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Child Conduct Problems and Parent Support: A Home-Based Counselling Intervention

by

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**A Dissertation Submitted in Partial Fulfillment of the
Requirements for the Degree of**

DOCTOR OF PHILOSOPHY

In the Department of Educational Psychology and Leadership Studies

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ABSTRACT

A mixed method research methodology based on the principles of empirical research in social learning family interventions and narrative inquiry was employed to explore and explicate the effects of in-home Parent Management Training (PMT) for mothers of children/adolescents who have Conduct Problems (CP). Prior research has indicated that mothers of such children and adolescents experience more psychological, social and emotional distress than their same-sex peers. As well, these mothers report feeling less confident about their ability to parent their children in the face of on-going challenging behaviors such as child non-compliance, defiance, disobedience and aggression. In previous research, mothers have described themselves as isolated socially, personally defeated, and often economically disadvantaged by the demands of coping with their children's/adolescents' acting-out behaviors at home, school, and in their neighborhoods. The current research evaluated the effectiveness of treatment for mothers and children based on a multisystemic approach (MST) to providing in-home PMT.

Mothers ($n = 26$) in the treatment condition were measured three times using standardized questionnaires of parenting stress and parenting self-agency. In addition, mothers and teachers each completed the appropriate form of the same behavior checklist of child/adolescent psychopathology three times. Nine of the mothers also participated in three narrative interviews, which queried their experiences of parenting a child/adolescent with CP, their subsequent experiences of the in-home parenting skills intervention, and their ability to cope four months post-treatment. Statistical analyses indicated positive changes in mothers' reported levels of parenting self-agency, and

reductions in their levels of parenting stress. Teachers' scores remained unchanged. Thematic analysis of mothers' interviews yielded data that supported the quantitative findings; however, the interview data was also found to contribute unique information about the quality of mothers' parenting, marital and other relationships, as well as their opinions of whether the in-home counselling was personally supportive and effective in teaching them additional behavior management skills.

Whereas most of the mothers interviewed reported feeling supported by the in-home counsellor, as well as significant improvements to their parenting skills, the mothers also reported that their children required on-going parenting efforts that were consistent with reduced but not unremitting child/adolescent CP. Implications for clinical practice and future research are suggested, based on the limited generality of the findings.

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Table of Contents

	<u>Page</u>
Title Page	i
Abstract	ii
Table of Contents	iv
List of Tables	vi
List of Figures	vii
Acknowledgments	viii
Dedication	ix
CHAPTER ONE - Introduction	1
Parameters of the Study	8
CHAPTER TWO – Review of the literature	15
Parent Effects	19
PMT Outcome Studies	23
Summary of Current State of Knowledge	45
Hypotheses of the Study	46
CHAPTER THREE – Methodology	48
Pilot Study	48
Dissertation Study: Child Conduct Problems and Parent Support	48
Research Design	50
Sample Selection	51
Procedures for Data Collection and Treatment	55
Measures	59
The Narrative Inquiry	64
Assumptions and Limitations	67
Summary	68
CHAPTER FOUR – Research Findings	70
Quantitative Results	70
Overview of Statistical Procedures	70
Description of Sample	71
Analyses Including the Control Group	72
Qualitative Data	78
Participants and Procedures	81
The Interviews	85
Cross Case Comparison of the Initial Interviews	118
Cross Case Comparison of Posttreatment Interviews	122
Comparison of the Follow-up Interviews	124
Summary	126

	v
CHAPTER FIVE – Discussion and Implications for Research	130
Summary of Research Problem and Method	131
Summary of Findings	134
Implications	137
Child Behavior Checklist and Teacher Report Form	137
Parenting Self-Agency Measure	140
Parenting Stress Index	141
Future Research	142
Conclusion	147
REFERENCES	150
FIGURES 1 – 6	163
APPENDICES	
Appendix A: The Pilot Study and References	169
Appendix B: Parent Information and Consent to Participate in Research	184
Appendix C: Child and Teen Consent to Participate in Research	186
Appendix D: Teacher Consent to Participate in Research	187
Appendix E: Script for Treatment Group Child	188
Appendix F: Waitlist Parent/Caregiver Letter	189
Appendix G: Waitlist Recruitment Script (Mother Phone Contact)	190
Appendix H: Consent for Research and Program Evaluation (Waitlist)	191
Appendix I: Client Information Sheet	192
Appendix J: Parent Questionnaire (Demographics)	193
Appendix K: Table 3	194
Appendix L: Narrative Interview Questions	195

List of Tables

	<u>Page</u>
Table 1 Treatment and Control Group Means (and Standard Deviations) for Pretreatment and Posttreatment, and Time by Group Interaction Effects for PSAM, PSI-C, PSI-P, and CBCL Internalizing, Externalizing, and Total Problem Scales	75
Table 2 Correlations between CBCL (Parent) and Teacher Report Form (TRF) across Pretreatment, Posttreatment, and Follow-up	77
Table 3 Correlations Between Parent Variables Across Treatment and Control Groups	194

List of Figures

	<u>Page</u>
Figure 1. Mean Parenting Self-Agency Measure (PSAM) scores for treatment group (n = 26) and control group (n = 5) at pretreatment and posttreatment	163
Figure 2. Mean Parenting Stress Index Child domain (PSI-C) scores for treatment group (n = 26) and control group (n = 5) at pretreatment and posttreatment	164
Figure 3. Mean Parenting Stress Index Parent domain (PSI-P) scores for treatment group (n = 26) and control group (n = 5) at pretreatment and posttreatment	165
Figure 4. Mean Child Behavior Checklist (CBCL) Internalizing scores across three times (pretreatment, posttreatment, and follow-up)	166
Figure 5. Mean Child Behavior Checklist (CBCL) Externalizing scores across 3 times	167
Figure 6. Mean Child Behavior Checklist (CBCL) Total scores across 3 times	168

Acknowledgments

I wish to acknowledge the many individuals who contributed to the completion of this research. Sincere appreciation and gratitude are expressed toward the co-supervisors of my dissertation, Dr. B. Harvey and Dr. B. Timmons, for their enduring scholarly support. I include a special thank-you to Dr. Timmons, because she has always understood the needs of the adult learner, and the appeal of longitudinal projects. To the members of my committee, Dr. J. Walsh and Dr. R. Ferguson, whose insightful questions and encouragement helped guide my efforts, I thank you for completing this with me.

I am grateful to all of the kids and families at Queen Alexandra Centre, who trudged through the paperwork and shared their experiences in the interviews. Thank you also, to my colleagues at the Capital Health Region and the Ministry for Children and Families, for working to improve services to children and adolescents at risk. I have appreciated the support of the Queen Alexandra Foundation and the Child, Youth and Maternal Health Research Advisory Committee. I am particularly grateful for their wisdom in providing clinicians with statistical and technical guidance through Dr. K. Kerns, and our research assistant, Mr. B. Williams.

At long last, I can voice heartfelt recognition of my family's patience with my slightly distracted participation at home over these last nine years. And to Dr. Donald Knowles, a gentle man and a scholar, who taught me the concept of "the good enough mother," I extend greetings and farewell. Finally, bravo to Dr. R. McMahon and Dr. Carolyn Webster-Stratton for their instruction and for gifts carried across the water.

DEDICATION

In memoriam, Herbert Rosenberg, 1917 to 1953, whose love and brilliance were truly inspirational; and The Never Sweats, born circa 1968 on Lasqueti Island, exiled from Calvert Island, February, 1972, adieu.

Chapter 1

Introduction

Conduct Problem (CP) is the term currently used to include the antisocial behaviors of both children and adolescents (McMahon & Estes, 1997; Webster-Stratton & Hammond, 1997): It encompasses a wide range of problematic behaviors, from non-compliance to aggression (Webster-Stratton & Hammond, 1997). The CP label is an "umbrella" term which includes behavioral criteria described under the Oppositional Defiant (OD) and Conduct Disorder (CD) sections of the DSM-IV (APA, 1994). This generic approach also serves to label a continuum of behavior which reflects the developmental progression of children's CP from early childhood through adolescence (Dishion, French & Patterson, 1995). The intensity and frequency of child and adolescent deviant behavior are influenced by an individual's unique temperament, as well as by familial, social, and educational environmental contexts (Bronfenbrenner, 1986; Dishion, et al., 1995). However, the age at onset of childhood CP is one of the most chilling predictors of persistent and chronic adolescent CP (Loeber et al., 1993).

Overviews of CP research (Dishion, French & Patterson, 1995; Hinshaw, Lahey, & Hart, 1993; McMahon & Estes, 1997) demonstrate powerful arguments for the role of time (age), intra-familial, peer, and environmental factors in the both the etiology and development of CP from OD and early onset CD. Forty to fifty percent of those adolescents who are diagnosed with CP will have been diagnosed with OD/CP earlier in their childhood (Loeber et al., 1993). There is support for the rationale that the lesser

misbehaviors such as non-compliance, temper tantrums, and arguing which are performed by younger children are predictive of the increased aggression and antisocial behaviors at the other end of the CP continuum (Dishion et al., 1995; Patterson, 1982). As CP children move from the more private domain of home and family to the more public setting of school, the variety, intensity, and frequency of their CP behaviors evolve to fit their expanded social context (McMahon & Estes, 1997). These children are at higher risk than their non CP peers for physical abuse, and to aggress against siblings in their homes (Patterson, 1982); to be rejected by peers at school (Coie & Jacobs, 1993; Dodge, Petit & Bates, 1994), and to be negatively judged by teachers (Lovejoy, 1996). Their conduct problems interfere with many areas of their development and cause considerable distress to both family and community. The documented relationship between pre-adolescent conduct problems and future criminality has helped to spur research into the ecology and development of this childhood disorder (Patterson, 1982; Serbin et al., 1991).

Insight into the increased intensity and diversity of CP behaviors manifested by individual children across time has led to increased research into the critical times at which interventions should be made in order to have the most impact on interrupting the course of CP (Conduct Problem Prevention Research Group, 1992; Costello & Angold, 1993; Patterson, Chamberlain & Dishion, 1993). Early intervention and prevention programs target identification of CP during kindergarten, with the delivery of multi-system services between grade one and six—the years when cognitive behavioral approaches are most likely to succeed among child populations with clinical level of CP (Patterson, 1982; Patterson & Reid, 1992). Current reviews of the literature support

identification and treatment of child CP before age twelve (12) as critical (Crowley & Kazdin, 1998); however, many youngsters with childhood CP, who are within this targeted age range will receive no treatment (Webster-Stratton, 1990), or will drop-out of treatment (Kazdin, 1990, 1998). The hypothesis that treatment of conduct problems is more effective before adolescence is supported by studies which place the parent-child relationship at the heart of both the problem and its solution (Patterson 1982; Patterson, Reid & Dishion, 1992).

Current reviews of treatment outcome studies yield a literature rich in variables related to parents' roles in both the etiology and remediation of their children's CP (Coie & Jacobs, 1993; Kazdin, 1998; Patterson, 1982; Patterson et al., 1992; Reid, 1993; Webster-Stratton & Hammond, 1997; Brestan & Eyberg, 1998). Both the implementing of effective treatment programs for children and their families, and helping families with treatment completion, are equally essential components of effective interventions which have been demonstrated to be efficacious in ameliorating child CP (Brestan & Eyberg, 1998; Prinz & Miller, 1996). Risk factors which prevent families from seeking treatment include: lower socioeconomic status; parental psychopathology, isolation, and stress; history of antisocial behavior; personal health concerns as well as substance misuse; marital discord or inappropriate partner, and higher levels of child CP (Crowley & Kazdin, 1998; Prinz & Miller, 1996). These same difficulties predict premature termination from treatment, with sporadic participation and premature drop-out rates of 50 to 60% (Kazdin, 1990; McMahon, Forehand, Griest & Wells, 1981). The most effective treatments for child/youth CP are cognitive behavioral therapies which are augmented with "booster" adjunctive social supports that are aimed at engaging and

retaining participants in treatment (Prinz & Miller, 1996). These adjunctive supports include treatment components which target parent's stress, isolation, mental health, and problem-solving skills, as well as components for children/youth that address educational dysfunction, and social skills relevant to family and school contexts (Kazdin, 1996; McMahon & Estes, 1997; Webster-Stratton & Hammond, 1997).

Cognitive behavioral, psychosocial, and social learning are all terms which denote similar conceptual frameworks upon which current treatments for child CP are based (Brestan & Eyberg, 1998). The terms are nearly interchangeable, and interventions derived from these theoretical stances are intended to improve the child's CP through shifts in child and adult behaviors, as well as changes to their attitudes and self-perceptions (Lonigan, Elbert, & Johnson, 1998). Reviews of the current outcome literature on the treatment of Conduct Problems (CP) support a psychosocial approach to the practice and evaluation of counselling interventions provided to CP children and their families (Achenbach, 1988; Brestan & Eyberg, 1998; Kazdin, 1998; Miller & Prinz, 1990; Webster-Stratton, 1991). Social learning theory highlights the relationship and perceptual contexts of behavior (Reid, 1993), and is relevant to the ways in which conduct problems in children and families are conceptualized (Patterson, 1982; Patterson, Reid, & Dishion, 1992) and treated (Kazdin, Esveldt-Dawson, French, & Unis, 1987a, 1987b; Dadds & McHugh, 1992). Behavioral change is said to occur through the influence of both behavioral reinforcement (contingent rewards) and observation (modelling) (Bandura, 1986). In current treatment and research, the application of cognitive behavioral therapies in varying contexts has been identified as empirically

supported, efficacious treatment for childhood conduct problems (Brestan & Eyberg, 1998; Kazdin, 1998; Lonigan et al., 1998).

In the family context, parental attention is considered a potentially significant reward and a potent reinforcement for both positive and negative behavior. Also within the family context, parent's modelling of behavior is considered a ubiquitous source of child imitative response. Thus, parents who model forceful solutions to their children's problematic behaviors teach their children an antisocial approach to solving social problems. Moreover, because these children observe, learn, and enact fewer appropriate responses to ordinary "hassles", they are more likely to demonstrate a constricted repertoire of prosocial skills at home and school (Patterson, 1982).

Four types of cognitive behavioral therapy, which will be discussed in detail in Chapter 2 of this paper, have been extensively researched and shown to be effective in the reduction of child and adolescent deviance (Kazdin, 1998). These are child/youth skill based (Problem Solving Skill Therapy; PSST); parent child management skill based (PMT); family systems behavioral therapy (FBT); and multisystemic therapy (MST). Although elements of each of these four interventions are found across effective cognitive-behavioral treatments, the practice of each of the four is usually not just an eclectic mix (Kazdin, 1998). Rather, the elements, contents, and processes of treatment implementation, and the evaluation of treatment outcomes are detailed in the treatment manual (Kazdin, 1996). Thus, treatments which are judged efficacious are based on specific manuals, and administered by clinicians who have been trained in the techniques described therein (Lonigan, Elbert, & Johnson, 1998). The treatment manual has been

developed from systematic application of practice guidelines, which include adherence to treatment protocols, and due diligence toward maintaining treatment integrity.

