belief in the family's capabilities. Without this therapeutic consciousness which involves understanding the correlational nature of these risk factors, it is easy to fall into approaching the parents with a bias of blame due to a linear view of parenting "causing" behavior disorders. And at times a directive, behavioral approach has been criticized for its linear approach to problems (Nichols & Schwartz, 1991) which could perhaps inadvertently suggest this stance of blame to these parents. In a unique qualitative
study of parents who have a child with a behavior disorder, Webster-Stratton and Spitzer (1996) found that parents of children with a behavior disorder tend to struggle with the issue of blame and feelings of stigma. These parents also indicated the importance of connecting with other parents in a similar situation. Thus it may be worthwhile to explore methods which could assist these parents with developing a perspective outside of blame. This seems particularly important when research suggests the importance of connecting with, empathizing with, and empowering the parental system when working with problem youth or adolescents (Chamberlain & Rosicky, 1995; Henggeler, 1994; Liddle, 1996) and not focusing on blaming the parents (Henggeler, 1994, Liddle, 1995). This concern stems from recognizing that blame is destructive in maintaining positive parental involvement (Guerney, 1991) and that parental engagement is an ongoing process (Liddle, 1995). Liddle (1995) suggested utilizing an ecological view of the parents which includes being sensitive to their views of frustration and focusing on themes that are personally meaningful for the parent. This may then assist with sustaining their motivation for continued engagement in the therapeutic process. This becomes an important point when parents of troubled adolescents and youth may seem to not want to be involved with treatment (Frankel & Simmons, 1992), yet they are seen as a significant factor for implementing change (Liddle, 1996).

The theoretical approaches which address the complexity of the parent-child relationship and its impact on behavior problems have varied across several different models. The information processing approach examines the role of the child's cognitive reasoning (which generally includes an affective component) to accept or reject parental authority. The model suggested by Grusec and Goodnow (1994) has 7 variables which pertain to the accurate or inaccurate perception of the parental message and 15 variables pertaining to the acceptance or rejection of the parental message. If the message is accurately perceived and then accepted by the youth, the parental message is internalized. This model is largely cognitive, although it does indicate affect plays a role in the process. It definitely suggests
that children are not just recipients of the parental influence, but rather actively engaged in determining issues such as whether the authority was justified. It would suggest the parent-child relationship plays an important role in this process. Similarly Braine et al. (1991) suggested that “the child’s view of authority relations is based on a complex interplay among perceived coercion, judgments of request legitimacy, and minimization of control by others” (p. 840). These models clearly identify the child as actively in an evaluative process.

Utilizing a biological model, there is a strong recognition of the interaction of the environment with the child’s personal characteristics. Thus the role the environment plays in the child’s resulting behavior disorder depends first, on the amount of stress in the environment and second, on the extent of the child’s predispositional risk. This diathesis-stress model (Martin, 1994) or the vulnerability-stress model (Lytton, 1990) can be used to explain how some youth can be resilient in the face of adversity; whereas other youth will struggle. It is this combination of both the biological predisposition and the necessary environmental stressors which would result in the expression of the disorder. Without one or the other, the disorder would be absent.

Other paradigms include cognitive-behavioral, psychoeducational, family systems, and psychodynamic (Wicks-Nelson & Israel, 1991). However, much of the research cited in the previous pages of this document seem to have been generated from a social learning theory perspective which is often paired with behaviorism (due to their joint focus on environmental consequences) and contextualism [which focuses on the “interaction between (1) the child as a psychobiological organism and (2) the child’s sociophysical environment” (Thomas, 1992, p. 249)]. Patterson et al. (1992) have provided an overview of this perspective with its two main orientations: (1) the social cognitive model [“children’s social behaviors are mediated by their expectations, attributions and social cognitions” (p. 3)] and (2) social interactional perspective [“which assumes that observed parent-child and child-peer interactions are key determinants for the socialization process” (p. 3)]. The social interactional perspective is
further divided into 3 components: (1) family and peer interaction, (2) context and interaction and, (3) attachment theory. These social learning models suggest treatment that is "structured, task-oriented, and for the most part focused on the present" (Chamberlain & Rosicky, 1995, p. 444) with the exception of attachment theory. Attachment theory seems to add a unique contribution to studying the family. Since this researcher plans to incorporate attachment theory and narrative therapy in this study, the following information provides a background to these two orientations.

Unlike the other frameworks, attachment theory seems to utilize a particularly wide angle lens concerning the family which leads to understanding the family in a more holistic sense. "Attachment theory is principally concerned with the role that enduring affectional bonds, or attachments, play in shaping the life course" (Lopez, 1995, p. 397). Bowlby (1969, 1988) identified how his early work, right out of medical school, likely impacted his conceptualization of attachment theory. He had worked in a setting with juvenile delinquents and began to recognize the impact of early maternal separation on these youth. He later formulated the base of attachment theory which was a safety mechanism for survival. He postulated that the infant or young child developed an attachment so that in times of vulnerability, the child could implement means to gain proximity to this attachment figure and therefore gain safety. It was further suggested that this early attachment leads to the development of an internal working model against which all other relationships are measured. "Thus, the quality of the caregiver's emotional availability early in life is fundamental to the nature of the child's relation to its attachment figure and the internal working model that subsequently develops" (Rosenstein & Horowitz, 1996, p. 244). Ainsworth's (1989) systematic observations of mother-infant dyads contributed to Bowlby's theory by identifying attachment patterns of the infants based on security (secure, avoidant, anxious/ambivalent, disorganized).
The Adult Attachment Interview (AAI) (George, Kaplan, & Main, 1996) has expanded this theory across the life cycle. The AAI has categorized adult patterns of attachment based on the coherency of the client’s life-history (secure/autonomous, dismissing, preoccupied, and unresolved/disorganized). The importance of a secure attachment is that it frees up the individual to go about the living of one’s life and providing a willingness to experience new opportunities and challenging oneself. However, with an insecure attachment, the constant threat of vulnerability blocks trying new behaviors or endeavors, limits life experimentation, and keeps people in a “stuck” path. Thus attachment theory recognizes the developing attachment of the child as well as the attachment style of the parent.

It is proposed that the parent’s attachment style leads to how the parent interacts with the child which then impacts the development of the child’s attachment style (Belsky, Rosenberger, & Crnic, 1995). Therefore it becomes a point of intervention to impact the parental attachment; to assist the parent with being able to conceptualize a coherent life story. Byng-Hall has suggested “it seems that it is not the painful experience, as such, that is important; it is what you make of the experience that counts” (1995a, p. 56). And Byng-Hall further indicated that “if a parent can make sense of what happened in childhood, and can see the motives behind each person’s behavior, then the parent is more likely to be able to respond appropriately to his or her child’s needs, and is consequently more likely to be securely attached” (1995a, pp. 48-49). Or as described by Kenny and Rice (1995):

The model ... suggests that some individuals with insecure attachments could, because of other healthy developmental influences or through modifications in their internal models, demonstrate later adaptive functioning, whereas some individuals with secure attachments could, because of other maladaptive developmental influences or a disruption of secure attachments, demonstrate subsequent adjustment difficulties. The developmental pathway model thus maintains that early relationships are formative in
later life, yet provides more opportunities for alterations in an established development course than are depicted by traditional psychoanalytic theory. (p. 437)

Researchers have found that those with insecure attachment may be more at risk for problematic behavior (Manassis, Bradley, Goldberg, Hood, & Swinson, 1994; Rosenstein & Horowitz, 1996), greater dependence needs (Sroufe, Fox, & Pancake, 1983), and lower cognitive functioning (Jacobsen, Edelstein, & Hofmann, 1994). Speltz, DeKlyen, Greenberg, and Dryden (1995) found that a rating of insecure attachment in preschool youth seemed to be valuable in assessing early disruptive behavior. Thus similar to the earlier research cited regarding the parent-child relationship, an insecure attachment can be a risk factor for less than optimum child development. This would suggest it would be beneficial to find methods to improve the parent’s attachment or internal working model which may subsequently impact the developing child’s attachment.

Thus quite possibly the more parents can be assisted to form a coherent story of their past, the more likely they can assist with passing this on to their children (Byng-Hall, 1995b). This may help the parent with moving out of parenting which is just from “habit” or what they learned from their past. Byng-Hall (1995b) suggested the continuity of transgenerational life. He noted that families operate from a family script which is “the family’s shared expectations of how family roles are to be performed within various contexts” (p. 4). These scripts are largely guided by the parents as they continue, react, or improvise on the family scripts that (s)he encountered while growing up. These parenting scripts need to be explored as to whether they fit for the current family’s needs or not. To assist one with coming to terms with one’s past would include finding a narrative which is functional for self and family (Byng-Hall, 1995b; Pocock, 1995). Incorporating attachment theory would recognize the need to help families with improvising and changing family scripts as is necessary for the individuals that comprise the family.
This focus on scripts or a coherent story of the past can also be found in narrative therapy. Narrative therapy recognizes the stories which surround family life about past events. “Stories can ... be understood as exercises in self-interpretation, by which people make sense of their experiences” (Baumeister & Newman, 1994, p. 688). “These stories not only shape the past and present but also impose real constraints on how all members of the family construct or envisage the future” (Boscolo & Bertrando, 1993, p. 79). Therefore flexibility is the key. As Boscolo and Bertrando described this need for flexibility they noted:

If a family can accept only a few stories or is huddled around a dominant myth, it will soon experience strain when faced with stories incompatible with its own. Certain periods of family life, especially adolescence, call for high degrees of flexibility and tolerance if new stories are to emerge. If this does not happen, anxiety, suffering, and frustration may lead to clinical symptoms. (pp. 79-80)

Besides the recognition of how one defines one’s past which then influences one’s future (Omer & Strenger, 1992), the narrative therapy approach also incorporates a dynamic view of the self-definition process. As noted by Lax (1992):

The narrative view holds that it is the process of developing a story about one’s life that becomes the basis of all identity and thus challenges any underlying concept of a unified or stable self. . . . This narrative or sense of self arises not only through discourse with others, but is our discourse with others. (pp. 70-71)

Thus this approach is an attempt to assist clients with creating new stories that have new possibilities (Cecchin, 1992; Epston, White, & Murray, 1992; Pare, 1996) which move clients “from being influenced by problem-dominated stories to more preferred stories” (Zimmerman & Dickerson, 1994, p. 233). The use of the word “story” is not meant as a static view of one’s life as explained by White (1993):

This perspective should not be confused with that which proposes that stories function as a reflection of life or as a mirror for life. Instead, the narrative metaphor proposes
that persons live their lives by stories - that these stories are shaping life, and that they have real, not imagined, effects - and that these stories provide the structure of life.

(p. 36)

As expressed by Gergen and Kay (1992) "...the potential of such reconstructions to re-orient the individual, to open new courses of action that are more fulfilling and more adequately suited to the individual's experience, capacities, and proclivities" (p. 175) is thought to have far reaching consequences. This is further described by Bugental and Bracke (1992):

"Discovering possibilities where none seemed previously to exist is an intrinsically powerful experience for those who have felt powerless and empty. The empowerment that comes from even a modest broadening of self-awareness will, for many, be an impetus to exciting steps toward an enlarged and enriched life experience." (p. 31)

This empowerment may be particularly important for families who may have seemed to define themselves as less than adequate due to a long history of difficulties. And as this definition may not only be fostered within the family, as Colapinto (1995) indicated that social services can dilute the family with a result of the family viewing themselves as inadequate.

I have to wonder if assisting the family to build its own coherent story might help to counteract the directive nature of the recommended behavioral interventions which may unwittingly be projecting or reinforcing a blaming perspective onto the parent. Perhaps this would assist with the families owning more of the treatment process. And this social constructionist view seems particularly suited to empowering the families as it strongly supports that the "story" belong to the family and not imposed by the therapist (Pare, 1995).

This study will attempt to utilize this social constructionist approach.

**Statement of the Problem**

The purpose of this study was to explore the value of assisting parents who have children in a day treatment program (1) to review their past for a coherent story, (2) to identify and utilize a parenting strength, and (3) to voice their hopes and fears to their child
with an emphasis on the child's potential. This therapeutic intervention was designed to enhance an already existing day treatment program which served children who have severe behavior disorders. The intervention was an attempt to operationalize elements of attachment theory and narrative therapy. And while attachment theory has traditionally been thought of as a long-term approach, it has been viewed as being able to be applied for use with short-term therapy (Biringen, 1994).

The hope was that this group would provide an opportunity for the parents to move out of a reactive stance and instead to deal with their many parenting challenges on a more global level. A group context was chosen as a means to augment the program's directive style of behavioral parent management and was supported by the qualitative study by Webster-Stratton and Spitzer (1996) who completed a study of a parent therapy group with parents of young conduct disordered children. These researchers noted their "findings suggest that group-based therapeutic approaches would be particularly helpful for these parents in that the group experience counteracts their isolation, normalizes some of their experiences and can provide support" (pp. 33-34). As suggested by Yalom (1995) groups can promote support, acceptance, and learning from one another's perspective. Thus this may be particularly important since the lack of social support has been cited as one of the factors which seems to be a barrier to successful treatment with these families (Chamberlain & Rosicky, 1995).

In this study all of the parents and their youth continued to receive the current level of care provided by the day treatment program staff. Each youth participated in a 3.6 Behavior Disorder specialized classroom setting and in daily social skills training provided by the educational staff. Each youth also received recreational, individual, and group therapy and all of the families are invited to participate in family therapy. However, half of the participants were randomly assigned to the enhanced treatment condition which consisted of a weekly parent group (lasting 1 1/2 hours each week) for a duration of five weeks. All of the parents were asked to complete a pretest and posttest to explore the parental perception of their
child’s problem behavior and their parental attitudes. Thus by accessing clients who are already involved in a treatment program, this study attempted to meet the challenge by Sexton and Whiston (1996) of integrating counseling practice with research.

**Research Questions and Hypotheses**

Listed below are the research questions and the corresponding hypotheses that this study will address:

1. Does a parent therapy group for the parents of the youth with a severe behavior disorder result in a significant decrease in the parents’ perception of their children’s problematic behavior as assessed by the Child Behavior Checklist (Achenbach, 1991a) as compared to parents who do not attend such a group?

   **Hypothesis 1.** It is hypothesized that while all of the parents will have a reduction in their perception of their child’s behavior problems; those parents that attend the parent therapy group will have a significantly greater reduction of perceived behavior problems as assessed by the Total Problem Scale of the Child Behavior Checklist (Achenbach, 1991a).

2. Does a five session parent therapy group for the parents of youth with severe behavior disorders result in significant improvement in parental attitudes as assessed by the Hereford Parent Attitude Survey (Hereford, 1963) as compared to parents who do not attend such a group?

   **Hypothesis 2.** Based on this researcher’s premise that the treatment of choice for this population is rather directive and may promote a blaming stance, it is hypothesized that the parents who attend the parent therapy group will have a greater focus on their strengths and have a higher total score on the Parent Attitude Survey.

3. Will a qualitative approach to the clients’ written responses to several open-ended questions assist in gaining useful information about the clients’ experience of a parent therapy group for parents who have children with behavior disorders?
**Hypothesis 3.** It is hypothesized that a qualitative approach will be a useful tool to gain information regarding the clients' experience of the group.

**Definition of Terms**

**Children with disruptive behavior disorders.** For the purposes of this study, these are children who have been removed from the regular school environment due to severe problematic behavior and are currently in a day treatment program which is designed to assist such youth. These youth have been staffed 3.6 BD through the public school system and have a clinical diagnosis which includes either attention deficit disorder, oppositional defiant disorder, or conduct disorder.

**Day treatment.** This is a cooperative program between the public school system and a community hospital. The school system provides for the educational component while the hospital provides the therapeutic staff. The current treatment involves family therapy (frequency often is limited by family attendance), individual therapy for the youth, group and recreational therapy for the youth, psychiatric consultations as needed, and daily social skill programming. There is not a parent group component in this program. Grades served by this program are 4th through 8th grade. All of the families have utilized other less intensive therapy with little or no success.

**Parent.** For this study, the parent is the primary caregiver of the child. Only one person was asked to complete the pretest and posttest from each family.

**Hereford Parent Attitude Survey (PAS).** The Parental Attitude Survey (Hereford, 1963) was designed to assess changes in parents' attitudes toward their children following parent training that utilized a group discussion process. This instrument has 75 items that require parents to identify strength of agreement or disagreement (five-point scale) and attempts to determine parental attitudes on five factors: confidence in the parental role, causation of the child's behavior, acceptance of the child's behavior and feelings, mutual understanding, and mutual trust. There are 77 items in the Parent Attitude Survey, but the
first two items are not used in the scoring process. As noted by Hereford (1963) "the first two items in the final form ... were 'set breakers', one a statement with which nearly all parents would agree, the other a statement with which nearly all would disagree. This precaution reduced the tendency of some to begin, and then continue, marking the undecided category for every item" (pp. 55-56).

**Child Behavior Checklist (CBCL).** The Child Behavior Checklist (Achenbach, 1991a) is composed of two parts. The Social Competence Scale has 20 items that provide scores in the areas of activities (hobbies, sports, games, etc.), social (clubs, organizations, friendships, etc.), and school (performance, problems, etc.). The Behavior Problem Scales have 118 items that load onto 3 main syndromes: the internalizing syndrome (composed of the withdrawn scale, the somatic complaints scale, and the anxious/depressed scale), the externalizing syndrome (composed of the delinquent behavior scale and the aggressive behavior scale), and neither the internalizing nor externalizing syndrome (composed of the social problems scale, the thought problems scale, the attention problems scale, and the sex problems scale). The global assessment of behavior problems is the Total Behavior Scale which is composed of the Total Behavior Score (the sum of all the problem behavior items). The CBCL is a widely used parent-report assessment designed to assess behavior problems in 4 to 16 year-old-children.

**Enhanced Treatment.** This is the random treatment condition where half of the parents were invited to participated in the parent therapy group while their child received a "bonus" recreational time with the staff recreational therapist.