The problem is to provide cost effective treatment to the families who parent children with CP, when these families are identified as belonging to a population which is characterized by its difficulty in engaging in treatment. The problems that deter parent's engagement in treatment persist even in the context of empirically based effective treatment (Kazdin, 1990; Kazdin, Mazurick, & Bass, 1993; Kazdin & Weisz, 1998). Kazdin, Mazurick and Bass found the rate of attrition ranges from 40 to 50% with premature termination of treatment greatest for parents with: younger mental age; single parent or minority-group status; socioeconomic disadvantage; higher personal and life event stress; adverse parenting practices; and for mothers, a history of childhood antisocial behavior. Child/adolescent characteristics associated with a family's dropping-out of treatment include severity, breadth and history of antisocial behavior; academic problems; current contacts with antisocial peers; and multiple psychiatric diagnoses. The accumulation of multiple risk factors placed families at increased risk for dropping out of treatment prematurely; "The results suggest that the more dysfunctional children and families may be at greater risk for dropping out of treatment" (Kazdin et al., 1993, p. 2).

The risk factors which increase premature termination from treatment on the part of the child or adolescent, and the family, challenge therapists to offer novel approaches to maintaining high-risk families in treatment (Kazdin, 1997; Prinz & Miller, 1996). However, many parents will decline PMT at initial offering, despite supports some early-intervention programs offer to provide in the way of transportation, meals, child-minding,

and monetary incentives (Dumka, Roosa, Michaels, & Suh, 1995). In their (1995) study of parent participation amongst high risk, inner-city families, Dumka and colleagues found that 30% of parents who were invited to participate in PMT did not attend, despite their having been involved with the development of the course (and incentives) for nine months prior to the first session. Early intervention is only successful as parents experience the need for change and are motivated to engage in PMT (Bandura, 1997); therefore the PMT therapist must assume a certain responsibility for helping parents to stay motivated.

For those parents who attend PMT groups, the literature supports the delivery of the curriculum within the context of collaborative goal setting between parent and counsellor. The participatory mode is important for both parent and counsellor in PMT teaching-learning. Demonstrations of target parenting behaviors are presented both from selected videotape vignettes (Webster-Stratton, 1987) and through therapist and group member's modeling. Group process; experiential learning and role playing; didactic and participatory learning; and homework are important elements of PMT (Kazdin, 1997; Webster-Stratton, 1991). The problem is how to provide the same efficacious treatment to people who receive the service in their homes, without the benefit of a peer group format. Whereas previous studies have evaluated the effectiveness of individually administered videotape-modelling delivered in community and clinic settings, (Webster-Stratton, 1990, 1992; Webster-Stratton, Kolpacoff & Hollinsworth, 1988), the current study examined this technique as it was delivered in the client's home.

Parameters of the Study

Assumptions of the study. In the current study, the effectiveness of delivering PMT to parents in their home was evaluated, with the assumption that an in-home PMT program offered to mothers (and their children) would have a very low rate of attrition. Because these families were party to the referral for home-based service, engagement and participation were assumed. However, since these children were part of a psychiatric population--many of whom have previously either received (or withdrawn from) clinic or hospital-based psychosocial programs--the mothers in the current study were expected to engage in the initial PMT, and complete the duration of the treatment, with varying levels of improvement. The question was whether having the mothers present physically meant that they actually continued to participate in the home-based PMT.

Delimitations of the study. Clients who choose home-based counselling do not have to cope with many of the operational difficulties that have been identified as obstacles to their participation, such as transportation, scheduling and child minding. However, their children are difficult—often with concurrent psychiatric diagnoses such as Attention Deficit Hyperactive Disorder (ADHD), Tourette's Syndrome (TS), anxiety disorder, depression (or dysthymia), pervasive developmental disorder, Asperger's, or schizoaffective disorder. In the current study there was no discrimination between children and adolescents who had or did not have co-occurring psychiatric problems. All mothers who participated in the study identified their child's CP as the primary reason for seeking treatment, and therefore treatment goals were directly aimed at ameliorating CP behaviors. The effects of co-occurring disorders were acknowledged during the individually administered PMT, but not analyzed.

The purpose of the current study was to evaluate treatment outcomes for children and their mothers, in an on-going program of home-based PMT. The program was based on treatment information contained in the scientific research on psychosocial programs for CP children and their mothers, (Lonigan, Johnson, & Elbert, 1998). The study was limited to teacher and parent measures of child improvement on behavior checklists, and did not include evaluation of the individual therapy provided to these children/adolescents. The child and adolescent psychosocial program included personal support and elements of PSST (Kazdin, 1998), aimed at enhancing anger management and other self-regulation skills. Child depression and self-harm management interventions were administered but not measured. Social skill development was modeled and taught using treatment manuals and relevant videos. Any gains from this treatment could contribute to variance on mother's reports, and should be investigated in further studies.

Objectives of the study. The study was an attempt to close two gaps in the current practice and research on parent child management training (PMT). First, there was very little in the literature about the effectiveness of working with parents in their homes as it relates to change in child behavior. (A notable exception is Dumas & Wahler's [1983] study, wherein home-teaching was used, but the brief duration and low frequency [six visits over six weeks] of visits may have affected the learning and implementation of PMT.) Whereas recent studies (cf. Webster-Stratton & Hammond, 1997) teach PMT in a clinic setting, and researchers have utilized home observation as a way of assessing child/parent interactions, there have been few outcome studies to date which evaluate the efficacy of PMT taught to parents in their homes. Individually administered videotape

treatment, with therapist consultation, has been demonstrated as an effective modality for PMT (Webster-Stratton, 1990). The present study measured the effectiveness of an individually administered PMT program (with selected video vignettes from the Webster-Stratton [1987] parenting course), delivered in clients' homes.

The preponderance of studies of home-based interventions focus on family systems behavioral therapy (FBT) and multisystemic therapy (MST) as the treatments which were used in the home (Henggeler et al., 1999; Kutash & Rivera, 1998; Lindblad-Goldberg, Dore & Stern, 1998). The problem-solving, advocacy and family therapy elements of these programs target families whose children have been receiving foster care, or psychiatric hospitalization. Thus, the success of the intervention is often determined according to whether or not the youngster remains out of foster care, or has a reduced length of hospitalization, respectively. Whereas most home-based interventions are aimed at family preservation, or crisis intervention, MST rather than PMT is the designated treatment (Henggeler et al., 1999). The current study was based on PMT in situ. Select use of MST and FBT occurred after mothers had learned PMT (with details specifically described in the model of treatment section). In the current home-based program, family preservation and minimizing youth hospitalization were underlying therapeutic goals, but not the measure of treatment success.

The present study also queried the generality of in-home PMT by examining teacher's perceptions of the child conduct problems in their schools. The third objective of this study was to compare parents' perceptions of their parenting efficacy as reported by them during narrative interviews, with their responses to scaled items on a theoretically derived measure of parenting stress.

Model of Treatment

Basic Parenting Program. The program is taken from the **Parent and Children Series Leader's Manual**, first published by Webster-Stratton in 1987, with additional notes, and literature review in the updated versions sold through the Parenting Clinic in Seattle, Washington. The Basic program has four major components which are: (a) play; (b) praise and rewards; (c) effective limit setting; (d) handling misbehavior. Webster-Stratton directs these teaching units at parents of children between the ages of 4 and 8 years. Her clinic offers additional units of parenting skills in subsequent manuals that include parents of children with CP through the age of 12 years. The current study used the Basic program with all mothers who participated in the study, with an emphasis on learning basic parenting strategies in order to adapt them for use with each family's CP child. In other words, even with mothers whose CP child was an adolescent, the Basic video vignettes of children aged 4 to 8 served as the springboard for teaching and practice. Role plays were enacted at the demonstration age, and then modified in language and tone to fit each child's chronological and developmental age. Thus, those parents who had missed essential first steps of parenting were encouraged to remediate parenting skill deficits.

The Home-Based Counselling PMT was called Positive Parenting, in order to emphasize the importance of play, praise, and rewards. From the first phone contact, parents were encouraged to articulate their goals for their children. The Home-Based (HB) coordinator, a psychologist, and the Home-Based Counsellor, a youth and family worker, collaborated with the mothers to establish behavioral outcomes. All of the Positive Parenting skills were introduced as strategies for mothers to shape their

children's behavior toward the achievement of these goals. As mothers became comfortable with praise and rewards, effective limit setting was introduced. Children were seen by the Home-Based counsellor separately. Mothers and children/adolescents met together, with the HB counsellor, as mothers were able to practice verbal praise with their youngsters. There were many choice points during the course of the HB treatment, where the counsellor could introduce family meetings.

Social support and advocacy. The current study was based on a family intervention which attempted to augment PMT with family directed advocacy. Like the FAST Track home-visiting staff described by McMahon and Sough (1996), the home-based counsellors recognized the need for advocacy to begin with "doing for," to progress to "doing with," and finally, for the counsellor to become the coach who is "cheering on" the parent's efforts. Teaching mothers social problem-solving supported their participation in their community, including a more positive presence in their youngster's school.

The current study examined the efficacy of an intervention designed to address parents' negative perceptions of their roles as parents of children with CP. The self-perceptions of interest include parents' sense of being unable to change their child's misbehavior, and their feelings of social isolation due to the financial and emotional demands of parenting. These parental experiences of aversive adult interaction, both from adults within their family and within their community, coupled with the intense demands of parenting challenging children, are the basic components of "insular parenting" (Dumas & Wahler, 1983). Insular parents, or families, are more vulnerable to early termination from treatment, and less likely to succeed in PMT (McMahon &

Slough, 1996; McMahon & Estes, 1997). Such parents were more likely to feel overwhelmed by their child's academic needs (Reid, 1993), and less likely to have a positive relationship with their child's teacher (Bierman, 1992). Insular parents require advocacy and PMT skill development in order to bridge the gap between home and school (Conduct Problems Prevention Research Group [CPPRG], 1992; Kazdin, 1996).

For the purposes of this study, insularity was measured by parent's scores on the Parenting Stress Index (Abidin, 1983), as well as by their narrative descriptions of their parenting experiences. Parent's perceptions of their parenting ability was measured by their scores on the Parenting Self Agency Measure (PSAM) (Dumka, Stoerzinger, Jackson & Roosa, 1996). Child deviance was measured by parent and teacher behavior checklists, the Child Behavior Checklist (CBCL; 1991a) and the Teacher's Report Form (TRF; Achenbach, 1991b).

Overview of the Study

In Chapter 2 of this paper, the literature related to child and adolescent CP is reviewed, with an overview of empirically sound treatment outcome studies that focus on evidence-based, psychosocial interventions. The role of parenting distress in child response to treatment is explored, in order to infer the social validity of the variables that were analyzed in the current study. In Chapter 3, the research methods are discussed. Two methods used to conceptualize and measure treatment outcome in the current study are reviewed; both lines of inquiry yielded complementary information, with quantitative and qualitative techniques employed to interpret the findings.

Chapter 4 reiterates the procedures, and describes the participants and the sample studied. The results are reported and evaluated in terms of whether or not the objectives

and hypotheses of the study were supported. Chapter 5 is a summary and discussion of the implications of the current study. Recommendations for future research, as well as recommendations for future treatment of CP children, adolescents, and their families are considered.

Chapter 2

Review of the Literature

Parenting distress, as a relationship and contextual factor, is subsumed within the theory and practice of social learning and behavioral family therapy interventions (Dumas & Wahler, 1983). As such, parenting distress is an important predictor of how effective parent training could be (Webster-Stratton, 1992). Social Learning Family Intervention (SLFI) is based on the principle that parents can act as behavior therapists for their children: Parents learn how positive child behaviors can be initiated and maintained by contingent rewards, and conversely, that negative behaviors are likely to desist when ignored. They are also taught that this re-inforcement dynamic is valid for those behaviors which are learned through modelling and for those behaviors which are unique individual child responses to their environment. The treatment components of SLFI include parent training in child behavior management (PMT); individual parent and child/adolescent assertiveness, social problem-solving and self-regulation (PSST); family participation in goal setting and problem-solving (FBT) (Achenbach, 1988; Patterson, 1982; Webster-Stratton & Herbert, 1993); and multisystemic therapy (MST), which refers to the inclusion of relevant family members, friends, and available community resources and personnel (Kazdin, 1996; Webster-Stratton, 1996). The MST component of SLFI addresses the family's social context—including any members of the identified youngster's "world" in a variety of supportive and social problem-solving dialogues (Crowley & Kazdin, 1998; McMahon & Slough, 1996).

Among families who have children with conduct problems, the system of rewards and reinforcement is likely to have been inconsistent and inappropriate (McMahon & Estes, 1997; Dishion, French & Patterson, 1995). These parents are thought to have inadvertently trained their children to misbehave by their ineffective, indiscriminate use of personal attention and tangible rewards (Forehand, Furey & McMahon, 1984; Patterson 1982; Patterson, 1992; Wahler & Dumas, 1983). The parent's negative, coercive, or inept response to her or his child's non-compliance reinforces the child's inappropriate behavior, and is thought to lead to the child's increased use of aversive behaviors (Patterson, 1982; Patterson, Reid & Dishion, 1992). The child's aversive, avoidant behavioral response to his or her parents directions is considered the cornerstone of the coercive model of family dysfunction (Dishion et al., 1995). The child's exercise and escalation of aversive behavior in an effort to avoid parental requests becomes an overlearned response, which is often identified as the child's role in "coercive family process" (Patterson, 1982). The SLFI model is bidirectional; the child is seen as influencing parent behavior, and the parent influences the child (Lytton, 1990). Adults are always the "responsible" member of the parent-child dyad--their child's loud, aggressive, non-compliance can be a serious deterrent to a parent's continuing a request, but SLFI emphasizes parents' need to respond appropriately in order to facilitate change. During the course of investigating the nature of parents' role in changing their children's CP behaviors, researchers have highlighted the contexts in which parent participation in PMT is likely to occur (Reid, 1993). Current studies of children's CP focus on the ways in which parents can be supported to implement and maintain appropriate attitudes and skills to effectively change their child's misbehavior despite difficult moments.

Through their participation in Parent Management Training (PMT) (Kazdin, Esveldt-Dawson, French & Unis, 1987; Patterson, 1992; Webster-Stratton, 1997) parents' improved parenting skills have been shown to be effective in decreasing their children's antisocial behavior. An SLFI approach teaches parents (a) to re-direct or ignore child non-compliance and aversive responses to the requests from their children; (b) to contingently re-inforce (reward) any efforts made by their youngsters to comply; (c) to create an economy at home which includes rewards and appropriate consequences; (d) to make their attention and rewards meaningful by being neutral during disciplinary interventions; (e) to reduce the frequency and intensity of their aversive responses to their children (self-control). The documented relationship between improved parenting practices and increased pro-social behavior on the part of their children is the basic component common to SLFI interventions, and provides the rationale for engaging parents in "parent training." However, given that PMT has been more effective in some families than in others, SLFI outcome research has begun to address issues related to parents' willingness to participate in parent training, as well as the investigation of adjunctive treatments which, when implemented with SLFI, can enhance parents' success (Reid, 1993). Parents have been shown to be at risk for premature termination from PMT when they report (a) high levels of personal distress and higher perceived levels of child CP behaviors (Forehand, Furey, & McMahon, 1984; Kazdin, 1990; Wahler & Dumas, 1983); (b) and a history of feeling defeated in learning to manage their children's behavior (Patterson, Chamberlain & Dishion, 1993). The older the child, the more likely that parents will report having had one or more failure experiences with PMT (Patterson, et al. 1993).

Some of the adjunctive treatments to PMT which have been studied and found effective in both the enhancement of parent participation and the reduction of child CP include the following: (a) PMT plus teaching parents the basic principles of social learning theory (Webster-Stratton & Herbert, 1990); (b) PMT plus teaching parents social problem-solving skills unrelated to parent-child problems (Pfiffner, Jouriles, Brown, Etscheidt & Kelly, 1990); (c) PMT plus teaching children social-problem solving skills (Kazdin, Esveldt-Dawson, French & Unis, 1987a); (d) PMT plus teaching children social problem-solving, with supervised parent-child sharing time (Webster-Stratton, 1997). In addition, parent attendance at PMT sessions has been enhanced through direct payment and/or supported child-minding, as well as the targeted child receiving academic tutoring (McMahon & Slough, 1996; Reid, 1993).

McMahon (1996) suggested that the first behavior management techniques taught to parents of children with CP would be to disrupt coercive behavioral chains. The author maintained that although child non-compliance is the primary target, parents cannot successfully implement consequences such as time-out until they have established a more positive pattern of parent-child interaction, with some successful practice of contingency reward. This emphasis on positive parent child/adolescent relationship is central to PMT interventions (Kazdin, 1996; Webster-Stratton, 1996). Whereas parents' ability to provide warmth and caring to their children is embedded within the parent training component of SLFI (Dishion, French & Patterson, 1995; McMahon & Estes, 1997), their ability to sustain the practice of appropriate parenting behaviors is compromised by a variety of stressors which include their children's CP (Patterson, 1982;

Patterson, 1992). Because their role is pivotal in changing their family's behavior, parent attitudes and behaviors have become important variables in the SLFI literature.

Parent Effects

Dishion and his colleagues (1995) stated that most parent-to-child behavior, as presented by their clients in home and clinic observation, was positive. However, two important features of parent-child interactions distinguish the coercive family from normative families: (a) chains of coercive behavior last longer and the level of hostility is likely to escalate, rather than decrease (Dishion, French & Patterson, 1995); and (b) while most of the observed parent-clients were positive or neutral in their interactions with their children, about ten percent (10%) of their parenting practices were more aversive than those observed in a normative family sample (Patterson, Reid & Dishion, 1992). Despite the relative insignificance of the percentages of aversive parenting practices reported in this particular study (only 10% of total parent-child interactions), the level of parent aversity is considered an important indicator of parenting efficacy (Dodge, Pettit & Bates, 1994; Forehand, Furey & Mc Mahon, 1984; Dumas & Wahler, 1983; Webster-Stratton & Hammond, 1997), and salient to the developmental course of child conduct problems (Dishion et al., 1995). Because of its central role in coercive family process, aversive parent behavior has also been targeted as a predictor of child clinical outcome posttreatment (Patterson, 1982).

Aversive parent behavior. Parents' ability to shape their children's and their own aversive behavior is integral to the theory and measurement of SLFI interventions (Kazdin, 1993; Miller & Prinz; 1990; Webster-Stratton, 1991). In outcome studies of families of young CP children (ages 3-9), a reduction in the number of spankings

administered, as reported by parents, has frequently been among the dependent variables (Dishion, French & Patterson, 1995; McMahon & Estes, 1997; Webster-Stratton, 1994; Webster-Stratton & Hammond, 1997). Parents self-report this behavior, and the information is compared with the home observations of a trained staff. Although parents could deny these spankings, they presumably do not, because their skill level increases observably and these two competing behaviors (skillful child management vs. spanking) cannot occur simultaneously. It is possible for parents to "fake good" parenting skills during some home and clinic observations; it would be unlikely that such deception would occur in the context of favorable child outcome posttreatment--particularly when the independent observation of child behavior is re-assessed after a lengthy follow-up period (Dishion et al., 1995; McMahon & Estes, 1997; Webster-Stratton and Hammond, 1997).

Parents of children with CP lack certain skills, and an increase in these skills positively correlates with a decrease in the number of spankings which they report. If, in addition, their children have observably improved in their ability to comply with their parents directions, without the parents' use of physical aggression, then their parents' reports of less frequent spankings are considered as a valid indicator of reduced parent aversive behavior (McMahon & Estes, 1997; Webster-Stratton & Hammond, 1997).

Other aversive parenting behaviors such as yelling, nagging and being overly critical may be directed at the CP child (McMahon & Estes, 1997). Hostile verbal remarks about authority figures in the child's life (Dishion, French, & Patterson, 1995), and high levels of parental conflict have both been associated with poorer outcome for child CP (Dishion et al., 1995). Parental substance abuse, criminal activities, and illness

have been associated with child CP behavior (Kazdin, 1993). Whether the negative parent effects are considered to be a function of disrupted parenting practices (Patterson, Reid, & Dishion 1992), or due to parents' modelling of antisocial behaviors has not always been conclusive. However, in studies of SLFI effectiveness, the reduction of aversive parenting and child CP behaviors receive equal and concomitant scrutiny with the evaluation of increased use of prosocial skills by both parent and child.

Aversive parent affect. Parental attitudes toward their children, as well as the relationship between parents' perceptions of their children's CP behaviors and the adults' own mental health symptoms, have been studied extensively (cf. reviews by Kazdin, 1993; McMahon & Estes, 1997). Negative, over-controlling behavior, when coupled with maternal personal or familial stress has been shown to predict further externalizing problems several years later (Patterson, 1982). Parental distress can be seen as a composite of intercorrelated factors, such as anxiety, depression, and marital dissatisfaction (McMahon & Estes, 1997). Within clinical populations, researchers have reported that higher levels of parental distress are associated with higher levels of observed child deviance (Dumas & Walhler, 1983; Forehand, Furey & McMahon, 1984; Kazdin, Esveldt-Dawes, French, & Unis, 1987a).

Parental distress, as a variable, helps predict how likely parents are to engage in treatment (Patterson, Chamberlain & Dishion, 1993) and once engaged, how likely to continue (Kazdin, 1990). Maternal negative affect is considered directly related to the etiology of conduct problems for those children who are vulnerable to attachment (bonding) problems (Greenberg, 1993); a troubled child/parent attachment relationship, in turn, complicates the parenting of children at risk for CP (Kazdin, 1993). Lack of

maternal warmth and reported maternal depression have been associated with higher incidence of CD among children (Patterson, Reid, & Dishion, 1992; Patterson, Bank, & Forgatch, 1994).

There continues to be a debate in the literature about the relevance of maternal depression in the reporting of child conduct problems (Patterson, Chamberlain & Dishion, 1993; Richters, 1992). The preponderance of authorities support models of family functioning where depression has a mediating effect on parenting practices (cf. review by McMahon & Estes, 1997; Bandura, 1997). SLFI interventions accommodate the bidirectionality of family member's affect, but also place mother's depression in a social context, with lack of positive adult relationships and less than adequate Social Economic Status (SES) being important covariables. This combined experience of depression, disadvantage and social isolation has been labelled "insularity" (Forehand, Furey & McMahon, 1984; Dumas & Wahler, 1983). Insularity has been characterized as a parental attribute which not only includes a sense of loneliness, and hopelessness, but also the expectation that almost any adult interactions concerning their children will be aversive. Dumas and Wahler (1983) found that mothers who were insular did not maintain the benefits of parent-training. Thus, social support to mothers that addresses their insularity, could enhance the effects of the intervention. Support to mothers has become an important feature of PMT. The use and evaluation of various modes of support embedded in PMT programs are important aspects of the PMT outcome literature (Kazdin, 1996).

Other studies of family/parent distress and insularity (perceived isolation and high level of aversive interpersonal exchanges within their community) measured parents'

perception of positive adult interchanges (Forehand, Furey & McMahon, 1984), and client-counsellor contact occurred in a clinic setting. Aversive parent experiences are thought to correlate significantly with aversive parent-to-child interactions on the same day (Dumas & Wahler, 1983); Patterson (1982) found that family crises, mother mood, and mother insularity scores covaried on a day-to-day basis with the rates of coercive behavior of both the mothers and their children. Dumas & Wahler's study (1983) did provide in-home parent-training in behavioral techniques, but with a limited length of the teaching interval (4 to six weeks). This study was seminal to the development of PMT outcome research.

PMT Outcome Studies

Maternal insularity. In their study of predictors of parent training effectiveness, Dumas and Wahler (1983) attempted to address both the qualitative and quantitative aspects of maternal insularity. They defined "Insularity" as a "specific pattern of social contacts within the community that is characterized by a high level of negatively perceived coercive interchanges with adult kinfolk and/or helping agency members" (1983, p. 302). Mothers' level of insularity was hypothesized to be equally as powerful a predictor of mothers' ability to achieve training criteria as was family socioeconomic disadvantage (SED).

Forty-nine mothers and their 49 children referred for CP participated in the first study (S1), and 18 mothers and their CP referred children participated in the replication study (S2). The children were aged 14 months to 12 years in S1, while children in S2 were 2 to 11 years old; mothers age ranged from 22 to 38 years, and 21 to 31 years for S1 and S2, respectively. Methods and analyses were the same across studies.

The index of socioeconomic disadvantage was a composite of six sociodemographic factors which included income, maternal education, family composition, family size, source of referral, and area of residence. In Study 1, 53% of the mothers were judged as high disadvantage (HD), and 47% were low disadvantaged (LD). Study 2 had 61% HD, and 39% LD. Mothers also completed the Community Interaction Checklist (CIC, Wahler, Leske & Rogers, 1979) twice weekly. Mothers rated their social contacts (from +3 to -3, with 0 = neutral). Trained observers rated the social exchanges between the identified child and other family members for 30 minutes biweekly. Measures were completed over 4 - 6 weeks of pretreatment home-visits. The treatment phase was as long as the baseline phase (4 - 6 weeks), with an experienced staff teaching the parent management training (PMT) in the client's home. PMT focused on teaching parents to reduce rates of child oppositional behaviors through use of a contingency time out and a point reward system. Twice weekly observations continued during PMT, diminishing to twice monthly and continuing over the course of one year.

At a one year follow-up, outcome was evaluated as "favorable" or "unfavorable" for each of the families based on percentage of child opposition and mother aversive behaviors observed during 10 second reporting intervals at home-visits. Outcome was considered favorable if child opposition and maternal aversive behavior were reduced by half; without that level of improvement, or if a family dropped out of the program before completing PMT, results were "unfavorable." In Study 1, 47% of families had favorable outcomes vs. 53% who did not. For Study 2, 30% of families had favorable outcomes, while 61% did not.

Correlations between all measures and treatment outcome were significant in Study 1, with the composite SED and insularity making greatest contributions in step-wise discriminant analyses in both studies. This two-variable model accounted for 49% of the variance in treatment outcome ($p < .001$). The results supported the important contribution which measures of daily community contact and SED make as unique and as a combined variable in accurately classifying mothers' membership in either successful or unsuccessful outcome categories. Moreover, this SED/Insularity model demonstrated linear relationships which predicted a steady increase in the probability of treatment failure as SED or level of Insularity increased, or were combined.

From these findings, counsellors planning PMT interventions could expect that noninsular mothers who were experiencing little or no SED would likely experience long-term success, whereas their insular counterparts who suffer from high levels of SED were almost certain for failure. For those mothers who were noninsular but disadvantaged, or advantaged but insular, their chance of success would be one in two.

Dumas and Wahler (1983) believed that the coercive processes which underlie the aversive community interactions in these families' lives concurrently undermine the effects of treatment. From their perspective, therapists and researchers need to consider the ecological context in which families commonly operate in order to effectively implement a PMT teaching regimen. The therapist who fails to acknowledge the parent's effort to cope, in the face of overwhelming adversity, misses an opportunity to model prosocial behavior, and may appear to be another link in the coercive community chain.

In their review of the role of maternal distress in parent training, Forehand, Furey and McMahon (1984) evaluated programs designed to enhance PMT outcome by directly

treating parent psychological symptoms. The study was nested within a series of published evaluations of a parent training program for parents of non-compliant children (Forehand, et al., 1984). Previous reports had confirmed that the program led to changes in parent and child behavior which generalized over time, settings, behaviors, and siblings (Forehand & McMahon, 1981). Also, when parents learned self-control techniques and the principles of social learning, generality improved further (McMahon & Forehand, 1983). Thus, teaching parents to cope with personal distress was the final component in this series of add-on, or adjunctive, strategies which were examined for their ability to enhance PMT efficacy. Citing Griest, Forehand, Briener, Rogers, Furey and William's 1982 study, Forehand et al. (1984) described enhanced positive outcomes for families who received PMT plus adjunctive therapy.

In their study, Griest et al. (1982) randomly assigned 17 mothers of clinic-referred CP children (ages 3 to 8 years) to either a PMT or PMT plus Enhancement (PMT+) group. Mothers in both the PMT, and the PMT+ Groups completed standardized measures which assessed personal depression, marital dissatisfaction, and insularity. All mothers were taught PMT individually. In addition, the PMT+ Group had group counselling sessions aimed at cognitive restructuring of their anxious/depressed mood; spouse communication skills; and prosocial skills practice aimed at increasing positive community interactions. The mood enhancement element preceded Phase 1 of PMT, while Phase 2 of PMT was preceded by the marital skills component and followed by the unit on social problem-solving skills relevant to extrafamilial and community contacts. Behavioral observations, by independent observers, occurred in the clients' homes, with

four 40-minute sessions used as baseline. Additional observation sessions were scheduled posttreatment, and at a 2 month follow-up.