**Overview**

The introduction chapter is an attempt to familiarize the reader with the disruptive behavior disorders as well as assist the reader to consider the importance of addressing the needs of these youth. This introduction narrows the discussion to the parent-child relationship and the importance of not assuming a causal link between the parent-child relationship and the
disruptive behavior disorder. A brief look at the theoretical approaches along with this study’s focus on the combination of attachment theory with narrative therapy, provide a basis for this researcher’s intervention. Additionally the introduction chapter provides a statement of the problem studied, research questions to be answered, hypotheses to be tested, and definitions of terms which are important to the study. Chapter 2 consists of the Review of Literature which is a survey of recent studies related to this study. Then the Methodology chapter follows which will include a description of the subjects, of the design of the study, of the procedures utilized, and the instrumentation used. The fourth chapter consists of the Results which will present the findings of this study. And the last chapter will present a Discussion and Summary of the findings along with Recommendations for future research in this area.
CHAPTER 2. REVIEW OF LITERATURE

Introduction

Since the previous chapter summarized the descriptive research regarding youth who have disruptive behavior disorders and identified the need for clinical intervention, this chapter will address the clinical research with this population. The focus of this literature review will be the treatment and intervention strategies used with the parental subsystem of this population. As noted by Hibbs (1995) "psychosocial treatment research for child and adolescent disorders has been on the back burner for at least two decades" (p. 1). Hibbs (1995) further bemoaned that "there is an even greater dearth of research for treatments such as psychodynamic, interpersonal, group, family therapy, and eclectic approaches, which are commonly used in the clinical settings and by private practitioners" (p. 2). A common concern is whether research accurately reflects the real world. As Chamberlain and Rosicky (1995) suggested, even when research is conducted, it may not accurately generalize to an actual clinical population. Unlike subjects frequently found in the research studies, clients in the real world are heterogeneous and frequently have comorbidity of disorders, their therapy tends to be less focused, their therapist’s training tends to be less intensive, their therapist tends not to use manualized treatment, the clients tend to have more severe and chronic difficulties, and there tends to be less monitoring of the treatment integrity (Chamberlain & Rosicky, 1995; Weisz, Donenberg, Weiss, & Han, 1995). However, recognizing the limitations which exist, Pinsof and Wynne (1995) provided a thorough review of the literature and recommended family therapy for youth who display disruptive behavior disorders, although noting that there is “no scientific data at this time to support the superiority of any particular form of ... family therapy over any other.” However, “the one trend and very preliminary hypothesis that emerged fairly consistently is that treatments that combined conventional family or marital therapy sessions with other interventions were more efficacious than standard family therapy approaches alone for severe disorders” (p. 604). This
recognition of the importance of the family when treating a child has not always been the case as noted by Estrada and Pinsof (1995):

Prior to 1965, most attempts to treat childhood disorders, focused exclusively on the child. Individual outpatient and inpatient therapy were the treatments of choice. In response to the limited success of these individual approaches, family therapy and social learning theory brought a strong psychosocial emphasis to the treatment of children with emotional and behavioral problems. (pp. 403-404)

Kovacs and Lohr (1995) noted their concern that "...the omission of parents from the treatment process diminishes their educational and psychological importance" (p. 20). Thus the involvement of parents seem to be an important factor when considering the treatment of youth. And this seems to have become generally accepted in the field as Fauber and Long (1991) indicated that "...the majority of child therapists see a need to involve the child's parents at some level in the treatment process" (p. 813).

When exploring the research that actually attempts to define just what treatment methods actually seem effective, it can be difficult to compare research studies due to the varying designs, sample populations, and outcome measures. Wiese (1992) suggested that it is important to recognize the limitations which can exist in these studies. Wiese completed a review of the parent training research from 1975-1990 and found the vast majority of studies have emphasized a behavioral approach. She indicated a concern that often the research did not include follow-up data, or employ control groups. "Without such information, it is impossible to determine if the interventions accounted for the observed changes or if the observed differences generalized over time, across settings, or across people" (p. 234). Also Wiese recommended two reasons for the inclusion of protocols for the study. She noted that "first, to help define exact procedures used in conducting the research, and second, to ensure that the intervention procedures can be accurately replicated in subsequent research" (p. 235). Serketich and Dumas (1996) also noted that although the effectiveness of behavioral parent
training was supported by the literature, there were concerns regarding the small number of studies that employ methodological rigor, the small percentage of controlled studies which compare behavioral parent therapy to another intervention, and the few studies which conduct a follow-up comparison of the experimental and control conditions. This concern with interpreting the literature is also extended into the statistical analysis. Stevens (1996) indicated concern regarding the frequent use of multiple statistical tests which is often found in survey research “where investigators are often interested in relating demographic characteristics of the subjects to the responses to items on a questionnaire” (p. 9). The result is that there is a greater chance of a type I error or a spurious result. Therefore power is an important consideration when utilizing statistical processes. Thus although this body of research provides definite trends which can be useful to the clinician, it is important that the results are viewed with a healthy dose of realism.

**Treatment Recommendations**

The focus on the family, specifically the parents, has been supported by many researchers. Roseby and Johnston (1995) expressed concern for children who live in high-conflict families and recommended group therapy for the children along with collateral work for their parents as a means to assist children in the revision of the social-cognitive scripts they have developed. They then provide several clinical case vignettes to demonstrate this process. Turecki (1989) recommended assisting parents of difficult children with developing the skill to stand back, be neutral, and think through the parenting situation. Holmbeck and Updegrove (1995) indicated the importance of interfacing clinical intervention with developmental knowledge of childhood and adolescents. They endorsed assisting parents to think developmentally which was also recommended by Liddle (1995). Thus assisting parents is more than just providing information, it is assisting parents with developing skills (Herbert, 1989).
Kemberg and Chazan (1991) suggested that an important element of the parent training for parents with children who have conduct disorders, is to build a secure relationship between the therapist and the parents which:

...directly affects earlier patterns of deviant interaction internalized by the parents.... These deviant and parental models are the inheritance from their own parents and are the ultimate targets of the therapist's interventions in parent-training paradigms. By effectively counseling the parents, the therapist assures the process of change, forging new links between the past and a positive future. (pp. 18-19)

This focus on internalized interactions is the basis of attachment theory which postulates that conduct disorder is manifested due to an insecure attachment between the parent and child. Kemberg and Chazan (1991) theorized that “the goal of the parent training program is to enhance feelings of mastery for the parents, which will in turn enhance their feelings toward their child. The increased sense of mastery is positively reinforcing for the parents and acts to further the growth of secure attachment between the parent and child “ (p.113). These authors promote combining this attachment focus with the social learning theory of Patterson (1982) which suggests parents inadvertently reinforce noncompliance. And so parents are taught effective ways of interacting with their children. Patterson (1982) has a strong emphasis on assisting parents to (1) learn behavioral theory; (2) develop the ability to define, monitor, and record the occurrence of problem behavior; and (3) modify the problem behaviors. All three of these authors recommended specific information to be dispensed to the parents regarding how to discipline and reinforce behavior.

Exploring interventions targeting both the parent as well as the child, Herbert (1989) provided an intervention model for aggressive and violent children which utilized a social learning approach. In this triadic model, a strong emphasis is placed on assisting parents and children (1) to analyze the antecedent events of the aggressive, non-compliant behavior; (2) to develop cognitive change regarding the antecedent events; and (3) to learn conflict resolution.
Herbert noted the need for an individualized therapeutic process for each family and to not apply techniques in a cookbook fashion. He further suggested that "there is little doubt that parents - in individual treatment or parent-training groups - can be taught to use behavioural methods with their children and that for aggressive problems (and other disorders) they are effective" (p. 198). Forehand and Kotchick (1996) further recognized the need to take into account the differences which exist among varying cultural groups of parents. Forehand and Kotchick suggested that "clinicians need to be sensitive to cultural differences in parenting and their implications for facilitating and hindering the success of parent training" (1996, p. 202). They suggested focus groups to discuss parenting views, modifying research instruments to assess parental attitudes, and designing research which recognizes cultural differences.

Miller and Prinz (1990) have expressed that researchers need to address the lack of favorable outcomes and attempt to address client resistance to treatment. Miller and Prinz (1990) noted in their review of the literature that "resistant behaviors in the form of inadequate in-session participation, dissatisfaction with the treatment regimen, parental noncompliance, and premature dropout are more the rule than the exception in treating childhood conduct-disordered populations" (p. 292). Chamberlain, Patterson, Reid, Kavanagh, and Forgatch (1984) suggested "given that in parent training, the parents are essentially told what to do with their youngsters, it is not surprising that resistance is generated" (p. 145). Thus it is important to promote methods of treatment which will not unwittingly foster this resistant process.

Horne and Sayger (1990) provided their suggestions for treating conduct and oppositional defiant disorders in children. They recommended clear problem definition, involvement of multiple systems (parents, siblings, school), interventions which impact the environment and facilitate positive expectation for change, development of self-control for the entire family, development of discipline measures as well as social enhancement methods, and a system to maintain positive change. Of course, medication is frequently considered an
important part of the treatment strategy, especially for youth with an ADHD diagnosis. As noted by Rapport (1992) "psychostimulant medication remains the mainstay strategy for the disorder, yet there is a clear consensus that few children with ADHD can be adequately managed by this or any other treatment modality by itself" (p. 158). This recognition of the need to utilize more than one modality of treatment is further supported by Bordouin (1994). Bordouin reviewed the literature in an exploration of how the juvenile justice system has responded to the treatment needs of adolescent youth who engage in criminal behavior. He acknowledged that although there has been little success historically regarding treatment for antisocial behavior in adolescents; the social-ecological models do seem promising. In these models there is a strong emphasis on the peer, school, and family systems. Bordouin further recommended to avoid blaming families and instead to develop creative interventions.

**Parental Involvement**

Szapocznik, Kurtines, Santisteban and Rio (1990) attempted to study one aspect of the therapeutic process - the actual engagement of the client to the therapy process. Of course, improving this, would allow more clients to receive the treatment of choice. Therefore Szapocznik et al. (1990) developed a structural system engagement which began with a phone contact and a strong focus on encouraging the clients to begin the therapy process. This study was designed to target the parental involvement right from the beginning of the therapeutic encounter. They compared this to the engagement-as-usual process (the basic outpatient protocol of clients just coming to the therapist’s office for their first therapy session). Since this study was targeting a Hispanic community with behavior problem children and adolescents, the researchers indicated that they were attempting to match the therapist’s role with the expectations of the population. Thus these researchers indicated that the treatment modality was for the therapist to "take an active, directive, present-oriented leadership role" (p. 697). In this study 108 families of behavior problem children were randomly assigned to the two treatment conditions. All other treatment was manualized and
consistent between the two conditions (treatment integrity was highly significant where the
two conditions were rated for adherence to treatment guidelines and the only differentiating
feature was the level of engagement effort applied). The design was strong and showed highly
significant engagement of the families involved in the treatment condition as well as retention
throughout treatment until successful termination. The researchers indicated an attempt to be
aware of the cultural needs by individualizing the treatment process to this population. This
study also suggested the importance of focusing on the parents for the engagement process.

Then Szaszcznik et al. (1990) made an attempt to further explore the importance of
family involvement when treating children with a behavior problem. The researchers
completed a study comparing the efficacy of structural family therapy with individual child
psychodynamic approach and a recreation group which served as the attention placebo control
condition. Treatment integrity guidelines and checklists were developed and the high
interjudge reliability suggested that these three conditions were indeed dissimilar. The
subjects were randomly assigned to the three conditions. The results indicated that both the
psychodynamic and the structural family therapy conditions were more effective than the
control, but surprisingly both were apparently equivalent in reducing behavior and emotional
problems of the children. However, they did find greater effectiveness of the family therapy
over the long-term in bringing about improved family functioning. This study seemed to
suggest that the family therapy component could result in producing a possible protective
function by its family focus.

This protective function was further explored by Beardslee, Wright, Rothberg, Salt,
and Versage (1996). These researchers completed a study that did not deal directly with
children who had a behavior disorder, but they recognized one of the risk factors often
associated with these children can be parents with affective disorders. So these researchers
investigated a "preventive intervention designed to diminish risk to children in families in
which one or both parents suffered from affective disorders” (p. 774). Of interest in this study is the attempt to positively impact the parenting:

... through addressing poor communication and misunderstanding within the family.

In addition, the project aimed to enhance the protective factors in the child through increased parental understanding of their own disorder and risks and resiliency factors in the children. Children's relationships and independent functioning were also encouraged. (pp. 774-775)

This study operated from a hypothesis “that it is necessary for families to link cognitive information to individual life experiences in order for changes in behaviors and attitudes to occur and be sustained over time” (p. 775). Thus in this study the researchers compared parents who received lecture-formatted interventions and parents who received clinician facilitated interventions. All the parents had experienced affective disorders and the treatment was designed to assist them in their parenting roles. There were 54 parents randomly assigned to the two treatment conditions. Unfortunately, the assessment tools were not clearly identified other than generically described as standard diagnostic interviews, child behavior scales, and semi-structured interviews. The results were noted to show significant differences in attitude and behavior changes (in categories such as increased communication and perceived closeness) for the clinician facilitated condition, although these findings varied over time, with the greatest change occurring after a 3-year follow-up. The researchers noted that the "findings suggest that the benefits may not be realized until a year or more after participation in the intervention" (p. 780). The strength of this study included the long follow-up period and the focus on preventative measures. However, the two treatment conditions were not quite parallel, as the clinician facilitated group received a booster session while the lecture-only group did not. Thus the long-term results could represent the effectiveness of the treatment, or it could also indicate that it was a booster session which helped to solidify information for the long-term.
Behavioral Parent Training

While the previous studies suggested the importance of the family in a youth's life, other researchers began to explore the specific type of treatment which would best assist families who have a youth with a behavior disorder. As noted earlier, many studies have focused on a behavioral approach, which may have been largely due to the ease of operationalizing this theory base. Kovacs and Lohr (1995) suggested that "possibly, researchers have come to favor behavior and cognitive therapies because they lend themselves to standardization, a criterion that has been emphasized in recent outcome treatment research" (p. 14).

Anastopoulos, Sheton, DuPaul, and Guevremont (1993) provided an excellent study which utilized parent training for children with Attention-Deficit Hyperactivity Disorder (ADHD). Advantages to this study include that this was an actual clinic setting with highly trained professionals and all 34 of the children met the DSM-III criteria for ADHD and 16 of these children had a secondary diagnosis (most frequently oppositional defiant disorder). The parents were assigned (not randomly) depending on clinician caseload to either parent training or waiting list. Manualized parent training was utilized for standardization and high treatment integrity. The treatment effects were significant for reducing ADHD symptoms "and improvement in parent functioning, in terms of reduced parent stress and enhanced parenting self-esteem" (p. 592). These researchers recognized that this study did not include observations of parent-child interactions, so whether the children's symptoms actually improved was uncertain. The researchers suggested that when taking into account the severity of the subjects, "it is unlikely that any of the ADHD symptoms were actually eliminated. A more likely explanation for the reported changes in child ADHD symptomology is that parents learned to manage these symptoms more successfully and therefore perceived them as less severe, which in turn was reflected in their child ratings" (p. 593).
Webster-Stratton and Hammond (1990) completed a study which involved 101 mothers and 70 fathers with conduct problem children. The intervention was a 10-week parent training program (five weeks focusing on play skills, praise, and tangible rewards and five weeks focusing on non-punitive discipline and problem solving approaches). The parents were recruited from a parenting clinic in a university setting and had children ranging in ages of three to eight years old. The families were not involved in any other treatment and the primary referral was conduct problems of the children. It was also noted that the conduct problems were of no more than six months in duration. A variety of assessment tools were utilized in this study. The findings suggested that the greatest contributions to observed child deviance were different for the two genders. For the mothers, marital status and depression were correlated to observed child deviance; while for the fathers, negative life events and socioeconomic status were correlated to observed child deviance. However, it was admitted that the actual variance accounted for was quite small (10-15% at the most). It is important to note that there was no control group and no random assignment to treatment in this study. Thus this study provides correlational information only and does not indicate a cause and effect relationship.

A study which combined a behavioral approach with cultural sensitivity was completed by Myers et al. (1992). These researchers utilized a nonclinical population to explore the effectiveness of behavioral parent training, while adding an element for cultural specificity. They provided a study of a culturally adapted cognitive-behavioral parenting preventive program for 389 African-American parents who live in a low-income, inner-city community. Parents were provided a monetary or household/personal gift for a participation incentive. The study was completed in two cohort waves (one year apart) and had 100 parents serving as the control group (these parents were contacted for the pretest and posttest only). The lack of randomization was due to real world conditions as the control and treatment groups were based on the school district officials choosing five treatment school and two control
schools. The intervention consisted of behavioral child management skills, a parenting approach designed to assist parents with thinking through their actions, and an emphasis on cultural pride. The results were noted as “mixed, but very encouraging” (p. 144). There were modest decreases in parental rejection and harsh parenting practices and some support for improved parent-child relationships for these parents of first and second graders. The one year follow-up supported that long term effects are difficult to achieve, and may show evidence of regression (parents had shown an increase in hostile parenting practices). The authors of this study suggested the "need to integrate booster sessions or other forms of support into program plans to maintain and reinforce" progress (p. 145).

Recognizing an interest in the long-term results of behavioral parent training, Long, Forehand, Wierson, and Morgan (1994) completed an unusually long-term study to follow-up on the participants of a parent training program. The target sample was youth who had participated with their parent in a parent training program at least 14 years earlier. The youth were now at least 17 years old and facing the transition from late adolescence to early adulthood. A matched community comparison group served as the control. All of the follow-up assessment tools (youth self-report on delinquency, relationship with parents, emotional adjustment and number of school grades completed) indicated no difference between the two groups. Thus “children who had participated in parent training with their parents some years earlier were now functioning as well as late adolescents/young adults from the community” (p. 106). Since there was not an untreated control group though, the intervention cannot be assumed to be the reason for their current level of functioning.