A 3 X 3 analysis of variance, with Groups and Assessments serving as factors was performed on each of the three targeted maternal behaviors (commands, rewards, contingent attention), and each of the two child behaviors (compliance or deviant behavior). The results indicated that PMT + Group members were more effective in changing child behavior and in sustaining posttreatment gains at follow-up than were their PMT Group counterparts. The control group scores did not change over the course of the three measurement points, indicating that the behaviors were stable across assessments. While these results required confirmation in larger samples, the Griest et al. (1982) study was seminal in articulating the role between parent distress and treatment outcome for CP children. Although the parent-training program was available to mothers and fathers, like many studies of parental distress, the unavailability of fathers (due to the higher percentage of single-mothers as well as fathers' voiced unwillingness to participate) meant that the observations and the questionnaires were measures of maternal distress. However, since these mothers were not selected on the basis of their level of personal distress, it would be important to query how effective the PMT + treatment can be for extremely distressed mothers.

Home-visiting programs. In-home counselling provided to parents of children and adolescents with CP has been thought to re-dress some causes of family attrition from treatment (Lindblad-Goldberg, Dore & Stern, 1998; Kutash & Rivera, 1996; McMahon & Slough, 1996). Home-visiting has continued to develop as an area of practice and research in the treatment of CP. Perhaps the most thoroughly researched

home-based counselling is multisystemic treatment (MST) (Henggeler et al., 1999; Kutash & Rivera; Lindblad-Goldberg, et al.). MST is a psychosocial intervention (or SLFI), which is characterized by its inclusion of both family work (FBT), and a theoretical perspective which encompasses the client's bio-psycho-social environments. Many MST studies have addressed the family preservation aspects of home-visits (Lindblad-Goldberg, et al.), whilst others emphasize the role of home intervention in support to the mother and her participation in PMT (Kazdin, 1996; McMahon & Slough, 1996; Webster-Stratton, 1996). The newest area of MST research is designed to serve the families of children and adolescents who have CP, and are considered to be in a psychiatric crisis that could require emergent hospitalization.

The provision of MST to families of children and adolescents who are experiencing CP, and are deemed to be in crisis, is a sensitive procedure (Henggeler et al., 1999; Kutash & Rivera, 1996; Lindblad-Goldberg et al., 1998). In-patient treatment is often the safest place for CP youth who are at imminent risk for harming themselves or someone else. However, in the current humanistic climate, community care is considered more client centered and family friendly than institutional treatment. This perspective facilitates the inception of programs that offer an essential, alternative treatment that is potentially both efficacious and more cost-effective than hospitalization.

Numerous state and provincial mental health systems are providing MST to youth in crisis, and the research literature has begun to conform, in rigor and design, to standards outlined in reviews of psychosocial treatment studies which are deemed empirically sound (cf. Lonigan & Elbert, 1998, entire issue). One of the most promising studies of MST outcomes, by Henggeler and colleagues, (1999), is a field (and home)

study with laudable design features. The participants (experimental condition, $n = 57$) were randomly selected for treatment, and were definitely members of a clinical sample (ages 10 to 17 years), with a well matched control group ($n = 56$). Treatment integrity was maintained through supervision of “manualized” treatment procedures. Assessment of outcomes included measures completed by a variety of informants, who reported at pretreatment, posttreatment, and follow-up. Only 3 families (among 116) dropped out of treatment at Time 1, resulting in a research attrition rate of 2.6%. Consumer satisfaction favored the intensive community and home-based MST intervention model. The results also favored the MST condition with regards to youths’ decreased externalizing symptoms (as rated by caregivers and teachers), and improved school and family functioning. The only superior measure for the non-MST condition was youth self-esteem.

Although both the MST group members, and the non-treatment group had some similarities in terms of services provided, the follow-up measurement which occurred 4 months posttreatment supported the view that an intensive, well-specified and empirically supported treatment model did (a) reduce length of hospital stay by 72%; and (b) reduce number of days in other out-of-home placements by 50%.

Home-visit counselling is almost always an MST intervention (Lindblad-Goldberg, Dore & Stern, 1998; Kutash & Rivera, 1996). It addresses the therapeutic components of counselling, as well as the psychoeducational, social and advocacy needs of the identified CP child/youth and the family. The ecological perspective of MST practitioners encourages the view that any individuals who are part of the identified youngster’s world are potentially supportive resources. Conflict resolution and social

problem-solving sessions are available to these folk, in any grouping that facilitates collaborative dialogue on the child and family's behalf. Service delivery hours are flexible, with 24-hour crisis intervention services an important safety feature. Therapists have small case-loads, to enable them to maintain an intense, continuous focus during the 3 to 6 months of therapy. Some follow-up service to clients is provided.

Family Behavioral Therapy (FBT) (Achenbach, 1988) is the usual approach during family sessions (Kutash & Robbins, 1996). Based on Family Systems Therapy (Minuchin, 1974), FBT places the therapist in the context of the family with the responsibility of modelling good relationship skills and encouraging the same from family participants during session. Co-leadership with parents and youth in turn occurs during "family meetings" (Achenbach). If FBT dialogue is disruptive, then the group rules are posted. If FBT dialogue remains hostile, then it is the counsellor's role to redirect family members during the FBT hiatus. During non-group moments, the more individual SLFI interventions, such as Problem-Solving Social Skills Training (PSST) (Kazdin, 1996) for children's improvement, and PMT can be practiced. The combined effect of MST and PMT requires further scrutiny, as there are few outcome studies currently available to evaluate the effectiveness of PMT delivered within an MST context.

Home-visit interventions which are meant to support the PMT curriculum taught in a community setting have been designated an integral component of the family intervention in the Conduct Problems Prevention Research Group (CPPRG) Family and School Together Track (FAST Track) longitudinal study (McMahon & Slough, 1996). However, the FAST Track home visiting was not designed as the sole teaching context of

the PMT. The FAST Track home visiting approach addressed the individualization of PMT material to each family's needs, yet relied on group participation for teaching:

"The skills taught in the Fast Track parent group, however, are most closely derived from the well-validated program presented in Forehand and McMahon [1981], with additional material drawn from the group-based program developed by Webster-Stratton [1987]" (McMahon & Slough, p. 97). The FAST Track home visit staff were enhancing, not introducing the PMT curriculum.

Individually administered videotape modelling (IVM). The PMT curriculum depends on videotape modelling to promote observational learning, role play, and practice of important parent-child interactions (Webster-Stratton, 1987; Webster-Stratton, Kolpacoff, & Hollinsworth, 1988). The practice of taking the curriculum, and the videotapes into client's homes is based on studies which support the individual use of the BASIC PMT program (Webster-Stratton et al., 1988), as well as supporting the increased benefit of adding therapist consultation to the IVM treatment (Webster-Stratton, 1990). The enhancement of PMT, through the use of IVM and therapist consultation is an important area of research which has had little investigation to date (Webster-Stratton, 2000). Webster-Stratton (1990) studied the treatment outcome of IVM plus therapist consultation in a clinic setting, and in her 1992 study she also evaluated who benefits (and who does not) from clinic based IVM plus consultation.

In her 1992 study of who benefits from IVM, Webster-Stratton examined the effectiveness of this treatment when participants were affected by intraparental and psychological factors such as marital discord, father absence, and maternal depression. The study also evaluated the significance of extra-familial factors such as low

socioeconomic status, and negative life stress. The author hypothesized that these variables/constructs would influence the PMT outcome for parents and children, from both teachers' and parents' perspectives.

The results indicated that mothers who completed the 10 treatment sessions reported less use of spanking and time-out, decreases in targeted negative child behavior, and increased child prosocial behaviors, as compared to their counterparts in the control group. Treatment fathers reported similar improvements, with the exception of no significant difference between treatment and control fathers' ratings of child behavior problems.

Only the parents (and their children) who participated in the IVM treatment were evaluated at follow-up. At one-year follow-up, mothers and fathers reported improvements to child behavior; however, whereas mothers reported significantly lower levels of stress, fathers did not. Teachers reported a significant improvement in children's behaviors at follow-up, but not at posttreatment measurement. Home observations of parent child interactions indicated that parents' behavior had improved at posttreatment, and that this improvement increased significantly by the follow-up measurement. Total observed child deviance also continued to improve at follow-up.

The second purpose of this study was to determine which predictor variables were related to treatment outcome. Three treatment outcome variables were chosen to assess whether a family's response to treatment was positive: (a) parent and teacher behavior checklists; (b) total parent critical statements; and (c) total child negative behaviors. The specific behaviors were selected from the DPICS (Eyberg & Ross, 1978), because previous research had shown that these behaviors discriminated between clinic and

nonclinic mothers and children (Patterson, 1982). The predictor variables were (a) depression; (b) socioeconomic status (SES); (c) negative life experiences; (d) mental age; and (e) marital satisfaction (or single vs. married status). Only correlations at $p < .01$ level were considered significant. At the 1-year follow-up, there were significant correlations between single-mother status and more negative perceptions of child behavior. There were also significant relationships between maternal depression, single status, low SES, and low mental age and more critical mother behaviors and more deviant child behavior. On the other hand, there was only a significant correlation between higher father mental age and teacher reports of increased child behavior problems.

This study indicated that factors associated with mothers' and fathers' success in treatment were different. In attempting to evaluate who might benefit from IVM, Webster-Stratton suggested that the data supported an argument for only mothers who were partnered, not depressed, and of higher mental age to be offered the IVM. Similarly, fathers who had low depression, low life stress and lower mental age would be more likely to benefit from IVM. Rather than approach the IVM participation from a set of criteria that would exclude many parents who most need help, the author suggested that all parents--even those who are depressed and highly stressed--should be offered the IVM program (with the caution that its use as the sole treatment available to highly stressed families is not recommended). Upon completion of the course, the counsellor's role would be to collaborate with parents to problem-solve impediments to learning and practice. Thus, despite the evidence that this approach may not be as successful with very highly distressed families, the approach should be considered as an initial treatment for those parents of CP children who cannot attend PMT group. For those mothers who

are single, distressed and socially disadvantaged (insular), IVM could be a promising beginning to longer-term treatment.

Socioeconomic status. Socioeconomic status (SES) and its relationship to the etiology of CP in children requires careful consideration: In the context of such a pervasive condition as poverty, what should PMT address? In their study, Dodge, Pettit & Bates (1994) considered the social processes which mediate between SES and child conduct problems. While there have been earlier studies that have highlighted the relationship between low SES and child CP (Patterson, Reid, & Dishion, 1992), the goal of Dodge and his colleague's (1994) study was to demonstrate how socioeconomic disadvantage would operate within the interactive processes of a child's socialization.

Parents of children attending schools which served a high proportion of low-income families, as well as parents of children who attended schools with a broader range of familial SES, were recruited when they registered their children for kindergarten. The recruitment spanned two annual cohorts, with 305 mother-child pairs in Cohort 1 and 270 in Cohort 2. The subject retention did not differ among various SES groups, with a gradual loss of about 12% of pairs at the time of the children's grade three assessments. Because peer sociometric interview data were completed for almost all children in the same schools as the participants, the authors determined that there was no significant difference in level of aggression among those children who continued, dropped out or never participated in the study. The full sample was considered representative of the schools' student populations.

During a 2.5 hour home-visit, two interviewer/observers focused their attention on either the mother or child, and on their targeted participant's role in dyadic interactions.

Mothers gave information about the family SES (35% of families were headed by single mothers). SES was measured according to Hollingshead's (1979) Four-Factor Index, including mother's years of education, mother's occupation, father's years of education and father's occupation (in single mother households mother's data were double-weighted). Five categories, from poorest to highest income were developed.

Demographics varied significantly between Group I (poorest) and almost all of the other groups: Families in Group I had more single parents, more illiteracy, more children, less education and more parental members of ethnic minorities than the other groups.

Eight social constructs were assessed in order to test whether empirical data could partially account for the correlation between SES and child CP. These included: (a) harsh disciplinary practice (HDP); (b) observed mother warmth toward child; (c) child's exposure to violence; (d) stability of peer group; (e) family life stressors; (f) maternal social support (insularity); (g) maternal values regarding aggression; (h) environmental cognitive stimulation. Child behavior problems were measured by teacher ratings and peer nominations done during the spring of each child's kindergarten, grade 1, 2, and 3 school years.

SES predicted both teacher and peer rated behavior problems in each of the 4 years assessed: "The correlation between the SES score and the multiyear Externalizing Problems score was -0.34 , $p < .001$ " (Dodge, Pettit, & Bates, 1994, p. 656). SES also had a significant, linear relationship with each of the social constructs investigated. Child CP was significantly related to all of the social constructs as well. However, of the 8 social constructs, harsh disciplinary practice (HDP) was the best predictor of child CP; it provided the only unique contribution to the regression equation ($\beta = .19$, $p < .001$).

Dodge et al. concluded that the data broadly supported previous reports (Patterson, Reid, & Dishion, 1992) which highlighted the role of parents' harsh disciplinary practice in perpetuating the coercive dynamics occurring in their families. In addition, the strong relationship between maternal insularity and HDP reported by these authors supported earlier reports by other authors (Dumas & Wahler, 1983; Forehand, et al., 1984) regarding the relationship between maternal insularity, HDP and child CP. Although the findings indicated that SES affects child CP through socializing experiences that are related to socioeconomic disadvantage, the social constructs did not account for all of the variance in the SES/CP relationship. The authors concluded that in addition to family social experiences, other factors (such as genetic, prenatal or perinatal conditions) could be associated with low SES, and that these influences also might also contribute to the detrimental effects of poverty. In summarizing, Dodge and colleagues recommended that first and foremost, future interventions should focus on changing parents' harsh disciplinary practice because this single variable accounted for the largest portion of the effect of SES on the development of child CP.

Child/adolescent effects. Reviews of studies of social learning techniques which have been focused on teaching children relationship and problem-solving techniques without the involvement of their families have demonstrated that this approach has not had a lasting effect in reducing CP behavior (Kazdin, 1993; Reid, 1993; Webster-Stratton & Hammond, 1997). Older children and adolescents appear to benefit more from cognitive-behavioral approaches to social skill and problem-solving deficits (PSST) (Kazdin, 1996), but generality from clinic to home and school has not been successful

(Kazdin, Esveldt-Dawson, French & Unis, 1987b). However, studies which include components of social learning for children and their families seem to hold more promise.

The work of Webster-Stratton and Hammond (1997) overarches both child and adult effects, and is representative of the contemporary approach to intense, multi-modal treatment. These authors compared the efficacy of treatment for a sample of CP children, whose age ranged from 4 to 8 years. The authors (1997) noted that the study extended the previous work of Kazdin, Esveldt-Dawson, French, & Unis (1987a, 1987b) by including independent observer measurement of the parent-child dyad's behavioral interactions. The objective of the study was to determine if child training enhanced the outcome of parent training as reported by parents, teachers, and independent observers.

Children and their parents were randomly assigned to child training (CT, $n = 27$), parent training (PT, $n = 26$), a combined group (CT + PT, $n = 22$) or a waitlist control (CON, $n = 22$) condition. Groups showed no significant differences for child age, symptoms, gender, ethnicity, or parents' marital and social status. Children participated in social problem-solving groups aimed at teaching them effective ways of solving conflicts with their peers and with their families. The parents participated in a clinic-based PMT program.

Webster-Stratton & Hammond (1997), like previous researchers (cf. the work of in Kazdin et al., [1987]) found that CT did enhance the effects of PT, but that teachers pre/post reports of child behavior problems at school did not reflect the same decreases in child deviance for any of the three treatment conditions. The effects of CT, PT, and PT + CT increased over time, with the combined treatment group continuing to demonstrate greater increases in child-child pro-social skills, child-parent warmth, and independent

observations of positive parent-child interaction than either of the two other conditions alone. In addition, the level of stress which parents attributed to their child dropped significantly from pretreatment to posttreatment, and remained stable at one year follow-up, indicating that relationship skills taught in the clinic and measured there and at home did appear to have both generality and enduring effect. Whereas the criterion of 30% reduction in observed child deviant behavior was achieved by children in all three conditions in the pre/posttreatment comparison, only the CT + PT group's observed child deviance decreased significantly between posttreatment assessment and measurement at one-year follow up ($p < .01$). In contrast, all three of the groups failed to effect teacher's perceptions of child CP; there was no significant difference between teachers' reports of child misbehavior pretreatment to posttreatment for any of the three treatment groups. There was, however, a significant difference between pretreatment and follow-up scores. This trend of teacher/parent perceptual variation--as opposed to covariation--has occurred with some frequency in the CP outcome literature (Patterson, Reid & Dishion, 1993), adding to the argument for the context specificity of SLFI. When children learn problem-solving and practice prosocial skills at the clinic, and within their families, they may still not know how to change their behaviors at school (Kazdin, Esveldt-Dawson, French, & Unis, 1987a, 1987b; Patterson, Chamberlain & Dishion, 1993; Webster-Stratton & Hammond, 1997).

Webster-Stratton and Hammond (1997) tentatively suggested that the young age of the children in the sample (ages 4 to 8 years) might have affected teachers' perceptions, since teachers rated only 60% of the children within the deviant range on the teacher report form (TRF) of the Child Behavior Checklist. However, many other authors report

similar lack of generality for home/clinic improvements that do not receive validation from teachers' perspectives. Indeed, although many other researchers have reported significant discrepancies between parental and teacher perceptions of child deviance (Webster-Stratton & Hammond, 1997), others report similarities in parents' and teachers' ranking of children's CP behaviors (Loeber, Green, Lahey & Stouthamer-Loeber, 1991).

Within the domain of "child effects" or "child risk factors," child traits such as temperament have had serious scrutiny (McMahon & Estes, 1997). Level of demandingness, associated with maternal stress (Kazdin, 1993; Greenberg, 1993) also affects bonding and attachment, which are considered secondary but important potentiating factors in child manifestations of CP (Dishion, French & Patterson, 1995; McMahon & Estes). Within the bidirectionality of child-parent effects, the traits of child temperament have an acknowledged if unexplored role in SLFI outcome literature. What types of children will benefit least, despite their parents' ability to practice PMT?

The question of child trait effect was explored by Wootton, Frick, Shelton and Silverthorn (1997) in their study of CP children between the ages of 6 and 13 who were referred for treatment at a community mental health center. The children were evaluated along two partially independent psychological dimensions. The first dimension was composed of two factors, labelled "interpersonal characteristics", (superficial charm, callous use of others, absence of empathy), and "emotional style" (lack of guilt, shallow emotions, lack of anxiety). The second dimension, included both unstable impulsive and aggressive behaviors. These labels were adapted from adult psychopathy, and combine the hallmarks of the psychopathic personality disorder with those of the antisocial personality disorder. The two-factor model was previously tested in a sample of clinic-

referred children (Frick, O'Brien, Wooton, & McBurnett, 1994) and the child traits were substantially consistent with the findings in adult samples (Wooton et al., 1997). The first dimension of callous-unemotional (CU) interpersonal style, and the second of CP (including poor impulse control, oppositional defiant disorder, and conduct disorder) overlapped modestly in both adult and child samples, yet remained distinct enough to allow for the investigation.

Of one hundred and sixty-six (166) children who participated in the 1997 study (1997) by Wooton, and colleagues, 54 were described as having CU traits. The authors hypothesized that the CU trait would not be associated with parenting socialization practices to predict the development of child CP. In the sub-sample of children with CU traits, the development of conduct problems would be relatively independent of parenting practices "because their unique motivational and affective style makes them relatively unresponsive to typical socialization practices" (Wooton et al., 1997, p. 302). Conversely, Ineffective Parenting was predicted to be more highly associated with conduct problems in children without CU traits. The dimensions of parenting which were most consistently linked to antisocial behavior in the CP literature (parental involvement, parental monitoring, harsh and inconsistent discipline) were examined, in order to demonstrate that these domains were more closely associated with the manifestation of child CP for children who were not identified as having CU traits.

The etiology of CU traits was suggested to be within the individual children's neurophysiological differences of behavioral inhibition (child ability to self-control), but the ramifications of a neurological component to CP similar to Moffitt's (1993) model were not central to the investigation (1997) by Wooton and colleagues, nor new to the

SLFI outcome literature. The utility of the CU traits in CP treatment interventions and research was more to the point of the Wooton, et al. (1997) study, and to that end their results substantiated their argument that treatment for these youngsters and their families must go beyond PMT to achieve successful outcome: "Ineffective parenting was associated with increased numbers of conduct problems, only for children without significant levels of CU traits" (Wooton et al., 1997, p. 305.). While the combination of CU traits plus ineffective parenting did not act in an additive fashion to enhance prediction of CP, children with CU traits exhibited high rates of conduct problems regardless of the quality of parenting they experienced (emphasis added).

It is a provocative argument among child CP researchers whether CU traits are themselves a product of child temperament or early childhood deficiencies. The age range of the sample (7 to 13 years) left many years where child CU could have been learned from a variety of parent, familial, and environmental influences. Having labelled the children, and determined the probable limits of PMT efficacy, clinicians and researchers are left with the problem of adding child treatments (CT) to the SLFI/PMT intervention, in the hope that social learning can teach children to be sensitive to others, and prepare them to receive the potential benefits of their parents' improved skills.

Measurement. The assessment of child CP is a multi-agent, multi-report, context-specific task fraught with potential for perceptual bias (McMahon & Estes, 1997; Patterson, Chamberlain & Dishion, 1993). Parental reports of child deviance, particularly mothers', are more closely related to their self-reported level of depression than to independent observer ratings of their child's behavior (Forehand, Furey & McMahon, 1984). Teachers' reports and parents' reports of child deviance have a

correlation of modest but significant magnitude ($r = .30$, $p = .05$) in many studies (cf. Kazdin, Esveldt-Dawes, French, & Unis, 1987a; Webster-Stratton & Hammond, 1997). In general, clinician researchers have used any reports of child deviance from child, parent, or teacher as a means of beginning screening and diagnostics. However, researchers have also continued to rely on behavioral observation in an attempt to obviate perceptual bias by reporting participants (McMahon & Estes, 1997; Patterson et al., 1993; Patterson & Forgatch, 1995). The behavioral observations of trained independent reporters have been considered the most reliable indicators of improvements in child, parent, and family dynamics. Microanalyses of intra- and interpersonal behavior have been considered both valid measures of SLFI interventions at posttreatment evaluation, and, more recently, as robust predictors of longer-term clinical outcome (Patterson & Forgatch, 1995).

Patterson and Forgatch (1995) demonstrated how well various measures of PMT outcomes predicted future child adjustment by comparing posttreatment scores on behavioral measures of parenting practices, child aversive behavior and family-problem solving to participant ratings of child deviance. Out of Home Placement (OHC) and future arrests (FA) were the two longer-term (2 year) outcomes. Sixty-nine CP children, between 5 and 12 years, and their families participated. Children were identified as having CP on the basis of parent or teacher reports (CBCL, Achenbach & Edelbrock, 1979), as well as observer scores at least .5 SD or more above the mean measure of the Total Aversive Behavior checklist (TAB; Capaldi & Patterson, 1989), as measured in their homes. Parent-child interactions were observed during the Family Interaction Task (Patterson & Reid, 1984) at the clinic. Behavior at children's homes was assessed among

family members by observers using the Family Process Code (FPC; Dishion, Gardner, Patterson, Reid, & Thibodeaux, 1983). Behavioral observations were carried out three times at baseline, and three times at post treatment, with results averaged at each measurement. Parenting Practices were divided into several variables targeted as important to the integral processes of PMT. These included: (a) Problem-solving outcome; (b) Home-observer impression of discipline; (c) Monitoring (parent-interviewer rating); and (d) Monitoring (child-interviewer rating). Parenting Practice Variables and reduction in child TAB at posttreatment were hypothesized to be the best predictors of OHP and future arrests at 2-year follow-up.

The results confirmed Patterson & Forgatch's (1995) hypotheses, with some exceptions. Whereas participant ratings by mothers, fathers and teachers of child deviance posttreatment were not good predictors of child OHP and FA at the two-year follow-up, the baseline participant reports of child deviance by fathers was relevant. If father reported high levels of child deviance at baseline, there was a 40% increase in the odds of the child's having an arrest between termination and 2-year follow-up. On the other hand, fathers' ratings of child deviance at termination were not accurate predictors of FA, while observer rated child TAB scores did significantly contribute to the prediction of FA. When child's TAB score was high at termination, there was more than a ninefold increase in the likelihood of a future arrest.

Among the Parenting Practices variables, observations of problem-solving, discipline (home-observer impression), and child reports of parental monitoring, posttreatment, were effective predictors of future arrests. The same variables were relevant for predicting OHP, with the notable exception of child TAB scores: Level of

observed child deviance was not predictive of OHC. Patterson & Forgatch (1995) suggested that children's OHP may have more to do with parental factors than child adjustment, as OHP is usually a decision determined by agencies and parents about parents' ability to cope.

The Forgatch and Patterson study (1995) re-iterated the value of behavioral observation, with equal validation for in-clinic and at-home observation of parent-child interactions as the basis for measuring key process variables and valid indicators of change. Although these authors suggested that parent reports of child adjustment, pretreatment and posttreatment were not a good choice for long term prediction of clinical outcome for children with CP, other authors argued for the use of these measures because of their role in the social validation of treatment (McMahon & Estes, 1997). In addition, the concordance of teacher and parent reports at baseline has been of use in validating diagnostic assessment (Loeber, Green, Lahey, & Stouthamer-Loeber, 1991), and predicting maintenance of reduced child deviance at follow-up (Kazdin, Esveldt-Dawson, French, & Unis, 1987a; Webster-Stratton & Hammond, 1997). Patterson and Forgatch (1995) did suggest that the accuracy of parents' and teachers' perceptions could be improved by focussing their evaluations on smaller, more specific time frames.

A final comment about the Patterson and Forgatch (1995) study should include commentary from another member of the Oregon Social Learning Centre about the use of Family Problem-Solving as a treatment intervention and as a measure of longer term clinical outcome. In their review of Family Problem Solving in the Psychosocial Treatment of Preadolescents, Vuchinich, Wood and Angelelli (1996), noted that successful ability to perform this task, as rated by a trained observer in a videotape made

with no therapist presence, had important variations in long term follow-up. For 10 year old children in single parent families ($n = 72$), good ability in this task significantly increased the risk of future arrest by age 16. However, for children in two parent families ($n = 130$), effective family problem solving when the child was age 10 significantly reduced the risk of arrest by age 17, even after taking into account the effects of SES, level of child antisocial behavior, quality of peer relations, and parental transitions. In other words, if treatment interventions are offered to a client group composed of single mothers and preadolescents, the therapist might want to put more emphasis on PMT which includes an emphasis on prosocial behaviors, rather than emphasizing negotiation and problem-solving. These are areas of treatment which require further investigation.

Summary of Current State of Knowledge

The current literature supports both PMT and MST with children and adolescents who present with CP. However, as with many effective psychosocial interventions, the mechanisms of change in both PMT and MST are still being identified (Kazdin & Weisz, 1998). Future research into the actual process of change should help to identify both the mediators and moderators of change (Weisz, 2000). Articulation of these processes and constructs would help to identify more clearly the ways in which challenging children, adolescents and families could be more effectively helped.

Issues that continue to call for further study in the treatment of child CP include longitudinal studies which can better delineate the developmental course of adolescent CP (Hinshaw, Lahey & Hart, 1993); the appropriateness of current CD criteria for females (Zahn-Waxler, 1993; Zoccolillo, 1993); and the etiology and longer-term outcome for co-occurring conditions such as ADHD, anxiety, and depression with CP

(McMahon, 1994). The etiology and developmental pathways of early-onset CP have received excellent attention (Leober, Wung, Keenan, Giroux, Stouthamer-Loeber, Van Kammen, & Maughan, 1993; Patterson, Reid, & Dishion, 1992). However, current research with pre-school CP indicates that further refinement is required as accurate predictions of future problems are still not possible at this early age: Some studies show as high as 85 percent false positives in trying to identify future child CP from pre-school parent, teacher or observer data (McMahon, 1994). The accuracy of predictions made at school entry, however, are much improved (Conduct Problem Prevention Research Group [CPPRG], 1992), and support the multiple agent, concurrent family and school intervention model; children with conduct problems are identified during kindergarten, with on-going interventions from grades one through five (CPPRG, 1992).

The current study, as described in the following chapters, evaluated the outcome of a treatment which included PMT and MST, with an emphasis on individual videotape modelling and social support for mothers. These difficult to treat families deserve our best effort, and motivate the clinician/researcher to extend the current knowledge of effective treatment for CP.

Hypotheses of the Study

The following hypotheses were based upon questions arising from the literature:

1. Children's/adolescents' psychopathology, as rated by their mothers or female caregivers, and as measured by the Child Behavior Checklist, would decrease after treatment and that treatment gains would be maintained at follow-up.
2. Children's/adolescents' teachers would report improvements, as measured by the Teacher Report Form, similar to those reported by mothers/caregivers.

3. Mothers' reported levels of self-agency, as evaluated by the Parenting Self-Agency Measure, would increase from pretreatment to posttreatment. Also, that there would be a corresponding decrease in their reported distress, as measured by the Parenting Stress Index, at posttreatment that would also be sustained at follow-up. An ancillary hypothesis was that the feelings of competence and distress reported by mothers/caregivers during narrative interviews at pretreatment, posttreatment and at follow-up would corroborate and complement information obtained on the appropriate standardized measures. For those participants in the control group, scores were expected to remain unchanged. Since the members of the control group did not participate in the narrative interviews, the ancillary hypothesis was not relevant.