Ruma, Burke, and Thompson (1996) explored whether behavioral parent training was equally effective for all ages of children. Utilizing a behavioral parent program administered in groups in various cities, they obtained the results of 206 mothers in a pre-post analysis. The parents (either self-referred due to having behavior problems with a child or referred by professional agencies or the court) attended classes which taught the skills of clear
communication, positive reinforcement and consequences, preventative and corrective teaching, self-control, and problem solving. When comparing the three age groups of children (early childhood, middle childhood, and adolescence), the results indicated that there were significant differences among these three groups of children. However, when examining the results the researchers found that it was not age, but the severity of the behavior problem which was the relevant factor. It was found that the older group of children had a less effective response; however, these children were also found to have a more chronic history of the disorder. These researchers suggested that “for children with more serious behavior problems, however, other services and treatment may be necessary to achieve clinical recovery” (p. 167). It is important to note that there was no control group and no random assignment to the treatment.

Serketich and Dumas (1996) indicate that “from it’s inception in the late 1960’s, behavioral parent training (BPT) has rapidly grown to become on of the most widely used therapeutic interventions for children and families” however, “BPT may be of limited effectiveness with families characterized by adverse sociodemographic characteristics” (p. 171). Thus the recommendation by Serketich and Dumas was that for these families this behavioral focus must be augmented by other approaches such as marital therapy, approaches which address parental depression, etc.

Behavioral Parent Training vs. Client Centered Approach

Thus while the behavioral parent training studies suggest that a behavioral focus can be a useful tool when assisting parents in difficult parenting jobs, researchers began to explore comparing this approach to a more client-centered approach. Kanigsberg and Levant (1988) attempted to explore the effectiveness of parent training as well as deal with one of the complaints frequently found in this research, which is the lack of standardization. This study utilized two treatment conditions (a behavioral skills group and a client-centered communication group) and one control group (no treatment received). Parents whose
children were in treatment at two mental health clinics were recruited for the treatment conditions (the parents were asked to participate in a parent education program) and then parents were randomly assigned to the two treatment groups; the control group consisted of those parents unable to attend the groups or randomly selected from the general clinic population. The behavioral skills group focused on clear rules and consistent consequences. The client-centered group focused on skills of empathy and genuineness and emphasized acceptance and respect for children. Both of the treatment groups operated from a systematic model focusing on skill development. The results showed that the "parent education groups were effective in changing some parent attitudes and children's self-concept, but not children's behavior as reported by their parents" (p. 159). The results further suggested, at a modest level, that the parents in the communication group felt more in control of their child's behavior at follow-up. These researchers suggested that helping parents to feel more in control with their parenting may be very valuable, even when this is not accompanied by a perception of an improvement in the child's behavior. Thus this study certainly speaks to the importance of parental perception.

Patterson, Chamberlain, and Reid (1982) completed a study comparing behavioral parent training at the Social Learning Center to regular treatment provided within the community. The parents in this study had a child ranging in age from three to twelve years old and described their child as being severely out of control. However, out of the initial 46 families that were referred, 10 of the families dropped out. Then 17 of the families were deemed to not have significant enough behavioral difficulties and these were dropped from the study. So 19 families were randomly assigned to either the treatment or the control condition. The control condition consisted of therapy provided by various practitioners in the community who operated from a variety of orientations (eclectic approach, behavior modification, Adlerian approach, structural family systems approach, and a combination of relaxation and physical exercise). The findings, which explored family interaction and the parental report of
the child’s problem behavior, supported the parent training at the Social Learning Center. However, these authors also looked beyond this significant outcome and indicated a concern regarding those parents who chose to drop out of the study. They suggested that “consistent outcome success requires the use of both parent training technology and a set of skills for dealing with client resistance, marital conflict and familial crisis” (p. 648).

Bernal, Klinnert, and Schultz (1980) expressed the noteworthy concern that although behavioral parent training is frequently identified as the treatment of choice for children with conduct problems, it had not been adequately compared with a condition representing the possible non-specific, maturation effects that could result from treatment. Therefore these researchers utilized a three group design: a behavioral parent training group, a client-centered group, and a wait list control group. The two treatment groups had random assignment of the subjects, while the wait list group was filled by therapist availability. In this study the “client-centered therapy was characterized by reflective statements intended to facilitate clarification of feelings and convey understanding and positive regard” (p. 682). The parents were paid for their participation in this study. The results showed that the behavioral parent training was superior (as assessed by verbal reports, observations, and self-report). Interestingly, the parental perception of improvement was highly significant for the behavioral approach, but the observational data did not show any differences between the three groups. And at 6-month follow-up “benefits reflected in parent reports and perceptions showed no maintenance over time of the superior effects of the behavioral relative to client-centered therapy, and the lack of differentiation between the two groups two years after treatment support” that “behavioral therapy was no more effective than client-centered therapy in reducing child conduct problems” (p. 688). These authors concluded with suggesting that rather than endorsing one type of treatment, these families may be better served with exploring which type of treatment for what type of family.
Enhanced Parent Training

Recognizing the value of moving away from the debate between a behavioral approach or a client-centered approach, the following researchers have focused on the value of integrating or enhancing various approaches. Wahler, Cartor, Fleischman, and Lambert (1993) attempted to enhance parent training with synthesis teaching. This synthesis teaching was to help parents "to separate their adult relationship problems from their child care problems" and become "more objective and sensitive observers of their own children" (p. 438). These 29 subjects were clinic referrals for oppositional and aggressive behaviors in the home and school settings as assessed by parental reports and scoring high on the externalizing behaviors category of the Achenbach (1991a) Child Behavior Checklist. In this study there were two conditions: parent training (the outline format was presented in the article), and parent training plus synthesis teaching (also an outline format was presented in the article, but this was more vague and individualized). This study utilized random assignment of subjects and independent observation which had high inter-rater reliability (this is unusual, as most of the studies utilize self-report methods). The authors were surprised that the raters were not able to find any significant effects for parents receiving the parent training. However, there were significant effects at the 6-month follow-up for parents in the synthesis teaching enhancement condition. These mothers were found to have a reduction in indiscriminate reactions (mothers discriminated more clearly between varying types of their child's misbehavior) and then the children of these mothers were found to have significantly reduced aversive behavior at the 1-year follow-up. It was suggested that sleeper effects may be present (that the subjects have a delayed positive response to the intervention). This study also seemed to suggest that whether or not change is assessed by external raters, what counts is the parent's subjective experience.

Focusing on child temperament and the need for a "good fit" between parental demands and child temperament, Sheeber and Johnson (1994) completed a study with 40
mothers of young children. Participants met the criteria of having a child (nonclinical) whom they perceived with extreme temperament difficulties on at least 3 out of 7 dimensions. Recruitment of subjects occurred by distributing fliers to preschools and utilizing local publications. Subjects were randomly assigned to either the temperament-focused, parent training (which would assist parents to understand and tailor their parenting to fit with their child's temperament) or a wait list control group. The parent training program was a group experience which had an identified objective for each session. There were eight different self-report assessment tools which provided results supporting the effectiveness of a temperament-focused, parent training program. However, it is difficult to know just what aspect brought about the positive effects of comfort in parental role, improved family functioning and parents' reduced perception of their child's disruptive behavior - whether it was the behavioral focus, the temperament focus or the combination. Again it is noted to be unclear whether the parents were more effective in managing their child's behavior or whether they just became more tolerant of their child's behavior.

Dadds and McHugh (1992) attempted to "enhance the effects of behavioral parent training for socially isolated, disadvantaged single parents of conduct problem children" (p. 252). Their goal was to alter the isolation and assist parents with experiencing an ally in their parenting endeavor. Twenty-two parents responded to advertisements for single parents who felt isolated, unsupported in their parenting, and were experiencing problems with managing their child. All children met the criteria of a behavior disorder (oppositional defiant or conduct disorder of DSM-III-R). There were three types of outcome assessments used: observations by researchers, self-report, and parent observations of their child. These parents were randomly assigned to child management training or child management training plus ally support training (where the ally was a person who was selected by the parent and agreed to be responsive to the parent on a weekly basis). Both groups showed results indicating some improvement in their child's behavior, a decrease in depression of the parents, and both
groups showed that their improvement was maintained at a 6 month follow-up. However, when more stringent outcome requirements were utilized (that parents reported a 50% reduction in their child's problem behaviors), only 50% of the parents indicated this level of success. It was found that the families who did experience this level of success had reported a significantly greater perception of social support from their own friends. However “having an ally failed to produce significantly different results from child management training alone” (p. 256). The authors speculated that the lack of significant findings could have been due to that the ally social support condition failed to operationalize true social support with its characteristic spontaneity. Also the authors further considered that since both groups received parent training in a group format and participants were encouraged to be supportive of one another; this may have diluted any affects that the ally support condition may have provided.

Hampson, Schulte, and Ricks (1983) completed a study which also utilized a combined parent training (behavioral parent management plus a reflective component), but then wanted to explore whether the parent training should be administered through a group format or individually to each family. These researchers utilized parent training to assist 18 foster families in dealing with the problem behaviors of their foster child. The combination of a behavioral parent training with a reflective training approach was delivered on both an individual basis and a group basis. The behavioral aspect focused on the principles of behavior modification while the reflective training focused on opening up communication, accepting, and understanding one another. Both conditions (group and individual) employed basic texts to facilitate the learning process. The researchers allowed some of the parents to choose the type of group they wanted, and the rest were randomly assigned to the treatment conditions. The outcome assessment tools where quite varied and included a parent attitude survey, behavioral vignettes, an expectation/evaluation questionnaire, and behavioral observations. The findings showed all the parents gained significantly in their knowledge,
attitudes, and ratings of perceived family functioning. They also found a modest significant difference in the effectiveness of the individual training over group training for both the short-term and 6 month follow-up. However, the study did not have control group comparisons (to see if parents would have also shown an improvement in attitudes just by being on a waiting list) and so these findings are difficult to interpret.

**Multimodal Approach**

Recognizing the diverse needs of youth with chronic behavior disorders, the following researchers have advocated a multimodal approach. These researchers suggest the importance of operating from a socio-ecological approach. A study conducted by Bank, Marlow, Reid, Patterson, and Weinrott (1991) suggested that intensive parent training can have a positive effect on families of chronic delinquents for reducing offense rates and incarceration. The treatment consisted of a manualized approach and the random assignment of 60 chronic delinquents to either an intensive parent-training treatment or to intensive service provided by the juvenile court. Once again, the researchers hypothesized it was not so much the altering of the child’s behavior, but of the parent’s behavior, that made the difference. The researchers suggested that “perhaps the main outcome of the treatment was to help the parents remain actively involved and responsible for the conduct of their boys” (p. 30). However, since the researchers did not directly assess the level of parental monitoring, this interpretation is not supported by this study. The applicability of this study was questioned by the researchers as to whether it would be feasible to implement such a program due to the intense level of service that they provided.

Zarski and Fluharty (1992) completed a study comparing a home-based intervention and an outpatient treatment for youth whose behavior was concerning to their families to such a degree as needing crisis intervention. The 70 families who participated in this study were provided monetary compensation. There were 36 families that had presented for home-based services and thus were in the treatment group; while 34 families had presented for outpatient
treatment at various clinics and served as the comparison group (they were not matched with the treatment group). The home-based intervention consisted of a variety of intensive services including crisis intervention, family focused services, parent training, family therapy, social casework, and time-limited services. The results showed no real differences as "the gains made by both groups were similar" (p. 347). The authors suggested the findings showed "there was a relationship between changes in family functioning and changes in child functioning" (p. 346).

Henggeler, Meton, and Smith (1992) completed a study with 84 juvenile delinquents who were at risk for out-of-home placement and had serious criminal involvement. The intervention was multisystemic treatment and this was described as being based largely on family system conceptualizations which "emphasizes reciprocity of interpersonal relations and posits that child behavior problems typically reflect dysfunctional family relations" (p. 955). There was a random assignment between this treatment condition and the usual-services condition with court process and the probation officer. With no more specifics regarding the actual treatment condition, it was noted that the average length of treatment was 13.4 weeks with 33 hours of direct contact and 24 hour case coverage. There were a variety of assessment tools utilized. The researchers did find that the multisystemic approach resulted in fewer arrests, incarcerations, and stronger family cohesion. This was a strong study methodologically except for the difficulty with replicating the treatment condition or grasping just what may have been effective in the multisystemic approach due to the lack of specific information regarding the treatment process.

It is important to realize that treatment for children with disruptive disorders can occur in a variety of settings. Grizenko et al. (1993) noted that "unlike outpatient treatment, day treatment is an intensive intervention that for severely affected children, cuts down on treatment time, reducing the risk of dropouts. Day treatment for children with behavior disorders is a promising modality..."(p. 128). The study by Grizenko et al. (1993) focused on
the premise that the problems of behavior disordered children are multidimensional and therefore require various types of therapy including family therapy. There were 30 children in a waiting list group and 30 children who were in a day treatment program. All of the children fit the criteria for behavior disorders and had been referred to the program as they were no longer able to function in their homes and school settings. The researchers found significant improvement with the treatment group as compared to the waiting-list control group. A strength of this study was that they utilized a variety of behavior, self-perception, academic, peer relations, and family functioning assessment tools; however, one methodological issue was the lack of random assignment of the clients to the two conditions (it was noted that the treatment condition was filled first). The treatment consisted of “multi-modality therapy with a psychodynamic orientation” (p. 129) which included daily special education, daily psychotherapy (individual play therapy, social skills and task groups, psychodrama, pet, art, occupational, and group therapies), and weekly family therapy. Results indicated high statistical significance for the treatment condition on improved behavioral functioning and improved self-perception. However, there were no treatment effects found for improvement in peer relations, family functioning, or academic performance. Unfortunately, it seems that the positive effects were not generalized to the greater spheres of peers, family, and school performance.

**Parental Views of Parent Training**

Since all of the previous studies noted a heavy reliance on parent training, it seemed appropriate that the following researchers examined this from a very different angle. Webster-Stratton and Spitzer (1996) completed a qualitative study which explored the subjective experience of undergoing the parent training experience. These researchers suggested that “while the end product of parent training has been well researched, the process has not” (p. 12). Thus these researchers wanted to explore the parents’ subjective experience, to explore
the impact of the therapeutic process and thus they moved from the quantitative focus on the outcome to a qualitative focus on the process.

These researchers held 20-24 weekly meetings of five different groups of parents (totaling 30 mothers and 30 fathers) that were videotaped. Then the parents were interviewed midway and at the end of treatment for their specific opinions regarding the progress of therapy. After reviewing a great deal of qualitative data, the researchers found two main themes regarding these parents’ experience. They found a nonlinear process of progress (that there was a setback midway through the process) and that specific cognitive shifts were made which included:

- reframing the child’s behavior as a matter of temperament and developmental phase;
- abandoning blame and guilt as a model and substituting the need for special parenting skills; incorporating the ideas of self-care and ongoing support as elements in one’s own stability and well-being; arriving at a view of oneself as competent, though imperfect, rather than a victim or failure - these are the cognitive shifts that we discovered. (p. 47)

These researchers further theorized that this was the process that clients went through to arrive at a new view of themselves as competent. Webster-Stratton and Spitzer further suggested that knowing this type of information could assists clinicians to better serve clients, such as preparing clients for the likely setbacks that are part of progress (the nonlinear progress) and fostering competency.

Webster-Stratton and Spitzer described the inductive process of building towards a theoretical construct by utilizing the qualitative approach. They described breaking the transcripts into small meaningful units, then beginning to pull the meaningful units together into categories, and last developing theoretical integration of these categories. The end result is to develop knowledge from the clients’ perspective regarding the process of therapy.
Summary

A review of the literature which addressed the clinical needs of this population revealed several consistent themes for treatment and intervention as well as limitations regarding this research. There is a consensus of the importance of including the parental subsystem in the treatment process of youth with behavior disorders. The research suggested that assisting parents to gain a feeling of mastery or competency may be a key whether or not there is actual change in the child’s behavior. This would seem to suggest that if parents are more confident and prepared, they may be more tolerant or less reactive. This may then impact positively on the parent-child relationship.

And while the interventions ranged from behavioral to client-centered to a combination of these, it seemed that no one method stood out as the definitive treatment. It may be that both the behavioral and the client-centered approaches are viable and need to fit the therapist style, the family type, and the severity of the problem.

Most of the research that has examined the parental involvement in the treatment of youth with conduct or behavior disorders has been from a quantitative methodology. This research paradigm has been compatible with the parent training interventions which have a strong behavioral focus. Thus with the strong behavioral aspect to parent training there has been less difficulty with meeting the standards of the quantitative methodology (such as manualized treatment, objective and behavioral outcome assessment, and replicability), and therefore these studies seem to have stronger merit when compared to client centered treatment interventions. However, even though there is strong support for the behavioral parent training, there is also a recognition of the limitations of this approach to meet all of the needs of this population. Researchers indicate a concern with engaging clients, with resistance, and with less than favorable treatment outcome. Therefore it seems a necessity to continue to explore effective means to treat this population. As suggested by Miller and Prinz (1990):
The ontogeny of social learning-based treatment for childhood conduct disorder is at a theoretical crossroads. One apparent path is the continued expansion of interventions and target behaviors to broaden models within the social learning framework. The other path involves a paradigm shift or at least the amalgamation of social learning theory with other theoretical perspectives to better explain and treat childhood conduct disorder. It might be argued that a paradigm shift is needed based on the view that social learning theory alone cannot account for childhood conduct disorder (pp. 301-302).