Chapter 3: Methodology

The Pilot Study

The Home-Based Counselling Service (HBCS) pilot study was part of a larger program evaluation of Mental Health Services (MHS) at Queen Alexandra Centre for Children's Health (QACCH) (Tate, Lampard, Keyes, & Saayman, 2000). Although the overall study collapsed data across six of the programs in the Ledger Building, each program was also evaluated individually. The results pertaining specifically to HBCS that are presented in Appendix A were based on questions about treatment outcome and client satisfaction which were asked of clients and colleagues throughout the Ledger programs. Scores derived from standardized rating scales lent themselves well both to collapsing and to extracting of the data for statistical analyses. Those pertaining to the HBCS pilot will be discussed in the results section of Appendix A. Qualitative data, on the other hand, were difficult to disentangle and remained grouped across programs throughout the Tate, et al. study. In the interest of brevity, the client satisfaction data are not reported; however, the narrative information gleaned from the focus group which included parents from all six programs will be discussed in Appendix A, as it related directly to future research projects and this document.

Current Study: Child Conduct Problems and Parent Support

The dissertation study was shaped by the findings of the pilot study, in terms of both the goals for treatment outcome evaluation previously put forth by parents during the focussed group discussion, and by the investigator's expectation that the intervention would make a positive difference to children's and adolescents' well-being. The current

study investigated those areas of parental distress, as well as parent perceptions of competence, which had been identified by the parent focus group participants (see Pilot Study, Appendix A). The intervention evaluated was a field study of Multisystemic Therapy (MST) delivered in clients' homes, with an added Parent Management Training (PMT) component also delivered in-home. Given that PMT is more effective when parents report feeling less personal distress (Webster-Stratton, 1992, 1994), and that parental distress is alleviated by perceived social support (Dadds & McHughes, 1992; Reid, 1993), the current study used support as an integral element of PMT for the mothers of children with conduct problems.

The elements of support which previous studies have identified, which were included in this study are: (a) Home-visits (Dumas & Wahler, 1983); (b) Social problem-solving skills (Kazdin, Esveldt-Dawson, French, & Unis, 1987a; Webster-Stratton, 1994); (c) Enhanced perceived efficacy in parent's self-regulation, affect and self-care (Forehand, Furey & McMahon, 1984); (d) Enhanced parenting efficacy (Webster-Stratton & Hammond, 1997); and (e) Narrative interviews focussed on the parent's experience (Wahler, 1996). These elements of support are adjunctive treatments to Parent Management Training, and consistent with the tenets of MST. Thus, the combination of MST and PMT could offer enhanced results for mothers who participate in the Home-Based Counselling Program. The challenge for the current study was to provide PMT without the benefit of parent peer group support, with the expectation that participation would be so accessible that the individually administered parent support and training would effect positive change for parents and their children.

Research Design

This was an outcome study of a cognitive behavioral therapy, Multisystemic Therapy (MST), administered in-home to families with children and adolescents whose parent/caregiver has requested treatment for the youngsters' CP. The study evaluated the effectiveness of including Parent Management Training (PMT) within the home-visit therapy. The study was a mixed design, with quantitative and qualitative data to support the evaluation of treatment effectiveness (Tashakkori & Teddlie, 1998). Both numerical scores on standardized psychological measures and narrative interviews contributed information relevant to the evaluation of treatment effectiveness. Because the methods of data collection and analysis were specific to the questions and measures used, the methodology section is divided into two parts. The first discussion presents information relevant to the standardized tests; the qualitative information derived from the narrative inquiry is explored in depth thereafter. This combination of numerical and qualitative data is recommended as a comprehensive approach to the evaluation of clinical outcome (Lyons, Howard, O'Mahoney & Lish, 1997; Webster-Stratton & Spitz, 1996).

The research design included the analyses of test scores from the outcome measures for the treatment group and the control group, which were conducted with SPSS 8.0. Comparison of the treatment and control groups was done with a 2 X 2 mixed design analysis of variance. This analysis was conducted for each of the three broad-bands of the Child Behavior Checklist (CBCL parent form; Internalizing, Externalizing, and Total symptoms), the Parenting Self-Agency Measure (PSAM), and the two domains of the Parenting Stress Index (PSI-parent and PSI-child). The Time by Group interaction effect was used to test the hypothesis that mean scores for the treatment group would

indicate improvement across time while the mean scores for the control group would remain constant. Individuals' scores at pretreatment were compared with their scores posttreatment and at follow-up to ascertain significant changes which might be due to treatment effects. Significant differences in treatment group means were examined through planned comparisons of the Time 2 and Time 3 means through the use of dependent sample *t*-tests, in order to test the hypothesis that treatment gains were maintained at follow-up.

Sample selection. This was a quasi-experimental design. The immediacy of service required by high-risk children/adolescents made random assignment an obstacle to client treatment. However, there was a treatment group (Group 1), and a control group (Group 2) who were recruited from the list of children awaiting admission to the Child and Family program at QAC Mental Health Services (MHS). Group 1 was potentially composed of 29 successive clients registered in the Home-Based Counselling Service (HBCS) at QAC, whose mother/female caregiver had identified CP as a primary treatment objective. Although treatment was not contingent upon participation in the study, all but 3 of the 29 eligible mothers and children/adolescents were invited to participate. Three mothers whose families were treated but excluded from the study (not invited to participate), included: (a) a mother who was using alcohol/drugs and not enrolled in her own treatment program; and (b) two mothers who were self-described as too physically ill to participate in the HBCS treatment program. These three women were offered a variation of the treatment that emphasized advocacy and support (including the PMT component), with a less frequent home-visiting schedule.

The study was reviewed and approved to proceed by the University of Victoria Human Research Ethics Committee, and by the Queen Alexandra Research Advisory Committee. Consents and scripts for engaging treatment group and control group participants have been included as Appendices B, C, D, E, F, G, and H. Information regarding child diagnostics and mother/caregiver demographics was recorded on forms which have been included as Appendices I and J, respectively.

During the first home-visit, consents for treatment and release of information were signed, and parents were oriented to the HBCS by the investigator. During this same visit, counsellors explained the purpose and procedures of the study. Mothers who agreed to participate were offered a \$20 incentive fee, payable at the follow-up assessment period (Time 3). Children/adolescents who gave permission for their parent and teacher to participate were given a \$7.50 reward at the second home-visit. Each child/adolescent's teacher was invited to participate; no reward or incentive was offered. Teacher participation was consistent, as many of the children were designated as severely behavior disordered (SBD), and teachers who participated from school districts 61, 62 and 63 reported having received instructions to include professionals from outside agencies in the individual education plan for special needs students.

Participants. Child and adolescent clients ranged in age from 7 years to 15 years old (mean age = 10.6 years; SD = 2.42). There were 9 girls and 17 boys. Twenty of the 26 youngsters were designated as having severe behavior problems by school personnel. Only one child was identified as having moderate behavior problems, and the remaining five were designated learning disabled. One adolescent was considered to have no special school needs. At pretreatment, children's/adolescent's mean score on the

Externalizing broadband subscale of the CBCL (parent form) was 69.19, just below the score of 70 used as the clinical cut-off for measuring CP. The mean score for children on the Total problem broadband subscale was 70.27, just above the clinical cut-off lower limit.

The 26 mother's ranged in age from 26 years to 45 years of age, with a mean age of 36.27 years (SD = 5.81). Of the 26 mothers, 7 reported having been under age 19 when the identified child was born. A brief questionnaire was used to establish mothers' annual income (see Appendix J). Nine of the 26 women reported income assistance from the provincial government as their main source of support. Of the remaining 17, only two were earning \$40,000 per year. Thirteen of the 26 mothers were married. Among the 13 mothers who were married, 7 had a combined family income of \$50-70,000; six of the 13 had lower incomes. None of the mothers/female caregivers had completed university. Eleven of the 26 women reported a history of mental health problems, all of whom were taking medication for anxiety, depression, post-traumatic stress disorder, or post sexual abuse trauma (this information was included in the notes within the child's/adolescent's medical record).

The control group. Mothers/female caregivers of children who were waiting for admission to the Child and Family program at QAC-MHS (Ledger) were invited to participate in the project. Their consent and participation in no way affected their admission to in-patient treatment. The mother's completed the CBCL, the PSI, and the PSAM twice, with a two to four month test-retest interim. Their teachers completed the TRF within the same time frame. Upon receipt of the second set of measures, children

received a check for \$10.00. In total, there were five children with complete data sets in the control group.

The control group children ranged in age from seven to ten years, with a mean age of 7.4 years ($SD = 1.34$). Mothers/female caregiver ranged in age from 26 to 48 years, with a mean age of 35.0 years ($SD = 7.71$). Two of the mothers had an income was dependent on social assistance in the group, and for two of the others, their husband was the sole wage earner, with an average income of \$45,000. The fifth was a grandmother whose income was under \$40,000. None of the mothers/caregiver had completed university.

Although the average ages of children and mothers in the control group were somewhat younger than that of the children and mothers in the treatment group, these children were similar to treatment group in that they were members of a clinical population. Each had been referred for treatment by a child psychiatrist, with a primary diagnosis of CP. The children's CP was characterized by out of control behaviors, and co-occurring diagnoses such as ADHD, and Tourette's Syndrome. One child was tentatively diagnosed with a co-occurring mood disorder. Three of the children were already on a medication regime to target symptoms of the above mentioned disorders. Mean score for the control group children at time 1 on the Externalizing broadband subscale of the CBCL (parent form) was 72.20. This score was considered in the clinical range for CP. The children's pretreatment score on the Total symptom broadband subscale was 71.20. Diagnoses were confirmed by letters and discussions with children's/adolescents' psychiatrists, as documented on client information forms (see Appendix I). Their CP and co-occurring symptom profiles were similar to those of the

children/adolescents in the treatment group. Given the clinical similarities, an argument could be made for comparability of the treatment and control groups.

Procedure for data collection. Each mother/female caregiver who agreed to participate completed the Child Behavior Checklist (CBCL, parent form) (Achenbach, 1991) pretreatment, posttreatment and at the four month follow-up. Mothers/female caregivers also completed the Parenting Stress Index (PSI) (Abidin, 1995), and the Parenting Self-Agency Measure (PSAM) (Dumka, Stoerzinger, Jackson, & Roosa, 1996) at the same measurement periods. (If mothers agreed to participate in the audiotaped interviews, the interview was completed before the standardized measures were presented, in order to minimize any effect from those instruments.)

Treatment procedure. Treatments consisted of two weekly home-visits, one of which was parent-focussed, while the other was child-focussed. In all, each family received 26 visits. The first parent session was devoted to clarifying several goals for treatment outcome; the counsellor collaborated with the parent to state the goals clearly, and to decide how success would be measured. Every parent session was 75 minutes long, and time was apportioned as follows: (a) checking-in (20 minutes); (b) reviewing the home practice from the previous week (10 minutes); (c) watching and discussing an excerpt from a video-taped vignette (10 minutes); (d) role playing (15 minutes); and (e) explaining the home practice for the next week. All parents watched selected videotapes from the BASIC Parent and Child series (Webster-Stratton, 1987). The Basic program includes teaching parents: (a) play and helping children learn; (b) effective praise and tangible rewards; (c) effective limit-setting, including dealing with noncompliance; and (d) handling misbehavior. Parents of children 10 and under were encouraged to read The

Incredible Years (Webster-Stratton, 1992). The book chapters correspond to the lesson plans in the **Parents and Children Series, Leader's Handbook** (Webster-Stratton, 1987, 1992). Lessons plans and videotapes were used selectively, as there was a plethora of material for each topic. Since parents and counsellors were not using the program in a group setting, the lesson plans were re-formatted to be less lengthy (instructions in the leader's guide allowed for selection of vignettes and length of session). For those parents who were reluctant to play roles, the counsellor accepted their decision, with some option for the parent to play the difficult child, or an adult who was "doing it wrong." The support components of HBCS intervention included coaching parents to participate in the PMT. Understanding was demonstrated through performance—"show me" was a phrase which counsellors used to ensure that a parent could give praise or practice ignoring small misbehaviors.

While mastery of the various techniques was a desirable goal, mothers also were allowed to say "no" or "not yet." There were many suggestions in the social learning literature, and in the Webster-Stratton handbooks, for helping parents to work through their resistance. Collaboration was the key; parents needed to believe that their goals for their children could be achieved. When counsellor persistence was not enough, an HBCS team technique for breaking through an impasse was to ask the mother to participate in a goal review. This allowed the coordinator back in the picture, to help uncover what else needed attention in support of mother's participation. For example, was there a need for personal counselling, medical attention, or child respite which would help this mother to feel less distressed and more willing to learn? Thus, what appeared to be an impasse could become an opportunity to support other changes in the family. Helping to augment

family resources was possible through the Ministry for Children and Families (MCF), or the Queen Alexandra volunteer service.

As soon as the counsellor had spent a weekly visit time with the child/adolescent client, and written down the youngster's goals, the "family meeting" was implemented. Family meetings could be as brief as a few minutes, allowing mother (and father) to explain any new rewards or consequences that she/he wanted introduced. Family meetings were a form of Family Behavioral Therapy (FBT), and the rules and methods were modelled by the counsellor. The purpose of the meetings was communication, and some pairs of family members were able to listen more easily to one another than others. Family rules and guidelines were important to develop. However, because of the level of difficulty which the family had experienced, HBCS therapists expected the meeting to occur as the family members became more able to disagree without verbal and physical aggression. In terms of a schedule, the FBT was usually scheduled weekly.

As important as FBT was to the HBCS work, there were mothers who could not participate comfortably. In those situations, the difficulty was acknowledged and the counsellor continued to work with parent and youngster separately. Children and adolescents were often initially resistant to FBT, but soon realized that rules and guidelines were going to be implemented without their advice or consent. Thus, most child/adolescent clients were willing to engage, in order to have a voice in the process.

The final frontier for HBCS was the client's school. When parents were oriented to the service at the first session, permission to obtain copies of previous psychological assessments and academic progress reports were requested. Within the first month of treatment, the first school-based team meeting occurred. The purpose of the meeting was

to help parents to have an informed relationship with their children's teachers. The ancillary outcome was more open communication between the HBCS therapist and the school. Use of a volunteer in the child/adolescent's school provided additional support to identified clients in their schools, within the comfort level of teacher and student. Some teachers were unable to find a role for the volunteers in their classrooms.

A community support team was developed on behalf of each client and family. Team members included the classroom or resource room teacher; a social worker from MCF; additional child care workers, and other therapists from agencies such as the Mary Manning Centre (child sexual abuse prevention and treatment); Hulitan Counselling (aboriginal family support service); the Dallas Society (substance abuse treatment), and various vocational and recreational personnel designated by the family. When medication was used or recommended, the child/adolescent psychiatrist was informed of clinical progress, and consulted as necessary. Although the constellation of helpers was somewhat different for each youngster, the network was important across cases, as a family support during and after the HBCS involvement.

The treatment timeline ranged from 3 to 5 months, and was dependent upon the ability of the HBCS counsellor and the mother to schedule the two weekly sessions. If parents requested ongoing support, the need and nature of this support were reviewed and addressed through the community team. Like many in-home MST programs, HBCS provided a link to emergency mental health hospital admission. Through a colleague team, Emergency Mental Health Service (for children 12 years and older), assessment was available during crises. For those children who were under 12, and whose parent required assistance to help them gain control, police, extended family or friends helped

mother to reach out during crisis. In general, when a child/adolescent required hospitalization, s/he was assessed at Victoria General Hospital first, and transferred to the Special Care Unit at QAC (Ledger) when space was available. With the approval of the psychiatrist and depending on availability, fast tracked admissions were arranged for clients who had been through an inpatient mental health program at QAC previously.

Although hospitalization was used judiciously, it did occur during HBCS intervention for 2 of the 26 participants. Prior to their HBCS treatment, 3 others, of the 26 children, had emergency hospitalization for out-of-control episodes. Emergency hospital time was 3 days for each. Eight of the 26 were referred to HBCS after receiving 6 weeks of inpatient mental health treatment at QAC. Following HBCS treatment, none of the 26 participants has had an emergency mental health hospitalization. However, two of the 26 had a scheduled admission to the inpatient Adolescent and Family mental health program since completing the HBCS program. In both cases, outcome measures for the current study were collected at the point of inpatient admission. One youth was hospitalized for four weeks during the HBCS intervention; however, he was retained in the study and returned to the HBCS intervention, as his parents and teachers maintained that he had made no improvements at home or school, despite his inpatient stay.

During the final home-visit, mothers completed the treatment outcome measures, and edited the discharge summary. The HBCS coordinator and principal investigator arranged the posttreatment narrative interview, which is discussed below. Follow-up contact was available to the family and school through the coordinator.

Measures. All mothers/female caregivers completed the Parenting Stress Index, Third Edition (PSI; Abidin, 1995). This is a paper and pencil test with 120 scaled items,

which takes about 20-25 minutes to complete. The PSI contains three domains of lived parenting experience: (a) the Child Domain scores indicate the parent's view of their child's characteristics and includes six subscales (adaptability, reinforcing qualities, demandingness, activity level, mood, and acceptability); (b) the Parent Domain scores reflect the parent's view of themselves, and their perception of their own functioning and parenting efficacy, including items related to depression, attachment to the child, spousal and social support/isolation, health, role restriction, and parent's sense of competence; and (c) the Life Stress domain provides additional information about stressful life-events--some of which may be more enduring than others--that are outside of the parent-child relationship, but affect the family. These would include loss of a relative, loss of a job, and other significant transitions which most families find distressing even when child conduct problems are not prevalent. For the purposes of this study, only the Child and Parent domain were used, which was consistent with research on child CP (Kazdin, 1990; McMahon & Estes, 1997; Webster-Stratton, 1994).

Internal consistency of the child and parent domains was presented in the manual (Abidin, 1995) as reliability coefficients (Cronbach, 1951) which were .90, .93 and .95 for the Child Domain (CD), Parent Domain (PD), and total Score (TS) respectively. Test-retest reliability coefficients ranged from .63 for the CD, to .91 for the PD, which demonstrated the stability of the scores across a 1- to 3-month interval (Abidin).

The general consensus amongst researchers is that there has not been any demonstration of the construct validity of the subscales (Allison, 1998; Barnes & Oehler-Stinnett, 1998); however, the CD, PD and TS scores do represent items belonging to child characteristics, parental role dissatisfaction and an overall estimate of the level of

stress occurring with the mother-child system respectively (Kazdin, 1987; Kazdin, Siegal & Bass, 1992; Webster-Stratton, 1994). The technical problem with the subscales had to do with the lack of a prior factor-analytic processes during the initial development. Although 95% of the 101 items in the CD and PD domains were developed from cross-referenced studies of related variables, the statistical procedures required to validate these subscales were not performed prior to the actual development of the subscales (Barnes & Oehler-Stinnett).

Concern has also been expressed about the lack of stratification in the normative population (Allison, 1998). The normative sample was thought to contain an overrepresentation of Caucasian and middle-class mothers (Allison; Barnes & Oehler-Stinnett, 1998). Reviewers did suggest that profile scores should be used cautiously, and that the use of labels and diagnoses was not recommended (Allison; Barnes & Oehler-Stinnett). Despite technical problems with normative and construct validity, the PSI has good concurrent validity with other measures of child CP, such as the Eyberg Child Behavior Inventory (ECBI, 1974) (Eyberg, Boggs, & Rodriguez, 1992), and with the Achenbach CBCL (Barnes & Oehler-Stinnett, 1998). Parent's scores on the PSI also correlate with measures of child abuse, such as the Child Abuse Potential Inventory (CAP, Milner, 1986) (Acton & During, 1992). Scores on the PSI have been shown to discriminate between abusive and non-abusive mothers (Heinze & Grisso, 1996). As a measure of treatment outcome, reduced scores on the PD of the PSI correlated with reduced levels of reported aggression posttreatment amongst a population of aggressive mothers and fathers (Acton & During, 1992).

This instrument was chosen as a potentially useful diagnostic tool, and also because it has become a thoroughly researched and widely used measure of treatment outcome in families in a variety of health settings and cultures (Abidin, 1995). Its use was particularly salient at this time, because it was also the outcome measure of program effectiveness for the Home-Based Counselling colleague team (the Professional Support Program at Nisika Community Services). It is possible that this instrument may prove a useful tool for evaluation and comparison among the High-Risk Teams. These are contracted services, through the Ministry for Children and Families, who provide much of the outreach counselling services to youth who are at-risk for serious self-harm and/or aggression.

Mothers/female caregivers also completed the Parenting Self-Agency Measure (PSAM; Dumka, Stoerzinger, Jackson, & Roosa, 1996) pretreatment, posttreatment and at follow-up. This is a ten-item scale that queries a parent's beliefs about her ability to handle challenging child/adolescent behaviors. There is currently very little information about the reliability and validity of this scale. Dumka and his colleagues found that only the five positive items loaded on one factor, indicating that five of the self-statements measure a general construct that has to do with parents' confidence in their role. The negative items, on the other hand, do not. However, Coleman and Karraker (1997) noted that the PSAM was a potentially useful measure of parenting efficacy.

Although self-efficacy is a term that refers to perceptions about specific (observable) behaviors (Bandura, 1997), self-agency is described as an individual's perceptions about more global capabilities. The construct of parenting self-agency, as defined by Dumka and colleagues (1996) is: "Parenting self-agency refers to parents'

overall confidence in their ability to act successfully in the parental role. This includes parents' perceptions of their ability to manage their child's behavior and to resolve problems with their child" (p. 216). Given the PSAM's focus on the contextual relationship problems that are central to effective parenting, it merited further trial.

Mothers/female caregivers completed the Child Behavior Checklist (CBCL/4-18, parent form; Achenbach, 1991a). This is a pencil and paper test that contains 113 items which are rated 0, 1 or 2, depending on whether or not the behavior queried is problematic. Child behavior is evaluated as a profile on 2 broadband scales (Internalizing, Externalizing), 8 narrow-band rating scales, and also yields a Total Behavior Problem scale. Reliability is considered adequate, with test-retest intra-class correlations of .952 for the 118 problem items (Achenbach, 1991a). The test-retest reliability of the scale scores (administered 7 days apart) was .89 for the problem scales. Construct validity was computed comparing correlations between the CBCL problem scales and similar scales of the Connors Parent Questionnaire (Connors, 1973). Pearson correlations ranged from .56 on Internalizing scales, to .67 for Externalizing scales, .86 on CP scales, and .82 for Total Problems (all r s were significant at $p < .0001$) (Achenbach, 1991a). Extensive normative data were provided in the manual.

The CBCL includes items concerning Social Competence related to children's activities, social relationships and success in school which were completed only at pretreatment, for diagnostic information. For the purposes of this study, only the scores from the Internalizing and Externalizing scales, and the Total Behavior Problem scale were used at pre-, posttreatment and follow-up, as a measure of treatment outcome.

Teachers completed the Child Behavior Checklist, teacher report form (CBCL, TRF; Achenbach, 1991b). The items are similar to the parent form, with some items unique to the school setting. It is used by teachers of students aged 5-18 years. The broadband Internalizing and Externalizing scales, as well as the Total Behavior Problem Scale were examined, comparing pretreatment, posttreatment, and follow-up scores. Psychometric properties are considered adequate, with a test re-test reliability of .75 and .66 for a sample of boys with behavioral/emotional referrals, over two months, and 4 months respectively (Achenbach, 1991b). In a sample of non-referred children, over a period of 15 days, $r = .92$ for problem scores. Interrater reliability for teachers seeing children under similar conditions was .60 for problem scores. Concurrent validity was measured by a comparison of the TRF and the Conners Revised Teacher Rating Scale (Goyette, Conners, & Ulrich, 1978). Correlations were .76 for Externalizing, and .83 for Total Problems (Achenbach, 1991b). Content validity was supported by the ability of the TRF scores to discriminate between referred and non-referred students. Normative data are presented in the manual.

Procedure for the analysis of data. Test scores were analyzed through SPSS 8.0, Statistical Program for the Social Sciences. Detailed descriptions of statistical approaches are presented in the results section, Chapter 4.

The Narrative Inquiry

Based on the belief that every parent has a story to tell about the experience of parenting a child/adolescent with CP (Wahler, 1996), nine of the 26 mothers participated in a set of three narrative interviews. The question asked of each at the initial interview was, "What has it been like for you to parent this child/adolescent?" The interview

format was developed by Weiss (1994). He suggested creating a “substantive framework,” a topic of inquiry that is introduced by an open-ended question designed to open the dialogue. The interviewer then continues to acknowledge what is said, and seek more detail from the speaker. The resulting interview yields qualitative data in the area of inquiry. This narrative format was explored in a masters project completed by D. Prette in 1999. As a continuing member of the HBCS staff Mr. Prette made an important contribution to service evaluation through his comparison of three initial narrative interviews and mothers’ scores on the PSI. While his study focussed on 3 women, and had only initial interviews and pretreatment PSI scores, he demonstrated that there was some overlap, as well as unique data yielded by both types of parent responses. He suggested that further comparisons would be useful as sources of complementary information regarding treatment effectiveness and how gains are sustained post-treatment.

Narrative interviews. Three interviews probed parents’ perceptions of their skills, challenges, burdens, support systems and goals or expectancies related to their past and present experiences of parenting a child with conduct problems. The interview experiences were meant to provide parents with a sense of validation, as much as it provided the interviewer with an understanding of the respondent’s internal perceptions and attributions. According to Wahler’s (1996) study of how narrative interviews contribute to parents’ use of PMT, the respondent’s disclosures help the counsellor to choose where the intervention could alter the “story”, or where the narrative should remain as it stands. As in a psychodrama (Moreno, 1958), the narrator is the guiding voice in her portrayal of family dynamics, while the counsellor/interviewer is the

attentive audience who listens carefully enough to provide future editorial suggestions about content and structure.

Parents participated in an initial interview (1.5 hours, audio-taped); an exit interview (45 minutes to one hour); and a four-month follow-up interview (30 minutes). Three HBCS counsellors completed the initial audio-taped interviews. In order to maintain a consistent approach to interviewing and categorizing the narrative information, staff members listened to one another's initial interview tapes during bi-weekly meetings. Whereas D. Prette was experienced with the narrative format, and had developed coding categories, the two other counsellors learned from his experience. The ten categories for organizing the data thematically, that had evolved during Prette's project, were retained for coding the interviews in the study. These included: (a) child temperament and effect; (b) parent management style; (c) parent/child relationship; (d) spousal relationship; (e) spousal parenting style; (f) personal health and social support network; (g) family of origin; (h) sibling relationships; (i) future orientation; and (j) additional issues or themes. Since the narrative information collected by each of the counsellors fit the ten categories, inter-rater reliability was considered acceptable. All three of the counsellors elicited similar information from their respondents during the initial interviews.

During the exit interview, which was done immediately posttreatment, mothers were seen in their homes by the HBCS coordinator (principal investigator). The interview adhered to the Weiss (1994) narrative inquiry format: Open-ended questions were developed to allow mothers' own voices to be heard; yet, the responses were guided to a similar focus for all the interviewees which allowed them to review their parenting

experiences within the context of treatment. Goals and difficulties which a mother had presented in the initial interview were re-visited in the second interview. Mothers were also asked what had changed and what remained the same. The final question asked was, "What else should we have done to help?"

The final interview took place four months posttreatment, at the same time that the standardized tests were received. The interview was conducted by the coordinator, and notes were taken. Once again the initial experiences and attributions were reviewed, with revisions given at the second interview included. Mothers were asked how their child/adolescent was doing, and how they were managing to maintain gains they had reported previously. The final question was, "Is there anything else I should ask you about your child and your involvement with HBCS?" Mothers' responses are presented in greater detail in the results section, Chapter 4.

Assumptions and Limitations of the Study

The study included the following assumptions: (a) Children and adolescents who were referred for treatment and identified as having conduct problems (CP) would respond to treatment; and (b) their mothers/female caregivers were targeted as "agents of change" who could make an important difference in their children's level of psychopathology. Whereas the study did not consider the ramifications of children/adolescents having been diagnosed with co-occurring mental health problems, most of the participants did have a dual diagnosis. Fourteen of the 26 identified child/adolescent clients had a co-occurring diagnosis of ADHD that had been confirmed by a child psychiatrist. These youngsters were also receiving prescribed medication. Many were taking three drugs: (a) stimulant; (b) soporific; and (3) anti-psychotic. Of the

remaining 12, several more had attentional problems, but had not received medication because of their mothers' preferences. The effects of medication or non-medication were not considered. Rather, the effects of teaching mothers best parenting practice remained the focus of this investigation. In addition, one child and one adolescent who participated had mood and thought problems which did not respond to medication, and they will require further service in future. However, their mothers participated because their child's CP could respond to PMT.

Finally, the study did not address gender issues. Although females with CP are more verbally than physically aggressive (Zocololo, 1993), these differences were addressed in individual treatment goals, rather than as separate categories of CP. Despite the ratio of males to females being two to one, for the purposes of the study, girls' CP was assumed to be as responsive to PMT as was their male counterparts'.

Summary

Home-visit programs which provide service to children and adolescents with CP present unique contexts for the development of field studies which put empirically based treatment strategies to the test. Rigorous research has provided empirical evidence of the efficacy of PMT in the treatment of children's CP (Brestan & Eyberg, 1998; Chambless & Hollon, 1998). The methods and procedures of the study were designed to evaluate an IVM PMT treatment that had demonstrated efficacy when evaluated in a clinic setting (Webster-Stratton, 1987), but required evaluation of its use in clients' homes. Due to the absence of random assignment to group, and the small size of the control group, the results can only be interpreted as a hopeful beginning for ongoing field research.