Thus the suggestion of a paradigm shift may be a way to expand the knowledge base. One example of this was the study by Webster-Stratton and Spitzer (1996) who utilized a qualitative paradigm instead of the usual quantitative paradigm. Thus this focus on the process of therapy rather than the sole focus on the outcome of therapy may produce new and useful information. Utilizing a more exploratory, inductive approach of qualitative methods seems to acknowledge that “we know very little about the interplay of various family variables and the etiology and treatment of conduct disorders in children” (Griest & Wells, 1983, p. 49) and this may assist with ultimately expanding our knowledge.
CHAPTER 3. METHODOLOGY

Introduction

The purpose of this study was to explore whether assisting parents in a therapy group to review their past, to identify and utilize a parenting strength, and to voice their hopes and fears to their child could be a valuable adjunct to a behaviorally based day treatment program. In an attempt to expand treatment beyond the behavioral paradigm, this parent therapy group intervention was designed to operationalize elements of attachment theory and narrative therapy and focused on the development of a coherent story. This intervention attempted to not duplicate the current provision of treatment which included daily social skills training, individual therapy, family therapy, and youth group therapy. Since this was a pilot study which incorporated new theoretical constructs for working with this population, two approaches to evaluate the effectiveness of this intervention was utilized. The first approach was a quantitative analysis involving a repeated measures design, specifically a split-plot design. The clients of a day treatment program were randomly assigned to one of the two treatment conditions (the enhanced treatment and the regular treatment condition) and the results of the clients' pretest and posttest responses to the Child Behavior Checklist (Achenbach, 1991a) and the Parent Attitude Survey (Hereford, 1963) were analyzed statistically. These two assessment tools were used to assess changes regarding parental perception of child behavior problems and parental attitudes.

The second approach used to evaluate the effectiveness of the parent therapy group was a qualitative aspect which analyzed the clients' written responses to several open-ended questions. This qualitative aspect was utilized in this study since this researcher was attempting to explore a new way of conceptualizing and working with these clients (there had been no research found utilizing narrative therapy or attachment theory regarding a coherent story with this specific population in a group therapy intervention); therefore, it seemed wise to not only utilize traditional methods to assess outcome but also an approach which might
provide additional insight to a pilot study. Thus the parents who attended the parent therapy group were asked to describe their parenting goals, their hopes, and their fears for their child both at pretest and at posttest. Also at posttest the parents were asked to provide an evaluation of their group experience. These responses were initially broken down into meaningful units by the researcher. Then three raters compiled the responses into categories and eventually attempted to develop a theoretical explanation of the parents' experience in the group.

**Subjects**

The subjects in this study were obtained from the roster of a day treatment program in the Midwest. All of the parents (two were grandparents in a parenting role) had a child who was unable to be maintained in a regular school environment due to severe behavior problems and the families had found prior outpatient treatment unsuccessful. All of the primary caregivers were female. The children had a clinical diagnosis of one of the disruptive behavior disorders, had all been staffed 3.6 BD in the school system, and were scheduled to attend the Fall 1996 program. All of the children selected for this study were male except for one female student. The 25 student names were randomly assigned to either the regular treatment condition or the enhanced treatment condition.

In the regular treatment condition one student did not attend the program as planned, one parent did not comply with completing the pretest data, and one parent was not able to complete the posttest data due to injury. These three subjects were dropped from the study. This left nine parents in the regular treatment condition who completed the pretest and posttest data collection.

In the enhanced treatment condition 13 students began the program; however, three parents refused to participate in the study and were dropped from the study. This left 10 parents in the enhanced treatment condition. All of these 10 parents completed the pretest data collection, but only eight agreed to participate in the parent therapy group. Of these
eight parents, two of the parents did not participate in the parent therapy group because their children were subsequently placed in another school or program. This left six parents to participate in the enhanced treatment condition, although seven parents participated in the parent therapy group (one was a spouse of the primary caregiver). Thus the total number of subjects for this study was six parents in the enhanced treatment condition and nine parents in the regular treatment condition. The demographic descriptors of these parents and children are listed in table form for ease of comparison (see Table 1).

**Independent Variables**

The quantitative aspect of this study used the two levels of treatment (regular treatment or enhanced treatment) and two levels of time (time at pretest and posttest) as the independent variables. This study examined whether there were any differences between the treatment of a parent therapy group and no parent therapy group. The parent therapy group was a new component to this day treatment program as there had never been a group for the parents. The parent therapy group was designed as a relatively short intervention since these parents were already involved in other aspects of the program. These families were identified by the staff as having multiple problems and likely to have difficulty committing to a long-term intervention. Therefore a five week parent therapy group was selected. Each weekly session would last approximately 1 1/2 hours and recreational therapy time was provided by the staff recreational therapist for the children whose parents attended the parent therapy group.

An agenda was utilized as a guide for the sessions (see Appendix A). The first session was primarily designed to build comfort within the group setting, to explore commonalities of parents with children who have behavior disorders, and discuss that the group would focus on their parenting strengths. The second and third sessions focused on assisting the parents with identifying a positive parenting strength, exploring parenting messages from their past, and focusing on a coherent story. Each parent was encouraged to discuss how one needs to adjust parenting depending on the temperament of the child and to recognize societal impacts on the
Table 1: Demographic information

<table>
<thead>
<tr>
<th>Regular Treatment condition</th>
<th>Enhanced Treatment Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ethnic group</strong></td>
<td><strong>Ethnic group</strong></td>
</tr>
<tr>
<td>African American=2</td>
<td>African American=1</td>
</tr>
<tr>
<td>Caucasian=7</td>
<td>Hispanic=1</td>
</tr>
<tr>
<td></td>
<td>Caucasian=4</td>
</tr>
<tr>
<td><strong>Caregiver’s relation to child</strong></td>
<td><strong>Caregiver’s relation to child</strong></td>
</tr>
<tr>
<td>Actual biological parent=8</td>
<td>Actual biological parent=4</td>
</tr>
<tr>
<td>Grandparent of child=1</td>
<td>Grandparent of child=2</td>
</tr>
<tr>
<td><strong>Age of caregiver</strong></td>
<td><strong>Age of caregiver</strong></td>
</tr>
<tr>
<td>30-35=5</td>
<td>25-30=1</td>
</tr>
<tr>
<td>36-45=2</td>
<td>31-35=1</td>
</tr>
<tr>
<td>46-60=1</td>
<td>36-40=2</td>
</tr>
<tr>
<td>&gt; 60=1</td>
<td>&gt; 50=2</td>
</tr>
<tr>
<td><strong>Highest education level of caregiver</strong></td>
<td><strong>Highest education level of caregiver</strong></td>
</tr>
<tr>
<td>&lt;12th grade=2</td>
<td>&lt;12 grade=2</td>
</tr>
<tr>
<td>12th grade=3</td>
<td>12th grade=2</td>
</tr>
<tr>
<td>some college=4</td>
<td>some college=2</td>
</tr>
<tr>
<td><strong>Marital status of caregiver</strong></td>
<td><strong>Marital status of caregiver</strong></td>
</tr>
<tr>
<td>Single=1</td>
<td>Single=1</td>
</tr>
<tr>
<td>Married=4</td>
<td>Married=4</td>
</tr>
<tr>
<td>Divorced=2</td>
<td>Divorced=2</td>
</tr>
<tr>
<td>Separated=1</td>
<td></td>
</tr>
<tr>
<td>Widowed=1</td>
<td></td>
</tr>
<tr>
<td><strong># of adults in the home</strong></td>
<td><strong># of adults in the home</strong></td>
</tr>
<tr>
<td>1 adult in the home=3</td>
<td>1 adult in the home=1</td>
</tr>
<tr>
<td>2 adults in the home=5</td>
<td>2 adults in the home=5</td>
</tr>
<tr>
<td>3 adults in the home=1</td>
<td></td>
</tr>
<tr>
<td><strong>Both biological parents in the home?</strong></td>
<td><strong>Both biological parents in the home?</strong></td>
</tr>
<tr>
<td>Yes=3</td>
<td>Yes=0</td>
</tr>
<tr>
<td>No=6</td>
<td>No=6</td>
</tr>
<tr>
<td><strong>Income level</strong></td>
<td><strong>Income level</strong></td>
</tr>
<tr>
<td>&lt;10,000=2</td>
<td>&lt;10,000=1</td>
</tr>
<tr>
<td>10,000-20,000=3</td>
<td>10,000-20,000=2</td>
</tr>
<tr>
<td>20,000-40,000=4</td>
<td>20,000-40,000=2</td>
</tr>
<tr>
<td>&gt;40,000=1</td>
<td>&gt;40,000=1</td>
</tr>
<tr>
<td><strong>Age of child in program</strong></td>
<td><strong>Age of child in program</strong></td>
</tr>
<tr>
<td>11 yrs old=2</td>
<td>&lt;11 yrs old=1</td>
</tr>
<tr>
<td>12 yrs old=2</td>
<td>11 yrs old=1</td>
</tr>
<tr>
<td>13 yrs old=3</td>
<td>12 yrs old=2</td>
</tr>
<tr>
<td>14 yrs old=2</td>
<td>13 yrs old=2</td>
</tr>
<tr>
<td><strong># of siblings child has</strong></td>
<td><strong># of siblings child has</strong></td>
</tr>
<tr>
<td>0 siblings=1</td>
<td>1 sibling=1</td>
</tr>
<tr>
<td>1 sibling=3</td>
<td>2 siblings=2</td>
</tr>
<tr>
<td>2 siblings=2</td>
<td>3 siblings=2</td>
</tr>
<tr>
<td>3 siblings=1</td>
<td>4 siblings=1</td>
</tr>
<tr>
<td>&gt;5 siblings=1</td>
<td></td>
</tr>
<tr>
<td><strong>Gender of child</strong></td>
<td><strong>Gender of child</strong></td>
</tr>
<tr>
<td>Male=9</td>
<td>Male=5</td>
</tr>
<tr>
<td>Female=0</td>
<td>Female=1</td>
</tr>
</tbody>
</table>
family system and the child with a behavior disorder. The fourth session provided an opportunity to discuss the parenting process of influencing or teaching the child from the identified parenting strength. Parents were asked to think about their hopes and fears for their child as this would be discussed with their child in the last session. The last session involved a summary of the group process and then the youth were brought into the session for each parent to share his or her hopes and fears for his or her respective child. The main emphasis of this process was for all to recognize the potential of each child. The group then focused on a closing process and ended with eating a meal together.

The researcher conducted each session of the therapy groups. The researcher had worked at this day treatment program in the past, but had ended employment with the facility six months prior to the study. The researcher had 8 years of post-Masters clinical experience.

**Dependent Variables**

The dependent variables in the quantitative part of this study were the parents’ perceptions of their child’s behavior as assessed by the Child Behavior Checklist (CBCL) (Achenbach, 1991a) and the parents’ attitudes as assessed by the Parent Attitude Survey (Hereford, 1963). These dependent variables were examined for any differences between the two treatment conditions (regular treatment and enhanced treatment).

**Quantitative Instruments**

The two tools utilized for the pre-and post-test assessments of the quantitative part of this study were the Child Behavior Checklist (Achenbach, 1991a) and the Parent Attitude Survey (Hereford, 1963). The Child Behavior Checklist (CBCL) (see Appendix B) is composed of two parts. The Social Competence Scale has 20 items that “obtain parents’ reports of the amount and quality of their child’s participation in sports, hobbies, games, activities, jobs and chores, and friendships; how well the child gets along with others and plays and works alone; and school functioning” (Achenbach, 1991b, p. 16). There are 118 problem items that are scored on a three step response scale (0, 1, 2).
following normed scales: the withdrawn scale, the somatic complaint scale, the anxious/depressed scale, the social problem scale, the thought problem scale, the attention problems scale, the delinquent behavior scale, and the aggressive behavior scale. These scales load onto three main syndromes: the internalizing syndrome (which is composed of the withdrawn scale, the somatic complaints scale, and the anxious/depressed scale), the externalizing syndrome (which is composed of the delinquent behavior scale and the aggressive behavior scale), and neither the internalizing nor externalizing syndrome (which is composed of the social problems scale, the thought problems scale, the attention problems scale, and the sex problems scale). However, a global assessment of all of these behavior problems is the Total Behavior Scale which is also normed and composed of the total behavior score (which is the sum of all the problem item responses). This total behavior score is described by Achenbach (1991b) as useful “for assessing change as a function of time or intervention” (p. 232). Therefore this study utilized the total behavior score (which is the Total Behavior Scale) as a means to obtain a global assessment of the parent’s perception of their child’s behavior problems. The CBCL is a widely used parent-report tool designed to assess behavior problems in 4- to 16 year-old-children. This assessment devise has a strong empirical base and noted “to be sensitive to treatment changes arising from parent-training interventions” (Sheeber & Johnson, 1994, p. 252). Achenbach (1991b) reported that “the inter-interviewer and test-retest reliabilities of the CBCL item scores were supported by intra-class correlations in the .90s” and the “test-retest reliability of the CBCL scale scores were supported by a mean test-retest r=.87 for the competence scales and .89 for the problem scales over a 7 day period” (p. 81). In terms of validity the Total Problem Scale has a correlation of .82 with the Conners (1973) Parent Questionnaire and .81 correlation with the Quay-Peterson (1983) Revised Behavior Problem Checklist (as cited in Achenbach, 1991b). Achenbach (1991b) further suggested that there should be a minimum of two months between
repeated testing of the same subjects. It was estimated that this checklist could be completed in 15-20 minutes.

The Parental Attitude Survey (Hereford, 1963) (see Appendix C) was designed to assess changes in parents’ attitudes toward their children following parent training that utilized a group discussion process. This instrument has 75 items that require parents to identify strength of agreement or disagreement (five-point scale) and attempts to determine parental attitudes on five scales: confidence in the parental role, causation of the child’s behavior, acceptance of the child’s behavior and feelings, mutual understanding, and mutual trust. The Total Scale Score (which was the sum of the five scales) was used in the statistical analysis of this study. Hereford (1963) indicated interscale correlations ranging from .33 to .62 and that these “correlation coefficients were high enough to indicate that all the scales were measuring related parent attitudes, but not so high as to suggest duplication” (p. 57). The split-half reliability was indicated to range from .68 to .86 on the five scales. In reviewing this scale Brand and Ellis (1991) indicated that “practitioners involved in parent education and counseling may well use the Hereford with confidence” (p. 437) and cited that the results of 16 studies “confirmed the sensitivity of the Hereford in measuring changes in parental attitudes after intervention” (p. 435). Kanisberg and Levant (1988) indicated that “the Hereford Parent Attitude Survey is one of the most widely used among the few parent attitude scales in existence” (p. 156). This survey was noted to take approximately 15-20 minutes to complete. Each parent was also asked to complete a personal data sheet (see Appendix D).

Qualitative Instrument

In addition to the above quantitative aspect of this study, the parents who attended the enhanced treatment (the parent therapy group) also completed several open-ended questions and these responses were analyzed with a qualitative process. These responses were examined for any themes of change regarding the way that the parents described their parenting goals as well as their hopes and fears for their child from pretest to posttest. These
parents were also asked to evaluate the parent therapy group. These responses were examined for common themes with how the parents described their experience of the group. Then these themes were used to assist in developing a theoretical explanation for the parents' experience of the group. The first set of open-ended questions which were used in this study asked the parents to describe their parenting goal and to identify their hopes and fears for their child (see Appendix E). The second open-ended question asked the parents to evaluate the parent therapy group and to indicate whether they would recommend it for other parents in the program (see Appendix F).

**Procedure**

The nonrandom list of students enrolled for the fall term of the day treatment program was randomly assigned to either the regular treatment condition or the enhanced treatment condition utilizing a random number table. Each parent was contacted and an appointment was set either at the therapy office or at their home. If there was no phone available, an introduction letter was sent home to the parents with their child and a follow-up visit was made to their home. All parents were informed of the purpose of the research project by providing them with the introduction letter for either the enhanced treatment (see Appendix G) or regular treatment (see Appendix H) and informed of confidentiality. If the parent was willing, the pretest was given at that time or another time was arranged. Five of the parents asked to have the pretest information given to them to complete at home by themselves. Seven of the parents preferred to have the researcher come to their home for the pretesting while the rest came to the therapy office to complete the pretest. At the time of the pretesting the parents that were in the enhanced treatment condition were told of the parent therapy group, asked for their time preference for a group, and asked to sign the consent form to participate in the group (see Appendix I). They were told they would be contacted once the time of the group was established which would be after considering the time preferences of all the parents. The pretesting took approximately 45 minutes to 1 hour, although some took
more time particularly if the parents were in the enhanced treatment group. All parents were informed that I would again be contacting them to complete the posttesting in about two months.

Due to the parents' time preferences, two weekly group times were offered (one at 10 a.m. and one at 6 p.m.) and all were reminded that their children could come for a recreation time with the program's recreation therapist. The children were also informed of this "bonus" recreation time that would be available if their parent attended the parent group. Since the children whose parents attended the morning group were already involved in the day treatment program, they were told that their "bonus" recreation time would be worked around their school and therapy schedule and this time varied weekly. The children whose parents attended the evening group, were invited to attend with their parent and would go into their own recreation time while their parent attended the parent therapy group.

Once the groups were established all parents were contacted as to the time and location of the groups plus reminder notices were sent home each week with their children. When a parent did not show for a group, the parent was contacted and encouraged to participate. Each group was provided with a snack (the morning group had rolls and juice) while the evening group had a snack for parents as well as the children since the children then went on to their recreation time. At the last group a meal was provided to the families which consisted of pizza and pop.

Collection of Data

Approval for this experiment was obtained from the Human Subjects Research Committee, the principal investigator's Program of Study Committee, and the Chairperson of the Department of Education (see Appendix J). Further approval was obtained from the hospital program which was the provider of the therapy services for this day treatment program and the school program. All subjects were informed of their rights to participate. If they completed the pretest and posttest data only (the regular treatment condition), their
willing completion of the forms served as their consent to participate. All subjects who participated in the enhanced treatment condition (the parent therapy group) signed a voluntary consent to participate form which was retained by the experimenter. The same parent was asked to fill out the pretest and posttest data.

It took two weeks to complete all of the pretesting. The morning parent therapy group began the next week; however, the evening parent therapy group began the following week due to only one person attending that first night.

**Quantitative Design**

A repeated measures design was utilized to compare the enhanced treatment condition and the regular treatment condition. Specifically this would utilize the split-plot ANOVA or a mixed model and is diagrammed in Figure 1.

\[
\begin{array}{c}
A_1 \\
A_2 \\
B_1 \\
B_2 \\
S_1 S_2 S_3...S_6 \\
S_1 S_2 S_3...S_6 \\
S_7 S_8 S_9...S_{15} \\
S_7 S_8 S_9...S_{15}
\end{array}
\]

A=2 treatment levels (enhanced treatment and regular treatment)  
B=2 levels of time (pretest and posttest)  
S=Subjects

Figure 1: Split-plot Design

This design attempted to determine if there were any statistical differences between the two treatments. Thus utilizing an analysis of variance it was possible to examine statistically whether there is a difference between the enhanced treatment condition and the regular treatment group as assessed by the Child Behavior Checklist (Achenbach, 1991a) and the
Parent Attitude Survey (1963). As noted by Kirk (1982) this design is particularly useful when interested in the interaction of the two variables which in this study is the treatment by time interaction.

Qualitative Design

A qualitative approach was utilized to examine the parents' written responses to several open-ended questions. This analysis was an attempt to learn about the parents' experience of the parent therapy group and whether there was a change in the way the parents described their parenting goals and their hopes and fears for their children following their participation in the parent therapy group. This qualitative approach was utilized since this was a pilot study and this researcher wanted to gather information regarding this therapeutic experience from an alternative method of investigation.

Quantitative Analysis of Data

The quantitative component to this study provided an analysis of the data collected by the Child Behavior Checklist (Achenbach, 1991a) and the Parent Attitude Survey (Hereford, 1963). The Child Behavior Checklist was utilized to assess the parents' perception of their child's behavior problems and this researcher utilized the Total Problem Scale which is composed of the total behavior score (the sum of all the problem item responses). The Parent Attitude Survey was utilized to assess change in parental attitude. The Parent Attitude Survey which is composed of five scales (confidence in parenting role, causation of the child's behavior, acceptance of the child's behavior and feelings, mutual understanding, and mutual trust) provided a Total Scale Score (which was the sum of the five scales) for the statistical process of this study. An analysis of variance (ANOVA) was completed first to test for the independence of the two groups at pretest, a stem and leaf plot was utilized to ensure the appropriateness of parametric statistics, and then an ANOVA was used to check for treatment effects. The SAS computer package (SAS Institute, 1990) was utilized, specifically by
utilizing the General Linear Model due to the uneven number of subjects in the cells. And last a test for simple effects was completed.

**Qualitative Analysis of Data**

The qualitative component of this study provided for further analysis of the clients' experience of the therapy group. Clients were asked for their responses about their parenting goals and their hopes and fears for their child both at pretest and at posttest. The qualitative analysis explored these data for any thematic differences in the way that the parents responded prior to the group compared to after their group experience at posttest. This same qualitative process was used to analyze the clients' responses regarding their evaluation of the group experience. The thematic, inductive process of compiling categories and then integrating these categories is thoroughly described by Lincoln and Guba (1985) as well as Webster-Stratton and Spitzer (1996). Since this was a pilot study which attempted to assist parents with moving out of a problem-saturated definition to one of empowerment, this study limited the qualitative scope to specific aspects of the parental experience. Thus this thematic process was utilized in the examination of the parents' responses to several open-ended questions.

The qualitative process utilized to analyze these written responses was to first break the responses down into small meaningful units. This researcher went through each written response and put the smallest, complete meaningful thought on separate index cards. Then a team of three raters (one of which was the researcher) was organized to jointly analyze these meaningful units. As noted previously the researcher had eight years of post-Masters clinical experience. The other two raters had their doctorates in the counseling field and one had over 10 years of post-doctorate clinical experience while the other had over 5 years of post-Masters clinical experience. These two raters were completely independent of this research project and neither worked at the day treatment program where the research occurred. Both were familiar with qualitative research and one had completed his doctorate utilizing
quantitative methodology and the other had significant experience working with children with behavior disorders.

First the raters compared each persons' pretest and posttest responses to explore any difference in the way that the parents described their parenting goals and hopes and fears for their child. Each parent's pretest and posttest responses were lined up so as to facilitate this compare and contrast process. Each of the raters identified their thoughts about the differences between the pretest and posttest responses and a discussion followed which served to clarify, and judge the appropriateness of whether the theme differentiated the pretest and posttest responses. Once a consensus was reached, then this thematic difference was written down. This compare and contrast process was completed with each client's pretest and posttest responses.

Next the raters went through each client's group evaluation responses and looked for themes. Again the discussion process was utilized until a consensus was reached and then these themes were also written down. Then the raters reviewed all of the themes that were written down to begin to integrate these themes and build a theoretical perspective. A discussion occurred until the three raters felt satisfied that they had accounted for all of the themes.
CHAPTER 4. RESULTS

Quantitative Analysis

The purpose of this study was to investigate the impact of enhancing an already existing day treatment program for youth with severe behavior disorders. The intervention consisted of a short-term parent therapy group which operationalized elements of attachment theory and narrative therapy and then compared this to the program's regular treatment. This group focused on assisting parents (1) to review their past for a coherent story, (2) to identify and utilize a parenting strength, and (3) to voice their hopes and fears to their child with an emphasis on the child's potential. The quantitative methodology involved utilizing a repeated measures design, specifically a split-plot design. From a list of parents whose children would be in the program, there was a random assignment of the parents to one of two treatment conditions (regular therapy as provided at the day treatment program and the enhanced treatment condition which was regular therapy plus the parent therapy group). All of the parents were asked to complete a pretest and posttest of the Child Behavior Checklist (Achenbach, 1991a) and the Parent Attitude Survey (Hereford, 1963). This was an attempt to explore whether the parent therapy group had any impact on changing the parents' perception of their child's problem behavior or their parental attitudes.

Differences between the groups

The first statistical analysis which was completed was an ANOVA for each of the dependent measures to explore whether there were any group differences at the time of pretest. The result of these ANOVAs showed there were no significant differences between...
the two treatment groups. Therefore at pre-test the two randomly assigned groups were statistically equal. This lack of significant difference is shown in Table 2.

**Parametric statistics**

Examining the stem and leaf plot of both variables suggested that the values reasonably approximated normality even with such a small sample size. Therefore this researcher utilized parametric statistics for the analysis of these data.

**Graph of the means**

Graphing the means of the two dependent variables by time provided the following pictorial representation of the results which is displayed in Figure 2.

<table>
<thead>
<tr>
<th>Dependent variable</th>
<th>F Value</th>
<th>Pr&gt;F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Behavior Scale (CBCL)</td>
<td>.05</td>
<td>.8330</td>
</tr>
<tr>
<td>Total Parent Attitude Scale (PAS)</td>
<td>.77</td>
<td>.3966</td>
</tr>
</tbody>
</table>

Figure 2: Graph of the two groups on the dependent variables by time
The first graph of the means at pretest and posttest (time1 and time2) indicate that both of the groups' mean scores improved for the Child Behavior Checklist. Since the means decreased for both of the groups, this would indicate there was a mean decrease in the parental reporting in child behavior problems for the two groups of parents and thus no treatment effect was present. Graphically it can be seen that there was no interaction between treatment and time and only a time effect is evident (over time both groups improved). For the second graph there does seem to be a slight difference between the two groups (the enhanced group had a slight mean decrease in their scores while the regular treatment group had a slight increase in their scores on the parent attitude survey), but it was not sufficient to be statistically relevant (as determined by the ANOVA results below).

Results of the ANOVA

An ANOVA was completed for the two dependent variables to explore for treatment, for time, and for treatment by time interaction effects. The results indicated no effects for treatment (no difference between the two groups) and no treatment by time interaction effects (no differences in the groups from pretest to posttest) for either of the two dependent variables. However, there was a significant time effect for the results of the Child Behavior Checklist. Thus all of the parents showed a significant change over time on the Child Behavior Checklist for both treatment groups. A summary of these ANOVA results are listed in Table 3. Therefore, the researcher's first two hypotheses:

1. ...that while all of the parents will have a reduction in their perception of their child’s behavior problems; those parents that attend the parent therapy group will have a significantly greater reduction of perceived behavior problems as assessed
by the Total Problem Scale of the Child Behavior Checklist (Achenbach, 1991a);
and

2. ...that the parents who attend the parent therapy group will have a greater focus on their strengths and have a higher total score on the Parent Attitude Survey were not supported.

Table 3: ANOVA results

<table>
<thead>
<tr>
<th></th>
<th>F statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Group Effect</td>
</tr>
<tr>
<td>CBCL</td>
<td>.003</td>
</tr>
<tr>
<td>PAS</td>
<td>.313</td>
</tr>
</tbody>
</table>

***p>.001

These results are consistent with the graph of the means in Figure 2 which indicated a time effect for the Child Behavior Checklist (CBCL). This was further verified by a test for the simple effects (even though there is no interaction, it can still be useful to explore the simple effects) which indicated a time effect for the CBCL (the results of an ANOVA for the simple effect for time was F=86.70 at p=.0002).

Qualitative Analysis

The qualitative process involved 2 main theme generating processes. First there was an exploration of the differences from pretest to posttest responses to each parent’s goal of parenting and their hopes and fears for their child. All of these responses were examined for any difference or change in how the parents responded to these open-ended questions. The second process was to examine all of the responses regarding the parents’ evaluation of the group. Thus these responses were examined for the themes that emerged regarding the
parents' experience of the parent therapy group. Then these themes were integrated into increasingly larger units of meaning until they could be subsumed under a theoretical base.

**Themes of how the parent responses changed**

Each of the parents' meaningful unit responses were examined by the three raters for themes of how the responses were different from pretest to posttest (see Appendix K for parent responses). The themes of change developed by the raters are listed in Table 4. These parents were responding to two open-ended questions on (1) their parenting goal and (2) their hopes and fears for their child. All of these parents signed a form which gave permission for their responses to be printed in the appendix.

**Themes of the parents' evaluations**

Then each of the parents' meaningful unit responses for the group evaluation (see Appendix L) was examined for themes. The themes that were arrived at by consensus of the three raters are presented in Table 5. It should be noted there is one additional person in this group since a spouse attended the parent group therapy (this person did not fill out any other of the responses since just the primary caregiver was to complete the pretest and posttest forms, but this person asked to fill out an evaluation form). Also the list in Table 5 represents the order in which the raters examined the responses.

**Theoretical themes**

Following the process of developing themes directly from the parents' responses, the raters then integrated these themes into larger themes until a theoretical construct emerged. The notes taken during this discussion process show how the themes evolved and eventually a theoretical concept emerged. The notes are presented as written during this discussion process. There is some difficulty of adequately representing the dynamic process of a discussion by way of the static written modality; however, this representation is presented below. Due to the raters finding themes from the data, this researcher feels the third
Table 4: Themes of how the parents responses changed

<table>
<thead>
<tr>
<th>Parent</th>
<th>Themes of how the parents' responses changed from pretest to posttest</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The parent shifted from the word “making” to “teaching” when describing parenting role.</td>
</tr>
<tr>
<td>1</td>
<td>Responsibility shifts from doing for them to teaching them to do it for themselves.</td>
</tr>
<tr>
<td>1</td>
<td>Shifted from a vague to a more specific focus</td>
</tr>
<tr>
<td>1</td>
<td>Seemed to be an addition of seeing the child wholistically with strengths and weaknesses (a perceptual shift.</td>
</tr>
<tr>
<td>1</td>
<td>Tentative theme: Parent went from an information to relationship focus</td>
</tr>
<tr>
<td>2</td>
<td>Seemed to be translating hopes into parenting goals at posttest (from a hope to a plan)</td>
</tr>
<tr>
<td>2</td>
<td>More specific at posttest</td>
</tr>
<tr>
<td>3</td>
<td>Unrealistic to realistic concerns or hopes</td>
</tr>
<tr>
<td>3</td>
<td>At posttest parent was more middle ground - not as black or white/all or nothing</td>
</tr>
<tr>
<td>3</td>
<td>A more balanced, realistic view at posttest</td>
</tr>
<tr>
<td>4</td>
<td>Shifted from parent responsibility to kids’ own responsibility or learning to do it for themselves</td>
</tr>
<tr>
<td>4</td>
<td>At posttest shifted to helping them take responsibility for their own life</td>
</tr>
<tr>
<td>4</td>
<td>Changed from general to specific</td>
</tr>
<tr>
<td>5</td>
<td>Shifted to I want a relationship/connection with the kids and not just an overseer or just a job</td>
</tr>
<tr>
<td>5</td>
<td>Seemed to shift from Maslow’s basic needs to more growth/relationship needs</td>
</tr>
<tr>
<td>5</td>
<td>Shifted from a self-focus to a child-focus</td>
</tr>
<tr>
<td>6</td>
<td>No real change thematically.</td>
</tr>
</tbody>
</table>
Table 5: Themes of the parents’ evaluation of the parent therapy group experience

<table>
<thead>
<tr>
<th>Parent</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Ideas on parenting did not change, but sense of hope, not being alone, sense of connection, reduction in alienation/anomie</td>
</tr>
<tr>
<td>6</td>
<td>New ideas, perspective. Perception change, saw things from a different point of view. Not cognitive change or change in point of view or thoughts, but a perceptual, experiential change.</td>
</tr>
<tr>
<td>6</td>
<td>From alienation to connectedness.</td>
</tr>
<tr>
<td>6</td>
<td>Hopefulness, not being alone, different ideas to work with/different ideas and perceptions. Different ideas not goal directed, but conceptual regarding parenting. Less specific, more global, relational</td>
</tr>
<tr>
<td>7</td>
<td>Relational base; feeling base</td>
</tr>
<tr>
<td>7</td>
<td>Sense of not being alone</td>
</tr>
<tr>
<td>7</td>
<td>Experience of closeness like a family</td>
</tr>
<tr>
<td>7</td>
<td>Giving back to facilitator</td>
</tr>
<tr>
<td>3</td>
<td>“We’re not alone”</td>
</tr>
<tr>
<td>3</td>
<td>Tool - something about it that gave specifics to do, things that were different</td>
</tr>
<tr>
<td>3</td>
<td>Focus on whole family rather than problem saturated kid</td>
</tr>
<tr>
<td>3</td>
<td>Went from “these kids have problems (let’s focus on and fix them) to let’s build on something in family and focus on that</td>
</tr>
<tr>
<td>3</td>
<td>Paradigm shift - parents think through, not get caught up in emotion, less reactivity</td>
</tr>
<tr>
<td>3</td>
<td>Sense of working together, experience cooperation, not didactic endeavor</td>
</tr>
<tr>
<td>4</td>
<td>Wanted more of group</td>
</tr>
<tr>
<td>4</td>
<td>Planful with parenting</td>
</tr>
<tr>
<td>4</td>
<td>Not alone</td>
</tr>
<tr>
<td>2</td>
<td>Helpful to not be alone</td>
</tr>
<tr>
<td>2</td>
<td>More information, something new and different, new ways to handle it</td>
</tr>
<tr>
<td>2</td>
<td>Enjoyable process - want to continue and liked it</td>
</tr>
<tr>
<td>5</td>
<td>Not in isolation, same problems</td>
</tr>
<tr>
<td>5</td>
<td>Normalizing, I’m not so weird</td>
</tr>
<tr>
<td>5</td>
<td>Less catastrophizing</td>
</tr>
<tr>
<td>5</td>
<td>Group was an easy process, non-threatening</td>
</tr>
</tbody>
</table>
hypothesis (that a qualitative approach will be a useful tool to gain information regarding the clients' experience of the group) was met. This will be more fully discussed in Chapter 5.

Discussion process of the raters building toward a theoretical model:

- Group seemed to be an empowering experience. The members provided assistance with one another. The group gave them a much stronger role in this process than just a receiving or didactic process which may be more typical of parent management training. This was an active teaching process—experiential. Something they had to say was helpful/meaningful to someone else and this seemed to be a new experience for these clients. With a didactic process, the client is in a one-down, “fill up the receptacle” type of process—this experience seemed different for these clients.

- Self-disclosure was a big part of sense of belonging. Self-disclosure begets more disclosure, begets intimacy, connectedness, closeness. Once have belongingness then this can foster self-esteem. Group seemed to fulfill deficit needs. When people have own basic deficit needs met then less energy has to go into meeting these deficit needs. Group fulfilling deficit needs allowed them to move into growth needs (i.e., altruism, process and integration of new information). If people have basic needs met for themselves, then have more energy to focus on other people. And this capability can be tapped—that it could happen on such a short-term basis suggests the quality is already a part of the parent (these parents have the capability, it just may need to be triggered).

- Definition of education is to draw out; not pour in, but to draw out. We [mental health professionals] often treat lower SES people as concrete operators, but given the opportunity for formal operations, they can formulate hypotheses or participate in a process group. Treat people as capable of being as if at formal operations. These clients began to redefine selves as capable, competent. They then saw kids as more capable.

- Clients gained new ideas, new sense of hope, situation normalized, and belonging seemed to be things gotten from group experience. Paradigm shift? Went from hopelessness to hopefulness. Went from lacking or deficit focus to valuing self. Empowered. Decreased reactivity. Able to see middle ground. Began with model of parenting as lonely, isolated experience and shifted to seeing that parenting can be a shared experience. Parents who get their basic needs of belonging met are more capable of giving this to their children. Discussed Maslow’s hierarchy. Can’t get kids to level if they aren’t at that level. Given the right environment, latent qualities can be realized and used to empower parents.

- Empowered. Hopeful. Less reactive. They felt more capable, better about selves by reducing their own deficits. Perception of selves shifted—shift in role as parents. Moved from just not able or capable to being more normal, not isolated, aware of capabilities and assets. Experience of “familiness” or connection. And knew that it felt like a family with cooperation—certainly have the ability. Waiting to be triggered.

- Back to Maslow—with deficit needs, the more get deficit need met, the less time spend on getting it met or focusing on it. With growth needs though just the opposite. The more growth need gets met, the more you want them, focus on them. So at first in group more deficit needs seen by more self-focus. This changed to child focus, altruism, wanting group to continue. Conceptual view of an hour glass with growth needs on the top (inverted triangle) and deficit needs on the bottom (upright triangle). Basing on theoretical construct of Maslow, once they got their “cup” full, the more they had to offer, less focused on self. Seemed the group fostered this process.
In summary the raters felt the themes generated from the parents' responses best fit Maslow's (1970, 1971) theory of the need hierarchy. The themes generated from the parents' responses seemed to suggest that the group assisted with fulfilling deficiency motivated needs (particularly belonging and esteem needs) and this may then assist the parents with focusing on growth motivated needs. This model was suggested for the following reasons. First, the parents' responses seemed to qualitatively change from pretest to posttest. In their descriptions of parenting, the parents seemed more relational focused, less reactive, and more child focused. Their group evaluations suggested themes of group fulfilling belonging needs as well as providing the experiential qualities of cooperation and working together. Overall the parents seemed more empowered. Second, since these themes were generated from a short-term intervention, it was further postulated that these qualities were already present in the clients and just needed to be triggered. Third, since the parents indicated the group was a positive experience, the raters felt this type of group experience may be particularly useful to decrease the resistance which is frequently discussed in the literature for this population.

Also the researcher/clinician was surprised by the degree of the parents' connection to the group. All of these parents requested for the group to continue, were supportive of one another with their ongoing parenting struggles, readily adapted to group process, and noted how it was different from what they expected.
CHAPTER 5. DISCUSSION, SUMMARY, AND RECOMMENDATIONS

Introduction

This study was designed to augment a behavioral day treatment program by the addition of a parent therapy group. This parent therapy group utilized concepts from attachment theory and narrative therapy as a means to assist families with moving out of a problem saturated or inadequate self-definition process. This study utilized quantitative methods to assess changes on the parents' perception of their child's behavior problems and the parents' attitudes. This study also utilized a qualitative approach to explore the parents' self-statements regarding parenting goals, their hopes and fears for their child, and their evaluations of the group experience.

A quantitative approach was coupled with a qualitative or thematic view of the clients' written statements as an attempt to use "...alternative, multiple methods for measuring a phenomenon..." (Sechrest & Sidini, 1995, p. 84). Sechrest and Sidini (1995) provided the distinction between formulaic data (quantitative) and clinical data (non-quantitative). They provided the example of a questionnaire and anecdotal evidence, noting that they "are complementary precisely because they do not share all the same sources of error or bias" (p. 84). Therefore in this study pairing the quantitative and qualitative approaches provided two completely different types of information regarding the treatment of this population.

This combination of the two different approaches to evaluate this intervention seemed particularly relevant, since the researcher was attempting to operationalize from a different theory base than what is generally utilized with this population. Thus this study utilized the type of quantitative assessment that is generally applied to this research area, but then augmented this with a qualitative approach to explore the parents' experience of this intervention.
Exploring the results of the quantitative approach, the enhanced treatment condition did not show any significant effect over the regular treatment condition for decreasing parental perception of their child’s behavior problems as assessed by the Child Behavior Checklist or for improving parental attitudes as assessed by the Parental Attitude Survey. There was a significant effect for time (with the Child Behavior Checklist) which indicated that both the enhanced treatment and the regular treatment groups changed over time. Thus all of the parents in this study reported an improvement in their child’s behavior. It would seem plausible that since both groups had received the program's regular treatment which was largely from a behavioral condition (this element was in common to the two groups), this may have been the source of both groups improving. This would support the findings of previous research for the effectiveness of the behavioral orientation with this population; however, this is a tentative conclusion. (There was a lack of a control group receiving no treatment which would eliminate the possibility that improvement would occur regardless of treatment).

However, the qualitative aspect of this study suggested that the group intervention did have value to the participants. This part of the study only examined responses of parents who attended the parent therapy group and was a modified qualitative approach as it utilized the responses to several open-ended questions rather than an interview process. By analyzing the responses of these parents, it was possible for three raters to generate themes which developed into a theoretical construct of the parents’ experience of the therapy group.

The raters felt that there was a definite shift or change in how the parents described their parenting goals and hopes and fears for their child. The responses the parents gave after the group experience seemed to reflect a sense of belonging, a sense of hopefulness, and decreased reactivity. The raters felt that overall the clients moved from a self-focus to a more child-centered focus. At posttest the responses seem to reflect a desire to teach self-responsibility to the child and a desire on the parents’ part to focus on relational goals. Parents seemed to feel there was a cooperative spirit in the groups and a valuing of one
another’s thoughts. Overall the parents’ responses seemed to reflect greater feelings of competency. An important element seemed to be that the group members reported enjoying the parent therapy group.

In terms of the inferences that the raters began to make from these descriptors of change and perceptions, there was an attempt to develop a model that would incorporate these themes in a consistent manner. The raters identified that members were quite articulate and seemed to readily adapt to a group process experience more quickly than might be expected, particularly when research reflects the difficulty with engaging these clients. The raters were also cognizant that this was a short-term intervention and noted surprise regarding the positive themes that developed in what was a relatively short period of time. Therefore the theoretical model that the raters chose would need to account for the possibility of a rather rapid change which seemed to be less accounted for by a directive process flowing from the group facilitator.

Thus the resulting theoretical construct formed by the raters described the group process as a means of assisting these parents with fulfilling deficit motivated needs. It was hypothesized that the pretest parental responses reflected a deficit model where the clients were more self-focused and had less energy. This would certainly parallel the behavioral parent training which suggests the need to assist parents with developing skills. However, unlike the parent training which can be envisioned as more of a directive, didactic process where the client is in a one-down, “fill up the receptacle” type of process; this group experience seemed to be more of an experiential process where clients gained a sense of belonging. It was theorized that the group experience helped the parents to meet these deficit needs, so then they were able to focus on growth needs (altruism, parenting) and offer more of themselves. It was suggested that until these deficit needs are met, perhaps parents cannot be in a state to give more toward the parenting and understanding of children with behavior disorders. The group experience seemed to help “draw out” (rather than to “pour in”) a sense
of competency. The short time period of the intervention seemed to also suggest that this ability to feel competent was already present and just needed to be triggered. Thus given the right environment, these latent qualities can be realized. The model the raters chose to explain these themes was based on Maslow’s (1970, 1971) hierarchy of needs.

It was puzzling that with such a positive response regarding the parent therapy group, there was not a corresponding, significant change in the quantitative results. Perhaps the assessment tools that were used did not quantify the type of attitudinal gain that seemed to be fostered by this group. It could be that the Parent Attitude Survey (Hereford, 1963) was not an appropriate assessment of parents’ attitudes who have children with severe behavior disorders (this survey was created by using a nonclinical population). Perhaps what seemed to happen in the group does not have a behavioral correlate, or at least not in the early stages. It may be that a longer intervention would have permitted time for this change to become solidified in the behavioral realm. The fact that there were such differing results brings an important question to the forefront which Krantz (1995) posed by asking “...how is success to be measured?...By whose criteria does one evaluate the outcome - the client, the therapist, the broader community?” (p. 94). This researcher would suggest that it is important to pool knowledge, incorporating the success rate of parent management training while recognizing the need for other options. As had been noted earlier, researchers have indicated concern regarding client resistance and the difficulties of engaging this population in a therapeutic process (Chamberlain et al, 1984; Frankel & Simmons, 1992; Miller & Prinz, 1990). Therefore it may be necessary to augment a parent management approach or a behavioral orientation with methods that may specifically address this issue. And since this parent therapy group did seem to be a satisfactory experience for the parents, it may be a useful tool to decrease this resistance or hesitancy regarding therapy.

On a conceptual level this intervention was an attempt to assist clients with finding a new “story” or self-definition. A story which moved away from a problem definition and
moved toward possibilities and strength. This researcher utilized elements of attachment theory (specifically, the importance of a coherent story of the past) and narrative therapy to formulate the importance of how clients view their past as well as their present and future. The way that the narrative therapy was operationalized dovetailed with attachment theory's focus on a coherent story. Basically for the purposes of a short-term intervention, the main emphasis was to promote the recognition that a person has the choice of replicating, correcting, or improvising from one's past. This was an attempt to loosen up any inferences of blame or feelings of being stuck with one's history. The focus on the client's strengths provided an avenue to focus on both the present and future. Group therapy was the chosen modality and this choice was based on Yalom's (1995) therapeutic factors of group therapy. Initially the clients were quite hesitant regarding this group therapy experience (this was a completely voluntary aspect of the program) and indicated a concern that they were just going to be told how to raise their children again. This researcher suspects that this was the resistance that Chamberlain et al. (1984) referred to when acknowledging that there was little wonder resistance is generated when treatment involves basically telling parents how to raise their children. It may be that this intervention which focused on the clients' strengths can be particularly useful toward decreasing this resistance, as all of the parents indicated a desire to this researcher to continue the therapy group.

The researcher does acknowledge the limitations imposed by a small sample size. From a quantitative approach, the small sample size significantly limits the power of the research design. However, this study attempted to integrate research into an actual clinic setting. Therefore the frequent difficulties which arise due to this setting were present in this study. The sample size was smaller than anticipated as the enrollment was lower than expected. Part of this was due to that the educational staff of the day treatment program had recently undergone staff changes and was gradually building enrollment toward full capacity.
This study was also designed to be the least intrusive to the rest of the program and its staff, thereby creating the greatest chance for this study to be completed.

This study's qualitative findings of parents becoming empowered and feeling competent was similar to Webster-Stratton and Spitzer's (1996) finding of clients gaining in feelings of competency following a parent training group. Perhaps it is not so much the style of the group (parent training or narrative therapy approach) that is particularly useful, but rather the group experience with peers and the opportunity for parents to gain a sense of connection, belonging, and normalization which promotes this sense of empowerment. However, this researcher does suspect that the clinician's orientation to the therapeutic process is extremely important to creating an environment which fosters a sense of empowerment. Having worked with this population in the past, this researcher found this group experience with its emphasis on strengths to be particularly helpful in moving past the usually encountered issues of frustration, blame, and victimization. By keeping the clinical orientation toward the client's narrative or dynamic self-definition process, the result (from the qualitative analysis) would seem to suggest that this promoted an experience fostering the parents to move from an overwhelmed self-focus to a child-focus which may better assist the parenting process. It is this researcher's hypothesis that the following four elements fostered this personal definition shift: (1) the small group size; (2) the rapid focus in the group on each person's strength derived from clients' actual statements; (3) the opportunity to practice and validate this strength within a group context; and (4) the experience of the parents sharing their hopes and fears with their child in a group setting which had an overall focus on the child's potential and began a similar re-storying process for the child initiated by the parent. Of course, this is only speculation and would benefit from further research.

A limitation of this study was that the population utilized for this study is specific to youth who have severe behavior disorders and their parent or caregiver. Particularly with the qualitative research these findings are specific to this group of parents and this specific
therapist. However, with rich description it is hoped that the findings can be transferable (Lincoln & Guba, 1985), and therefore this researcher attempted to provide the group agenda and rationale, the clients’ responses, the themes, and the theoretical construct process either within the text or in the appendix for this reason.

A second limitation may be of this researcher’s involvement with both the therapy as well as being a rater of the clients’ responses. Of course there would be bias; however, with qualitative methodology, this simply is part of using the human as an instrument in the research process (Lincoln & Guba, 1985). The other two raters were present to help keep the analyses centered directly on the data. It was clear that this researcher/clinician enjoyed the parent therapy groups. Although the clients initially were rather hesitant regarding the whole group process, this research/clinician was impressed with the quality of the group process and connection in just five sessions.

A third limitation was that this researcher did not ask for written responses to the open-ended statements from the clients in the regular treatment group to see if they would also have had similar changes from pretest to posttest as those who experienced the parent therapy group. This was not done at the time because it was felt that this self-assessment was a part of the process that was fostered in the group; however, on retrospect, it may have been interesting to see if the questions fostered this change or if it was the group experience (and administering the questions to both the enhanced treatment group as well as the regular treatment group would have provided this information.)

As noted earlier, a fourth limitation of this study was the small sample size. Although a sample size of 16 certainly raises issues of generalizability, the hope is that this was alleviated somewhat by utilizing an actual clinical setting.

Last, one of the qualitative findings was that some of the clients shifted from describing their parenting as a process of “making” their children do things to more of “teaching” at posttest and this was seen as a positive change. It was thought that this would
result in less reactivity and perhaps recognizing and accepting parental limits. However, it should be remembered that this was one of the topics in the group (see Appendix A) and may represent less of a parental change, but just a compliance with what the parents thought that the researcher/group leader wanted to hear.

**Summary**

This study explored the effectiveness of augmenting a day treatment program, which largely operated from a behavioral perspective, with a parent therapy group. This parent therapy group attempted to operationalize narrative therapy and attachment theory. The results from a quantitative perspective showed no treatment by time interaction (no significant effect of adding the parent therapy group) as assessed by the Child Behavior Checklist and the Parent Attitude Survey. However, there was a time effect for the Child Behavior Checklist which indicated that all of the parents perceived an improvement in their child’s behavior. The qualitative perspective of this study included a thematic viewing of the clients’ responses to several open-ended questions. The results showed the clients found the group to be helpful, particularly with decreasing feelings of isolation, increasing competency and connection. These themes were integrated along with the recognition that clients experienced a change in a brief amount of time and a theoretical model emerged. From a theoretical model it seemed that the group fulfilled deficit needs which allowed the clients to focus on growth needs such as parenting. The goal of this group was to provide the clients with an opportunity to “re-story” their lives, focusing on their strengths. The qualitative aspect of this study suggested that the clients may have experienced a positive self-redefinition. This group intervention is suggested as a means to augment a behavioral orientation when working with this population and may decrease the resistance which is commonly found with this population.

**Recommendations**

Although there have been many research studies exploring issues pertaining to conduct disorder youth, most of these are from a descriptive process. The ones that explore treatment
interventions generally have been from a behavioral orientation. It seems important to continue to find creative, alternative methods which might assist in increasing the chance of a successful intervention process. This researcher would encourage others to venture into finding new ways to operationalize a theory base and to research it for effectiveness. It seems important that if a process is difficult to manualize it may be important to provide a clear description of the therapeutic process and rationale. This would seem to benefit the field through a more clear exchange of information.

This researcher also feels it is important for clinicians to continue to provide research ideas and methods. Greenberg (1994) discussed how frequently there is a gap between researchers and clinicians. It seems clinicians may particularly have a "pulse" on the more subtle characteristics of the therapy process due to their work "in the trenches" and this can result in realistic challenges of what may be oversimplified views of clients. Kiesler (1994) indicated how clinicians may be at the forefront by noting "in short psychotherapy research always 'plays catch-up' to psychotherapy practice" (p. 143). Thus clinicians may have an intuitive process regarding treatment issues which may then provide for refinements in research methodology and ultimately theoretical models.

Another recommendation which is endorsed is for further research focusing on assisting the parents with children of behavior disorders. Perhaps it is with an optimistic view that this researcher/clinician promotes recognizing and attempting to "draw out" the parents' competency. However, it seems that assisting parents to re-story their lives toward competency can be a useful theoretical tool which would likely diminish any blame focus toward the clients. It would be useful to more fully explore the resistance that researchers have identified with this population; whether it is indirectly fostered by the behavioral perspective (due to its tendency toward a linear perspective of causality) as suggested by this researcher, and whether another paradigm could counteract this effect. And as a suggestion to expand the pilot study completed here, this researcher would suggest three steps. First,
due to the parents' positive response to this therapy group, it is suggested that recruitment could be enhanced by having parents who are in the group invite new parents to the group, hopefully decreasing hesitancy to join the group. Second, if there was an accompanying recreational time for the children as this study utilized, it is suggested that periodically the parents be brought into the recreational time with the children to further promote a new "story" or experience regarding enjoyable activities. Third, it is suggested that other outcome assessment tools be utilized to explore the usefulness of such a parent therapy group, particularly to see if there is any change in hopefulness, depression, resistance, or a tool which operationalizes Maslow's hierarchy of needs.

Last, this researcher would recommend for the specific day treatment program where this study was conducted to recognize the value of this pilot study. The hope is that this program will adopt a parent therapy group within a spirit of continued exploration for effectiveness.
Group Agenda

Session 1:
The group began with introductions and a discussion of confidentiality. This group was encouraged to highlight the commonality of all the group members by sharing about their experiences as parents with children who were in the same day treatment program. A review of the group was provided which included that this would be different from other aspects of the day treatment program. I noted that I would not be teaching about specific parenting techniques, but instead this would be a group to examine their own parenting strengths that each have and how best to apply this with their child. To begin this group process the topics that were discussed included what parenting has been like for them, what advice they have gotten from others over the years, what they believe causes behavior disorders, when did they feel that this child posed different or difficult parenting challenges for them, how each views their parenting goal.

Session 2:
In an attempt to begin the process of recognizing how a group process is different from conversations, we discussed how what people have to say frequently says more about themselves than about the topic they are discussing. I then shared particular themes for each person which were based on three or more specific statements that each made in the last group. Others in the group were encouraged to provide their feedback and each member had the opportunity to discuss if this parenting strength fit them or not and whether they would prefer to modify or change the strength during this discussion or during any upcoming group. We discussed how each might use their parenting strength with their particular child. Then the focus of discussion moved to exploring whether this strength was learned from one’s own upbringing (replicative process), changed or reacted to way one was brought up (corrective process), or created completely new from the family of origin experience (improvisational process). This was a relatively short discussion, but with an emphasis on that each person has a choice of what to bring from the past and what to create new.

The group ended with a discussion about current parenting situations and each parent was encouraged to focus on how their personal strength could be an asset in dealing with their child. The focus was always on promoting on how the parent might share this strength with their child by “teaching” this strength (breaking the skill down into small steps) rather than expecting the child to operate from their same tendencies.

Session 3:
Discussed societal impacts on the family as well as on their children who have with the characteristics of a behavior disorder. Attempted to foster empathy for how societal pressures may be difficult for each child, so discussed how the parents might assist their child to combat negative social pressure by small steps. For instance attempted to empathize with how an impulsive child may experience a society which promotes immediate gratification. Discussed
what small skill a parent may want to try to start with teaching to child to help combat this pressure.

Session 4:

Created expectation that change is possible. Discussed how each person has learned meaningful things in their life by each giving examples. Then related this to how children learn and that often parenting is about teaching (learning is less likely to occur when told something than when experience something). Identified how each parent action or behavior can be an opportunity to teach something to their child. Described how some children seem to have a more difficult development than others. Then moved into a discussion of the difference between focusing on outcome and focusing on their parenting effort. Noted how easy it is to get frustrated when focusing on outcome (expectations of what child’s behavior “should be”) rather than if focus on one’s personal effort and take pleasure in that no matter if outcome is less than satisfactory. Discussion moved to how children often get impression from all the professions and their parents that are “on their backs” that everyone just sees them as a problem. Opened discussion re: parents belief in their child’s potential. Discussed how many of the characteristics of behavior disorders can be positive if used in the right way. Identified the last session as a chance to try to give children a chance to “hear” their parent’s belief in their potential. Discussed option of having children come into next session and each parent taking time to tell respective child their hopes and fears.

Session 5:

Began the group meeting with the parents as usual. Parents talked of current parenting situations and they were supportive of one another. If one stumped on what to do asked if another could use her/his parenting strength to think of way to handle discipline, etc. Then prepared for the upcoming hope and fear discussion. Did discuss child may not have much response at the time, but likely will be listening intently when others are involved in the process.

Brought children into session with the parents. Each parent told hopes and fears for own child. The rest of the group members were asked to comment on what they heard about that child. Each child was given an opportunity to respond. There was a wrap-up discussion regarding the potential. Group ended with pizza and soda served for all.

Group Rationale

Each parent was told a parenting strength or theme that I pulled together from a least three specific comments from the first group. I wanted the clients to have an early experience of:

* Their comments were important and would be listened to closely
* Their comments really served to identify themselves and their values
* That my feedback was completely tentative and based only on a first impression
Since this was a short-term therapy group experience, I wanted to provide the parents with an early experience of pulling a theme from someone’s statements—to read between the lines or look for meaning within verbalization. As an example of this, one parent was provided the feedback that she seemed to have a strength with being able to see the “bigger picture” and to fight the common tendency of tunnel vision. This comment was based on four comments that she had said the previous session; and these were shared with her in group:

1. Her ability to appreciate her child’s non-academic skills (she had shared of her pride of his artistic ability if though at times frustrated with his poor school performance.
2. Her sharing how she will try new things to use as rewards for her son - always trying to find his interests.
3. She described her ability to keep her “cool” when her children are irritating
4. She stated several times that she will always “be there” for her kids no matter what they do.

These strengths were then tied in with their parenting. The hope was that this could be a theme with how they could focus their parenting. For example this parent could always focus on helping her son to see the “big picture” by asking him to do something small that would approximate this skill (e.g., recognize consequences instead of just thinking of immediate gratification by giving him a chance to list all of the consequences when he breaks a rule).

This was an attempt to operationalize the narrative therapy component by taking their responses and tentatively posing an alternative view of what was presented. The emphasis was to move away from a problem saturated descriptor, to one of personal agency. All of the parents indicated a strong desire to find a way to help their child change his or her behavior. This lead to a discussion of the similarity of parenting to teaching. Learning cannot be made to happen, but perhaps it can be fostered. This provided a recognition of the parent as a true resource as well as a discussion to focus on how change or learning takes place.

Then to operationalize attachment theory, the group discussed replicative, corrective, and improvisational processes with these strengths regarding their family of origin (This was modified from Byng-Hall, 1995). A discussion of enjoying the family/parenting characteristics they wished to carry on as well as any innovations of change.

As parents shared regarding parenting situations, the topic was introduced that learning cannot be MADE to happen, but perhaps it can be fostered. Each parent discussed ways that they felt they had learned or noticed how others had learned things. The discussion of differentiating outcome and effort was made to focus on that it may take several or many repetitions of a type of parenting or teaching before any positive outcome may be seen. This was discussed since parents can get so focused on the outcome of the child’s behavior and lose their perspective due to frustration.

Then as the sessions progressed and the parents brought up current parenting dilemmas they were encouraged to look at ways to tackle the situation from their parenting strength. Other parents would also suggest thoughtful ways of trying creative ways to teach a new skill.

The last session was an attempt to allow the focus on potential, to encourage the parents to develop positive future story lines, even in the presence of their concerns. This was discussed as proof that the parents felt strongly that each child could be successful and use
their talents in ways to help themselves. In a way these parents were asked to mirror the behavior I had completed in the second session by providing information regarding child's potential or strengths. Parents were encouraged to not use a blaming perspective and that when even describing a fear to keep an eye on potential and current time orientation (e.g., "I fear you will end up in prison"). This statement does not bring any source of potential into it; however, the statement, "I fear that your attitude will get in the way of you being successful in math" provides a source of potential and is current in time perspective.)
### APPENDIX B. CHILD BEHAVIOR CHECKLIST

**CHILD BEHAVIOR CHECKLIST FOR AGES 4-18**

**Please Print**

<table>
<thead>
<tr>
<th>CHILD'S FIRST NAME</th>
<th>CHILD'S MIDDLE NAME</th>
<th>CHILD'S LAST NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SEX**

- Boy
- Girl

**AGE**

**ETHNIC GROUP OR RACE**

**TODAY'S DATE**

**CHILD'S BIRTHDATE**

<table>
<thead>
<tr>
<th>MONTH</th>
<th>DAY</th>
<th>YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**GRADE IN SCHOOL**

**NOT ATTENDING SCHOOL**

**Please fill out this form to reflect your view of the child's behavior even if other people might not agree. Feel free to print additional comments beside each item and in the spaces provided on page 2.**

### I. Please list the sports your child most likes to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.**

<table>
<thead>
<tr>
<th>COMPARED TO OTHERS OF THE SAME AGE</th>
<th>ABOUT HOW MUCH TIME DOES HE/SHE SPEND IN EACH?</th>
<th>COMPARED TO OTHERS OF THE SAME AGE, HOW WELL DOES HE/SHE DO EACH ONE?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don't Know</td>
<td>Less Than Average</td>
<td>More Than Average</td>
</tr>
<tr>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SAMPLE**

### II. Please list your child's favorite hobbies, activities, and games, other than sports. For example: stamps, dolls, books, piano, crafts, cars, singing, etc. (Do not include listening to radio or TV.)

<table>
<thead>
<tr>
<th>COMPARED TO OTHERS OF THE SAME AGE</th>
<th>ABOUT HOW MUCH TIME DOES HE/SHE SPEND IN EACH?</th>
<th>COMPARED TO OTHERS OF THE SAME AGE, HOW WELL DOES HE/SHE DO EACH ONE?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don't Know</td>
<td>Less Than Average</td>
<td>More Than Average</td>
</tr>
<tr>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### III. Please list any organizations, clubs, teams, or groups your child belongs to.

<table>
<thead>
<tr>
<th>COMPARED TO OTHERS OF THE SAME AGE</th>
<th>HOW ACTIVE IS HE/SHE IN EACH?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don't Know</td>
<td>Less Active</td>
</tr>
<tr>
<td>None</td>
<td></td>
</tr>
<tr>
<td>a.</td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td></td>
</tr>
</tbody>
</table>

### IV. Please list any jobs or chores your child has. For example: paper route, babysitting, making bed, working in store, etc. (Include both paid and unpaid jobs and chores.)

<table>
<thead>
<tr>
<th>COMPARED TO OTHERS OF THE SAME AGE</th>
<th>HOW WELL DOES HE/SHE CARRY THEM OUT?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don't Know</td>
<td>Below Average</td>
</tr>
<tr>
<td>None</td>
<td></td>
</tr>
<tr>
<td>a.</td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td></td>
</tr>
</tbody>
</table>
Please Print

V. 1. About how many close friends does your child have? □ None □ 1 □ 2 or 3 □ 4 or more
(Do not include brothers & sisters)

2. About how many times a week does your child do things with any friends outside of regular school hours?
(Do not include brothers & sisters) □ Less than 1 □ 1 or 2 □ 3 or more

VI. Compared to others of his/her age, how well does your child:

<table>
<thead>
<tr>
<th>Worse</th>
<th>About Average</th>
<th>Better</th>
<th>Has no brothers or sisters</th>
</tr>
</thead>
</table>
a. Get along with his/her brothers & sisters? | □ | □ | □ | □ |
b. Get along with other kids? | □ | □ | □ | □ |
c. Behave with his/her parents? | □ | □ | □ | □ |
d. Play and work alone? | □ | □ | □ | □ |

VII. 1. For ages 6 and older—performance in academic subjects. □ Does not attend school because

Check a box for each subject that child takes

a. Reading, English, or Language Arts  □ Failing □ Below Average □ Average □ Above Average
b. History or Social Studies  □
c. Arithmetic or Math  □
d. Science  □
e. Other academic subjects—for example: computer courses, foreign language, business, etc.  □
f. □
g. □

2. Does your child receive special remedial services or attend a special class or special school? □ No □ Yes—kind of services, class, or school:

3. Has your child repeated any grades? □ No □ Yes—grades and reasons:

4. Has your child had any academic or other problems in school? □ No □ Yes—please describe:

When did these problems start?

Have these problems ended? □ No □ Yes—when?

Does your child have any illness or disability (either physical or mental)? □ No □ Yes—please describe:

What concerns you most about your child?

Please describe the best things about your child:

Peeple Print

V. 1. About how many close friends does your child have? □ None □ 1 □ 2 or 3 □ 4 or more
(Do not include brothers & sisters)

2. About how many times a week does your child do things with any friends outside of regular school hours?
(Do not include brothers & sisters) □ Less than 1 □ 1 or 2 □ 3 or more

VI. Compared to others of his/her age, how well does your child:

<table>
<thead>
<tr>
<th>Worse</th>
<th>About Average</th>
<th>Better</th>
<th>Has no brothers or sisters</th>
</tr>
</thead>
</table>
a. Get along with his/her brothers & sisters? | □ | □ | □ | □ |
b. Get along with other kids? | □ | □ | □ | □ |
c. Behave with his/her parents? | □ | □ | □ | □ |
d. Play and work alone? | □ | □ | □ | □ |

VII. 1. For ages 6 and older—performance in academic subjects. □ Does not attend school because

Check a box for each subject that child takes

a. Reading, English, or Language Arts  □ Failing □ Below Average □ Average □ Above Average
b. History or Social Studies  □
c. Arithmetic or Math  □
d. Science  □
e. Other academic subjects—for example: computer courses, foreign language, business, etc.  □
f. □
g. □

2. Does your child receive special remedial services or attend a special class or special school? □ No □ Yes—kind of services, class, or school:

3. Has your child repeated any grades? □ No □ Yes—grades and reasons:

4. Has your child had any academic or other problems in school? □ No □ Yes—please describe:

When did these problems start?

Have these problems ended? □ No □ Yes—when?

Does your child have any illness or disability (either physical or mental)? □ No □ Yes—please describe:

What concerns you most about your child?

Please describe the best things about your child:
Below is a list of items that describe children and youth. For each item that describes your child now or within the past 6 months, please circle the 2 if the item is very true or often true of your child. Circle the 1 if the item is somewhat or sometimes true of your child. If the item is not true of your child, circle the 0. Please answer all items as well as you can, even if some do not seem to apply to your child.

Please Print:

0 = Not True (as far as you know) 1 = Somewhat or Sometimes True 2 = Very True or Often True

<table>
<thead>
<tr>
<th>Item</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Acts too young for his/her age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Allergy (describe):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Argues a lot</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Asthma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Behaves like opposite sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Bowel movements outside toilet</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Bragging, boasting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Can't concentrate, can't pay attention for long time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Can't get his/her mind off certain thoughts; obsessions (describe):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Can't sit still, restless, or hypersensitive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Clings to adults or too dependent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Complains of loneliness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Confused or seems to be in a fog</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Cries a lot</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Cruel to animals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Cruelty, bullying, or meanness to others</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Daydreams or gets lost in his/her thoughts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Deliberately harms self or attempts suicide</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Demands a lot of attention</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Destroys his/her own things</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Destroys things belonging to his/her family or others</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Disobedient at home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Disobedient at school</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Doesn't eat well</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Doesn't get along with other kids</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. Doesn't seem to feel guilty after misbehaving</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Easily jealous</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. Eats or drinks things that are not food— don't include sweets (describe):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29. Fears certain animals, situations, or places, other than school (describe):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. Fears going to school</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SAMPLE

0 1 2 31. Fears he/she might think or do something bad
0 1 2 32. Feels he/she has to be perfect
0 1 2 33. Feels or complains that no one loves him/her
0 1 2 34. Feels others are out to get him/her
0 1 2 35. Feels worthless or inferior
0 1 2 36. Gets hurt a lot, accident-prone
0 1 2 37. Gets in many fights
0 1 2 38. Gets teased a lot
0 1 2 39. Hangs around with others who get in trouble
0 1 2 40. Hears sounds or voices that aren't there (describe):

0 1 2 41. Impulsive or acts without thinking
0 1 2 42. Would rather be alone than with others
0 1 2 43. Lying or cheating
0 1 2 44. Bites fingernails
0 1 2 45. Nervous, highstrung, or tense
0 1 2 46. Nervous movements or twitching (describe):

0 1 2 47. Nightmares
0 1 2 48. Not liked by other kids
0 1 2 49. Constipated, doesn't move bowels
0 1 2 50. Too fearful or anxious
0 1 2 51. Feels dizzy
0 1 2 52. Feels too guilty
0 1 2 53. Overeating
0 1 2 54. Overstressed
0 1 2 55. Overweight
0 1 2 56. Physical problems without known medical cause:
   a. Acnes or pims (not stomach or headaches)
   b. Headaches
   c. Nausea, feels sick
   d. Problems with eyes (not if corrected by glasses) (describe):
   e. Rash or other skin problems
   f. Stomachaches or cramps
   g. Vomiting, throwing up
   h. Other (describe):

Please see other side
<table>
<thead>
<tr>
<th>Item Number</th>
<th>Description</th>
<th>Code 0</th>
<th>Code 1</th>
<th>Code 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>57</td>
<td>Physically attacks people</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>58</td>
<td>Picks nose, skin, or other parts of body (describe):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>59</td>
<td>Plays with own sex parts in public</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60</td>
<td>Plays with own sex parts too much</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>61</td>
<td>Poor school work</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>62</td>
<td>Poorly coordinated or clumsy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>63</td>
<td>Prefers being with older kids</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>64</td>
<td>Prefers being with younger kids</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65</td>
<td>Refuses to talk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>66</td>
<td>Repeats certain acts over and over; compulsions (describe):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>67</td>
<td>Runs away from home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>68</td>
<td>Screams a lot</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>69</td>
<td>Secretive, keeps things to self</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>70</td>
<td>Sees things that aren't there (describe):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>71</td>
<td>Self-conscious or easily embarrassed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>72</td>
<td>Sexual problems (describe):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>74</td>
<td>Showing off or clowning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>75</td>
<td>Shy or timid</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>76</td>
<td>Sleeps less than most kids</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>77</td>
<td>Sleeps more than most kids during day and/or night (describe):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>78</td>
<td>Smears or plays with bowel movements</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>79</td>
<td>Speech problem (describe):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>80</td>
<td>Stares blankly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>81</td>
<td>Steals at home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>82</td>
<td>Steals outside the home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>83</td>
<td>Stores up things he/she doesn't need (describe):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>84</td>
<td>Strange behavior (describe):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>85</td>
<td>Strange ideas (describe):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>86</td>
<td>Stubborn, sullen, or irritable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>87</td>
<td>Sudden changes in mood or feelings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>88</td>
<td>Suiks a lot</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>89</td>
<td>Suspicious</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90</td>
<td>Swearing or obscene language</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>91</td>
<td>Talks about killing self</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>92</td>
<td>Talks or walks in sleep (describe):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>93</td>
<td>Talks too much</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>94</td>
<td>Teases a lot</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Temper tantrums or hot temper</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Thinks about sex too much</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>97</td>
<td>Threatens people</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>98</td>
<td>Thumb-sucking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Too concerned with neatness or cleanliness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>100</td>
<td>Trouble sleeping (describe):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>101</td>
<td>Truancy, skips school</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>102</td>
<td>Underactive, slow moving, or lacks energy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>103</td>
<td>Unhappy, sad, or depressed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>104</td>
<td>Unusually loud</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>105</td>
<td>Uses alcohol or drugs for nonmedical purposes (describe):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>106</td>
<td>Vandalism</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>107</td>
<td>Wets self during the day</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>108</td>
<td>Wets the bed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>109</td>
<td>Whining</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>110</td>
<td>Wishes to be of opposite sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>111</td>
<td>Withdrawn, doesn't get involved with others</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>112</td>
<td>Worsens</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>113</td>
<td>Please write in any problems your child has that were not listed above:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Please be sure you have answered all items.**

**Underline any you are concerned about.**
APPENDIX C. PARENT ATTITUDE SURVEY*

Instructions

On the following pages are a number of statements regarding parents and children. Please indicate your agreement or disagreement with each statement in the following manner:

- Strongly Agree ——cross out letter “A” on answer sheet
- Agree ——cross out letter “a” on answer sheet
- Undecided ——cross out letter “u” on answer sheet
- Disagree ——cross out letter “d” on answer sheet
- Strongly disagree———cross out letter “D” on answer sheet

For example: if you strongly agree with the following statement, you would mark it this way:

Boys are more active than girls. A a u d D

All your answers are to be marked on the green answer sheet. As you turn each page, the next column of answers will appear. Please do not write on this page or on the statements.

This survey is concerned only with the attitudes and opinions that parents have; there are no “right” or “wrong” answers. Work just as rapidly as you can—it is your first impression that we are interested in. There is no time limit.

REMEMBER..........................A=Strongly Agree
                                   a=Agree
                                   u=Undecided
                                   d=Disagree
                                   D=Strongly Disagree

Please turn the page and go ahead...........................


Reproduced with permission
1. Parents have to sacrifice everything for their children.

2. Parents should help children feel they belong and are needed.

3. Taking care of a small baby is something that no woman should be expected to do all by herself.

4. When you come right down to it, a child is either good or bad and there's not much you can do about it.

5. The earlier a child is weaned from its emotional ties to its parents the better it will handle its own problems.

6. Most of the time giving advice to children is a waste of time because they either don't take it or don't need it.

7. It is hard to let children go and visit people because they might misbehave when parents aren't around.

8. Fewer people are doing a good job of childrearing now than 30 years ago.

9. With all a child hears at school and from friends, there's little a parent can do to influence him.

10. If a little girl is a tomboy, her mother should try to get her interested in dolls and playing house.

11. A child has a right to his own point of view and ought to be allowed to express it, just as parents express theirs.

12. If children are quiet for a while you should immediately find out why.

13. It's a rare parent who can be even tempered with the children all day.

14. Psychologists now know children are just the same at birth; it's what happens to them afterwards that is important.

15. One reason that it is sad to see children grow up is because they need you more when they are babies.

16. The trouble with trying to understand children's problems is they usually just make up a lot of stories to keep you interested.
17. A mother has a right to know everything going on in her child's life because her child is a part of her.

18. Most parents aren't sure what is the best way to bring up children.

19. A child may learn to be a juvenile delinquent from playing games like cops and robbers and war too much.

20. There is no reason why a child should not learn to keep his clothes clean very early in life.

21. If a parent sees that a child is right and the parent is wrong, they should admit it and try to do something about it.

22. A child should be allowed to try out what it can do at times without the parents watching.

23. It's hard to know what to do when a child is afraid of something that won't hurt him.

24. Most children are just the same at birth; it's what happens to them afterwards that is important.

25. Playing with a baby too much should be avoided since it excites them and they won't sleep.

26. Children shouldn't be asked to do all the compromising without a chance to express their side of things.

27. Parents should make it their business to know everything their children are thinking.

28. Raising children isn't as hard as most parents let on.

29. There are many things that influence a young child that parents don't understand and can't do anything about.

30. A child who wants too much affection may become a "softie" if it is given to him.

31. Family life would be happier if parents made children feel they were free to say what they think about anything.

32. Children must be told exactly what to do and how to do it or they will make mistakes.

33. Parents sacrifice most of their fun for their children.

34. Many times parents are punished for their own sins through the bad behavior of their children.
35. If you put too many restrictions on a child, you will stunt his personality.

36. Most children’s fears are so unreasonable it only makes things worse to let the child talk about them.

37. It’s hard to know when to let boys and girls play together when they can’t be seen.

38. I am faced with more problems than most parents.

39. Most of the bad traits that children have (like nervousness or bad temper) are inherited.

40. A child who misbehaves should be made to feel guilty and ashamed of himself.

41. Family conferences which include the children don’t usually accomplish much.

42. It’s a parent’s duty to make sure he knows a child’s innermost thoughts.

43. It’s hard to know whether to be playful rather than dignified with children.

44. A child that comes from bad stock doesn’t have much chance of amounting to anything.

45. A child should be weaned away from the bottle or breast as soon as possible.

46. There’s a lot of truth in the saying, “Children should be seen and not heard”.

47. If rules are not closely enforced children will misbehave and get into trouble.

48. Children don’t realize that it mainly takes suffering to be a good parent.

49. Some children are so naturally headstrong that a parent can’t really do much about them.

50. One thing that I cannot stand is a child’s constantly wanting to be held.

51. A child’s ideas should be seriously considered in making family decisions.

52. More parents should make it their job to know everything their child is doing.

53. Few parents have to face the problems I find with my children.

54. Why children behave the way they do is too much for anyone to figure out.

55. When a boy is cowardly, he should be forced to try things he is afraid of.
56. If you let children talk about their troubles they end up complaining.

57. An alert parent should try to learn all his child’s thoughts.

58. It’s hard to know when to make a rule and stick by it.

59. Not even psychologists understand exactly why children act the way they do.

60. Children should be toilet-trained at the earliest possible time.

61. A child should always accept the decision of his parents.

62. Children have a right to activities which do not include their parents.

63. A parent has to suffer much and say little.

64. If a child is born bad there’s not much you can do about it.

65. There’s no acceptable excuse for a child hitting another child.

66. Children should have a share in making decisions just as grownups do.

67. Children who are not watched will get in trouble.

68. It’s hard to know what healthy sex ideas are.

69. A child is destined to be a certain kind of person no matter what the parents do.

70. It’s a parent’s right to refuse to put up with a child’s annoyances.

71. Talking with a child about his fears most often makes the fear look more important than it is.

72. Children have no right to keep anything from their parents.

73. Raising children is a nerve-wracking job.

74. Some children are just naturally bad.

75. A child should be taught to avoid fighting no matter what happens.

76. Children don’t try to understand their parents.

77. A child should never keep a secret from his parents.
APPENDIX D. PERSONAL DATA SHEET

Basic Information
(For confidentiality, do not write your name on this form)

1. Your age: __________

2. Your gender: (circle one) male female

3. # of adults in the home (include yourself): ________________

4. When did your child start the FOCUS program: ________________

5. The current age of your child who is in the FOCUS program: _______

6. The number of brothers and sisters your FOCUS child has: ____________

7. The gender of your FOCUS child: (circle one) male female

8. Your income level: (check one)

   • less than $10,000
   • $10,000 - $20,000
   • $20,000 - $40,000
   • $40,000 - $60,000
   • over $60,000

9. Highest level of education you completed: ___________________________

10. Your current marital status: (circle one)

    Single Married Divorced Widowed

11. Are both of the FOCUS child’s biological parents living in the same household?

    (Circle one) yes no
APPENDIX E. OPEN-ENDED QUESTIONS REGARDING PARENTING

Parent Opinion

Please write down what you consider your goal of parenting:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

What are your hopes and fears for your child that is in the FOCUS program?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Group Evaluation Form

Please take a few minutes to provide comments regarding this group experience.


Was it helpful?


Would you suggest it for other FOCUS parents?


Dear FOCUS parent:

I am in the process of completing my Ph.D. at Iowa State University in the area of counseling and have designed a study to assist parents who have children in the FOCUS program. This study involves providing parents with a brief group experience which is a new element to the FOCUS program. This group experience was created to help parents combat the feelings of blame which can often accompany parenting children with behavior problems, understand family patterns, and recognize parenting strengths.

It was my experience working as a therapist in the FOCUS program from December, 1994 to February, 1996 that fostered my desire to better assist the parents of FOCUS. Therefore I developed this group experience both as a result of the input I received from the parents I had worked with as well as the current research that is in this area. I decided on a group since parents often indicate it is useful to meet with others who have experienced similar struggles.

To complete this study I have obtained the permission of both Broadlawns Medical Center and Iowa State University. While both of these organizations recognize the value of providing assistance to parents, it can only be a meaningful study with your help. Therefore I am asking for your participation in this study. Your involvement as well as your child's involvement in this study is voluntary. Your responses on the evaluation tools will be confidential and all members of the groups will be asked to uphold the confidentiality of one another.

Please review the enclosed information sheet for the specific aspects to this study. If you have any questions regarding this study, please leave a message at 282-5727 and I will return your call as soon as possible.

I look forward to your involvement in this study. I feel that this can be a beneficial experience to you as well as for the future programming of FOCUS.

Sincerely,

Susan Schiltz-Day, LMHC, CAC-I
Dear FOCUS parent:

I am in the process of completing my Ph.D. at Iowa State University in the area of counseling and have designed a study to explore the effectiveness of the FOCUS program. I decided to explore the opinions of the FOCUS parents due to my experience working as a therapist in the FOCUS program from December, 1994 to February, 1996. This experience fostered my desire to better assist the parents of FOCUS. Therefore you are asked to complete survey data regarding your opinions about parenting and your child's behavior. It will take about 30-45 minutes of your time to complete the questions. I will also ask for your input again in 5 weeks. It is very important that you fill out this information as soon as possible and return this to the FOCUS program.

To complete this study I have obtained the permission of both Broadlawns Medical Center and Iowa State University. While both of these organizations recognize the value of providing assistance to parents, it can only be a meaningful study with your help. Therefore I am asking for your participation in this study. Your involvement in this study is voluntary. Your opinions about parenting and your child's behavior will be completely confidential. I appreciate your willingness to help with this evaluation process.

Please review the enclosed information sheet for the specific aspects to this study. If you have any questions regarding this study, please leave a message at 282-5727 and I will return your call as soon as possible.

I look forward to your input.

Sincerely,

[Signature]

Susan Schiltz-Day, LMHC, CAC-I
APPENDIX L CONSENT TO PARTICIPATE IN GROUP FORM

Consent to Participate in the Parent Group

Thank you for agreeing to participate in this parent group for the FOCUS parents. This group is designed to coordinate with the therapy you are already receiving at FOCUS. All members participating in this group are asked to maintain the confidentiality of the group.

Participation in this group is voluntary and you may withdraw at any time. However, it is hoped that participants will make every effort to attend the 5 group sessions.

Participation in this group may bring about change in your life. It is hoped that this group experience will be useful to the parents of the FOCUS program, especially as they meet the challenges that parenting can often bring.

Signing this form indicates you understand the issues noted above.

Signed__________________________________________

Date________________________
APPENDIX J. APPROVAL FROM THE HUMAN SUBJECTS REVIEW BOARD

Last Name of Principal Investigator  Susan Schiltz-Day

Checklist for Attachments and Time Schedule

The following are attached (please check):

12. ☑ Letter or written statement to subjects indicating clearly:
   a) purpose of the research
   b) the use of any identifier codes (names, #s), how they will be used, and when they will be removed (see Item 17)
   c) an estimate of time needed for participation in the research and the place
   d) if applicable, location of the research activity
   e) how you will ensure confidentiality
   f) in a longitudinal study, note when and how you will contact subjects later
   g) participation is voluntary; nonparticipation will not affect evaluations of the subject

13. ☑ Consent form (if applicable)

14. ☑ Letter of approval for research from cooperating organizations or institutions (if applicable)

15. ☑ Data-gathering instruments

16. Anticipated dates for contact with subjects:
   First Contact   Last Contact
   8/25/96         11/1/96
   Month / Day / Year   Month / Day / Year

17. If applicable: anticipated date that identifiers will be removed from completed survey instruments and/or audio or visual tapes will be erased:
   12/1/96
   Month / Day / Year

18. Signature of Departmental Executive Officer   Date   Department or Administrative Unit
   A. J. Newton   7/16/96   Professional Studies

19. Decision of the University Human Subjects Review Committee:
   ☑ Project Approved   ___ Project Not Approved   ___ No Action Required

   Patricia M. Keith   7-22-96
   Name of Committee Chairperson   Date   Signature of Committee Chairperson

GC: 8/95
<table>
<thead>
<tr>
<th>Goal of Parenting</th>
<th>Pretest</th>
<th>Posttest</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>• Not making my children afraid to tell me anything.</td>
<td>• Not making my children afraid of me.</td>
</tr>
<tr>
<td></td>
<td>• Keeping them safe as humanly possible.</td>
<td>• Teaching them age appropriate behavior.</td>
</tr>
<tr>
<td></td>
<td>• Respecting them as children and their rights.</td>
<td>• Teaching them how to stay safe.</td>
</tr>
<tr>
<td></td>
<td>• (For child) to leave FOCUS.</td>
<td>• Keeping communication open about anything.</td>
</tr>
<tr>
<td></td>
<td>• FOCUS may help her.</td>
<td>• She will return to a regular classroom and adjust well to it.</td>
</tr>
<tr>
<td></td>
<td>• That she may not leave FOCUS.</td>
<td>• She will lose sight of her good qualities and pay attention only to the bad ones.</td>
</tr>
<tr>
<td>2</td>
<td>• To make (the child) the best person he can be.</td>
<td>• I would like (the child) to learn to deal with problems without losing his temper</td>
</tr>
<tr>
<td></td>
<td>• To make (the child) see he can be whatever he wants to be.</td>
<td>• and to respect adults</td>
</tr>
<tr>
<td></td>
<td>My hopes are that (the child) can learn to control his temper and learn that he’s not always right.</td>
<td>• and not to argue back all the time.</td>
</tr>
<tr>
<td></td>
<td>My fears are that (the child) won’t let anyone help him.</td>
<td>• My hopes are for (the child) to learn control of temper and understand that there’s always two sides to a situation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• My fears are that if (the child) doesn’t think before he reacts he probably won’t finish school and he could be anything he wants to be if his attitude doesn’t get in the way.</td>
</tr>
<tr>
<td>3</td>
<td>• To always show my children love and understanding.</td>
<td>• To help teach my children to know the difference between right and wrong.</td>
</tr>
<tr>
<td></td>
<td>• To teach them to be productive.</td>
<td>• To teach them to become successful adults</td>
</tr>
<tr>
<td></td>
<td>• [To teach them] to follow the rules of the serenity prayer.</td>
<td>• and to allow them to make their mistakes and learn from them.</td>
</tr>
<tr>
<td></td>
<td>• That they can accomplish many things when they take the chance.</td>
<td></td>
</tr>
</tbody>
</table>
Hope
- I hope that he will learn to be productive
- and to accept it as such and to accept his shortcomings so as it won’t make his life so critical.
- I hope that he will be able to learn to cope with life and be successful.

Fear
- That if we are not capable of successfully teaching (the child) to deal with his own fears, problems, responsibilities, or accepting his shortcomings that he will become so depressed he will be suicidal or violently enraged that he will be incarcerated.
- I fear that he won’t become as successful as he needs to and that his anger will be crippling to the point of him ending up in the legal system or in out-of-home placement.
- an incident now makes me afraid that he will hurt someone in a rage of anger.

4 Goal of Parenting
- Help my kids out in every way I can.
- To be there for them when I can.
- Find a way to help each and every one of them.
- Kids to be successful.
- Get them to know how the world is.
- To stand on their own 2 feet.
- Once they fall, get back up and keep fighting - they’ll get what they want in the long run.

Hopes & Fears
- That I can find someplace for my son and that somewhere, somehow, someone can help him find what he needs in life because he is a good person to work with when you know him.
- Hope that he does a 180° turn and goes for the good.
- I fear that someday they’ll call and say “come and identify your son” or “your son is arrested”.

5 Goal of Parenting
- Keeping my children safe all the time.
- Getting help when needed.
- Trying to understand better my son’s feelings and wants out of life.
- Getting out and doing more with my children.

Hope
- That my son could put himself in my shoes for one day.
- Getting his feelings under control and to understand his wants and his presence as a child in our family.

Fear
- Things will get worse to where I lose my son forever.
Goal of Parenting

- My goals are for them to be caring, sharing, respectful, hardworking, make good choices in life.
- To be the best they can be.
- To be good parents and raise their children with pride.

Hopes

- Focus on his education (reading, math, etc.) to respect other people (teachers).
- Work hard and get back to his regular school.
- Caring, loving, respect, honest, and hard working.
- Get an education.
- What to avoid and what to pursue.
- The importance and value of family, how to work hard, to respect people, to be honest, and to love one another.
APPENDIX L. PARENTS MEANINGFUL UNIT RESPONSE FOR GROUP EVALUATION

1 Group Evaluation

Posttest
- It was good to find out that we weren’t alone as parents with children who had emotional problems.
- (It was good) to exchange ideas about parenting.

Helpful?
- Yes

Suggest it for other FOCUS parents?
- Yes

2 Group Evaluation

- I really enjoyed the group.
- (The group) helped a lot just to talk about the things that worried me about (the child) and
- [it helped to talk about] if I’m making the right choices
- and it helped to listen to other parents with the same problems and
- [it helped to listen how other parents] handled their child.

Helpful?
- Yes it was.

Suggest it for other FOCUS parents?
- I think it would help other parents deal with child and different ways to handle it.

3 Group Evaluation

- This group has been a tool in my battle as a parent.
- Our family has learned that other families are having difficulties also.
- The children were especially ready for each meeting and tuned into the fact that we were all learning to cope with disabilities of each other.

Helpful?
- Yes. this gave the children good rec therapy instead of childcare worries
- while parents worked together on concerns and strengths.
Suggest it for other FOCUS parents?

- Most certainly. Parents can really get caught up in the emotions and difficulties of raising a needy child that there is little time for their needs.
- This group is less worries, it enables parents to take a break and think through tough situations before taking action, while having an overall good experience.

4 Group Evaluation

- Really liked it.
- Seeing how others deal with kids helped, heard what other parents did to deal with kids.
- Would have liked it to continue.
- Hearing others helped me to think about my parenting ahead.

Helpful?

- Yes

Suggest it for other FOCUS parents?

- Yes

5 Group Evaluation

- A lot of things helped me to understand about other children and parents that have the same problems as I do with my child was very helpful.
- To talk to different parents about problems and different ways to help out our children in need from every day life.

Helpful?

- Yes, telling each other how to get through the hard times and the good times/situations.

Suggest it for other FOCUS parents?

- Yes, very helpful and easy to talk out loud to other parents.

6 Group Evaluation

- The group experience was helpful to me.
- It made me see that I am not alone; sometimes you need to know that you are not walking that line by yourself.
- The group gave me different ideas to work with.
- When I feel like giving up, the group gave me that extra push to make me want to try again.
7 Group Evaluation

- Some things that look big or terrible to me, the group always made it look small or made me look at another side of the picture.
- Yes. I am sorry it ended after 5 sessions.
- Yes. The parents worked together and gave each other that extra strength.
- I want to take this time to thank you for giving me the opportunity to participate in your family group therapy sessions.
- We came into these sessions complete strangers. After giving our thoughts and opinions on certain issues we found out so much about each other as well as on self.
- When we departed I felt we were becoming one big family.
- I wish you luck. And I hope your career soars.
REFERENCES


ACKNOWLEDGMENTS

I wish to acknowledge my major professor and the members of my committee for their assistance and guidance. I would like to acknowledge the significant contribution that Deb Larkin, the staff recreational therapist, made to this study by providing the "bonus" recreation time for the youth and providing assistance with this study. I wish to thank Dave Grove and Barry Ulberg for serving as independent raters to this study. They were able to provide valuable insight for the qualitative analysis. And I wish to thank Vern Hoyt for her technical assistance.