The next chapters present the results and summarize the implications of the findings of the study. Chapter 4 presents the statistical analyses and outcome of treatment, as well as the commentary of mothers who participated in the narrative interviews. The objective of creating a mixed study was to use quantitative data to support the probable clinical effectiveness of in-home MST plus PMT, and to use qualitative data to enable the reader to hear the unique experiences of these troubled families. Although it is a challenge to put the criteria for clinical effectiveness in a human context, by helping mothers to tell their stories in their homes, the treatment evaluation process moved out of a controlled setting, and served to illustrate the families' struggles and victories.

Chapter 4

Research Findings

Quantitative Results

The hypotheses discussed in previous chapters in terms of outcome variables, were evaluated in this section. Variables which expressed an improvement (or not) in the client's well-being were the basis of the treatment diagnostics and outcome (or effectiveness) measurement (Lyons, Howard, O'Mahoney, & Lish, 1997). In the study sample, differences between treatment and control group mean test scores were indicators of whether or not the treatment was effective across time. Normal distribution of test scores was assumed.

Overview of Statistical Procedures

The Treatment Group data were screened for outliers using box plot analyses in SPSS 8.0. Given the small number of outliers and the lack of influence on the data, all data points were retained in order to maintain an adequate sample size. Outliers in the control group were checked manually as there were not enough participants to subject these data to a statistical procedure for outlier identification. No data points were removed from the control group due its small size. Histograms were constructed for each variable in the Treatment Group to assure that the distribution of scores approximated a normal distribution.

Each of the outcome variables was subjected to two analyses. The first analysis examined the treatment and control groups across two points in time (pretreatment and posttreatment). The focus of this analysis was to determine any differential patterns of

change for the outcome variables across time between the two groups. Where significant differences were found, a dependent samples t-test was conducted to examine whether effects were sustained at follow-up.

Description of Sample

Treatment group. Twenty-six mothers/female caregivers of clients registered for treatment in the Home-Based Counselling Service (HBCS) at Queen Alexandra Centre for Children's Health (QACCH) were invited to participate in the study. Children and adolescent clients had been referred for in-home treatment of conduct problems (CP). These children and their mothers were the treatment group. The children ranged in age from 7 years to 15 years old, with a mean age of 10.6 years ($SD = 2.42$). Mothers' age ranged between 26 and 45 years, with a mean age of 36.27 ($SD = 5.81$). Children/and adolescents were asked to give signed consent for their mothers and teachers to participate (see Appendix C). Mothers gave written consent for their children's teachers to participate, too. Children received an incentive fee of \$7.50, which was paid at the second home-visit. Mothers were paid \$20.00 after they completed the follow-up measures. Teachers received no remuneration. Examples of parent, child, and teacher consents are included as Appendices B, C, and D. The script read to children is included as Appendix E.

These children/adolescents were referred for service by a variety of professionals which included school counsellors, social workers, psychologists and psychiatrists. More extensive descriptions of their clinical profiles were presented in Chapter 3.

Control group. Mothers/female caregivers of five children who were waiting for admission to the Child and Family program at QACCH Mental Health Services in the

Ledger Building were invited to participate. Permission for mothers' participation was obtained from the children, who received \$10.00 after their mothers/caregivers had completed the measures at Time 2. Mothers ranged in age from 26 to 48 years, with a mean age of 35.0 years ($SD = 7.71$). Children ranged in age from seven to ten years, with a mean age of 7.4 years ($SD = 1.34$). Examples of letters, telephone scripts, and consents for engaging the control group participants are presented in Appendices F, G, and H, respectively.

The control group participants were similar in clinical profiles to that of the treatment group. All were referred for treatment by psychiatrists. Children's clinical profiles and the diagnostic information supporting their similarity to the treatment group are depicted more fully in Chapter 3.

Analyses Including the Control Group

A 2 X 2 mixed design analysis of variance was conducted for each of the three broadbands of the CBCL (parent form), the PSAM, and the two domains of the PSI (child and parent). The Time by Group interaction effect was used to test the hypothesis that mean scores for the treatment group would indicate improvement across time while the mean scores for the control group would remain constant. Statistically significant effects were followed-up with planned comparisons. These took the form of paired samples t-tests comparing Time 1 versus Time 2 for each group (control and treatment). In order to account for multiple comparisons alpha (.05) was divided by the number of comparisons conducted for each analysis. Accordingly, follow-up comparisons that yielded a significance value of .025 or less were considered significant at the .05 level.

Further analyses, in the form of dependent sample t-tests, were conducted in order to determine whether treatment gains, if any, were maintained at Time 3.

PSAM. There was a significant interaction effect for Time by Group on the PSAM, $F(1, 29) = 4.82, p = .036$. Means, standard deviations, and Time by Group interaction effects are presented in Table 1. The Time by Group interaction effect is depicted in Figure 1. The mean PSAM score for the control group at Time 1 ($M = 8.0, SD = 7.21$) was not significantly different than the mean PSAM score at Time 2 ($M = 5.8, SD = 7.85$), $t(4) = 1.06, p = .351$. The mean PSAM score for the treatment group at Time 1 ($M = 4.69, SD = 6.61$) was significantly lower than the mean PSAM score at Time 2 ($M = 8.73, SD = 5.56$), $t(25) = 3.44, p = .002$. A subsequent dependent samples t-test was conducted to determine if there was a significant difference between Time 2 and Time 3 treatment group means. There was no statistically significant difference between the means.

PSI. There was a significant Time by Group interaction effect on the PSI for the child domain scores $F(1, 29) = 6.02, p = .020$ (see Table 1 and Figure 2). The mean PSI-C score for the control group at Time 1 ($M = 147.40, SD = 12.18$) did not differ significantly from the control group mean ($M = 157.80, SD = 10.62$) at Time 2, $t(4) = 1.36, p = .245$. The treatment group mean for PSI-C at Time 1 ($M = 145.08, SD = 23.28$) was significantly higher than the mean for PSI-C at Time 2 ($M = 137.19, SD = 20.74$), $t(25) = 2.69, p = .013$. A subsequent dependent samples t-test was conducted between Time 2 and Time 3 means. No significant differences were found.

The relationship between PSI-P and Time was dependent on Group; $F(1, 29) = 6.71, p = .015$. Figure 3 depicts the Time by Group interaction effect (see Table 1). The

PSI-P mean for the control group at Time 1 ($M = 142.4$, $SD = 26.88$) was significantly lower than the mean at Time 2 ($M = 158.4$, $SD = 23.60$); $t(4) = 3.66$, $p = .022$. The mean for the treatment group at Time 1 ($M = 145.62$, $SD = 28.39$) was significantly higher than the mean at Time 2 ($M = 131.65$, $SD = 27.98$); $t(25) = 2.82$, $p = .009$. A dependent samples t-test was conducted between Time 2 and Time 3 means. No significant differences were found between Time 2 and Time 3.

CBCL (parent). There was no significant Time by Group interaction for any of the CBCL (parent form) broadband scores. For Internalizing, $F(1, 29) = 1.83$. The Internalizing means for the control and treatment groups at Time 1 ($M = 62.60$, $SD = 5.03$; $M = 67.12$, $SD = 7.36$, respectively) and the means at Time 2 ($M = 63.40$, $SD = 6.66$; $M = 62.31$, $SD = 9.06$, respectively) are presented in Table 1. Treatment group means are depicted in Figure 4. For Externalizing, $F(1, 29) = .89$. The Externalizing means for the control and treatment groups at Time 1 ($M = 72.20$, $SD = 71.80$; $M = 69.19$, $SD = 7.28$, respectively) and the means for the control and treatment groups at Time 2 ($M = 71.80$, $SD = 6.06$; $M = 66.00$, $SD = 7.47$, respectively) are presented in Table 1. The Externalizing means for the treatment group are depicted in Figure 5. For Total Problems, $F(1, 29) = 2.03$. Means for the control and treatment group, at Time 1 ($M = 71.20$, $SD = 3.49$; $M = 70.27$, $SD = 65.85$, respectively) and for Time 2, respectively ($M = 71.30$, $SD = 4.56$; $M = 65.85$, $SD = 7.26$) are presented in Table 1. Treatment group means are depicted in Figure 6.

CBCL (TRF). There was no significant Time by Group interaction for any of the TRF broad-band scales. Therefore, no subsequent analyses were conducted.

Table 1

Treatment and Control Group Means (and Standard Deviations) for Pretreatment and Posttreatment, and Time by Group Interaction Effects for PSAM, PSI-C, PSI-P, and CBCL Internalizing, Externalizing, and Total Problem Scales

	Treatment (n = 26)		Control (n = 5)		F (1,29)
	Pretreatment	Posttreatment	Time 1	Time 2	
PSAM	5.00 (6.28)	8.75 (5.18)	8.0 (7.21)	5.8 (7.85)	4.82*
PSI-C	145.08 (23.28)	137.19 (20.74)	147.4 (12.18)	157.8 (10.62)	6.02*
PSI-P	145.62 (28.39)	131.65 (27.98)	142.4 (26.88)	158.4 (23.60)	6.71*
CBCL					
INT	67.12 (7.36)	62.31 (9.06)	62.60 (5.03)	63.40 (6.66)	1.83
EXT	69.19 (7.28)	66.00 (7.47)	72.20 (4.32)	71.80 (6.06)	.89
TOT	70.27 (6.86)	65.85 (7.26)	71.20 (3.49)	71.40 (4.56)	2.03

*p < .05

Correlations between CBCL (parent) and TRF. Pearson's correlation coefficient was used in order to examine the relationship between parent and teacher ratings of children's and adolescents' behavior at Time 1, Time 2, and Time 3 for the three broadband scales, Internalizing, Externalizing and Total behavior problems (see Table 2). This analysis was done in order to test the hypothesis that there would be modest correlations between mothers' and teachers' ratings of behavior. The results indicated that parent and teacher ratings on the Internalizing scores were not significantly correlated. On the Externalizing broadband scale, however, parent and teacher scores were significantly correlated at Time 1 ($r(24) = .447, p < .05$), and at Time 3 ($r(12) = .632, p < .05$). For the Total behavior problem scale, parent and teacher ratings were significantly correlated only at Time 3 ($r(12) = .542, p < .05$). For each of these correlations, the relationship was positive, indicating that high ratings from mothers were associated with high ratings from teachers, and similarly, low ratings from mothers were associated with low ratings from teachers. Table 2 provides a summary of the parent and teacher correlations across the three times.

Table 2

Correlations between CBCL (Parent) and Teacher Report Form (TRF) across Pretreatment, Posttreatment, and Follow-up

	Pretreatment (n = 26)	Posttreatment (n = 26)	Follow-up (n = 14)
CBCL (Parent x Teacher)			
Internalizing	.235	.088	.319
Externalizing	.447*	.353	.632*
Total	.276	.100	.542*

* $p < .05$

Summary

There was an hypothesis for each of the tests used as an outcome measure. When treatment group parent scores were compared with control group parent scores, there was no Time by Group interaction effect for the CBCL, parent and teacher forms. For the PSAM, the PSI-C, and PSI-P, there were significant interaction effects. For the PSAM, the mean score for the treatment group at Time 2 was significantly higher than the mean PSAM score at Time 1. As regards the PSI-C, the treatment group mean at Time 1 was significantly higher than the mean for PSI-C at Time 2. The same pattern followed for the PSI-P; the mean for the treatment group at Time 1 was significantly higher than the mean at Time 2. For the PSAM, as well as the PSI-C and the PSI-P, treatment gains at

Time 2 were maintained at Time 3. The hypotheses for the PSAM and the PSI were confirmed.

The hypothesis that parents' (mothers') scores on the CBCL broadband scales would correspond with teachers' ratings for the broadband scales of the TRF was rejected for Internalizing at Times 1, 2, and 3. For Externalizing, there were significant correlations between mothers' and teacher's scores at Times 1 and Time 3, but not at Time 2. For Total problem behaviors, there was a significant correlation between mothers' and teachers' ratings at Time 3 only.

All dependent parent variables for the treatment and control groups were included in a correlation matrix (see Table 3, Appendix K). Significant relationships between treatment group mothers' scores on the PSI and the PSAM are discussed in Chapter 5.

Qualitative Data

The overall design of the study was a mixed model (Tashakkori & Teddlie, 1998). The mixed model included questions about treatment outcome that were evaluated with quantitative data, as well as qualitative inquiry based on narrative interviews with mothers of children/adolescents who have CP. The objective of qualitative inquiry was to put "flesh on the bones of the quantitative data" (Webster-Stratton & Spitzer, 1996). Use of standardized measures informed the outcome study, but the additional information from mothers was essential to assess the overall meaning of the phenomenon of parenting a child with CP. In comparing the use of quantitative and qualitative methods in studies of CP children, Webster-Stratton and Spitzer suggested that:

Quantitative methodology has a well-deserved role in advancing our knowledge, for quantitative data and statistical analysis help to establish

and verify facts. Qualitative research offers the promise of advancing our understanding by giving new dimensions and depth to factual knowledge, embedding fact in culturally relevant meaning, and perhaps providing rich clues for new lines of investigation. By pursuing both approaches to the phenomenon we wish to understand, we stand a better chance of overcoming the deficiencies and biases of each. (p. 4)

Like the parents who participated in the Webster-Stratton and Spitzer (1996) study, the mothers in the current study were asked to describe their experience of parenting their CP child. This type of interview has elements of both the case study and the ethnographic traditions of qualitative research (Cresswell, 1998). Elements of each of the women's story were unique, the personal documentation of the onset and progression of their children's CP presented as a case study. On the other hand, their struggles with their children were similar, and could be placed in a cultural context that would include a population of all mothers of children with CP. Examining the relationships between such youngsters and their mothers might better fit the ethnographic tradition of qualitative inquiry if more of the researcher's observations had been included. Given the lack of field observation, however, the mothers' narratives are better understood as a collection of case studies with many similar themes. The combined examination of a single case study with other cases, is called cross-case analysis (Cresswell, 1998). This method was chosen to illustrate the mothers' personal experience as members of a population that has been studied frequently in the CP literature (Patterson, Chamberlain & Dishion, 1993), in terms of their potentiating role in the development and amelioration of their children's CP. In other words, there is a vast body of literature which demonstrates a mother's effect on

the outcome of PMT, yet has so far provided little insight into how this process of change occurs, and what it is like to be involved in PMT:

Despite the volume of quantitative research showing correlations between child conduct problems and the more coercive styles of parental discipline, it is far from clear whether there is a causal relationship (and, if there is, which factor is cause and which is effect). This question is part of a larger question, namely, what it is like to parent a child with conduct problems. Apart from anecdotal information, we know very little about how parents experience their conduct-problem children, how they perceive and react to the problematic behavior over time, and what difficulties they encounter as they try to cope with the behavior. This is a question ideally suited to the methods of qualitative research, for it is a matter of understanding these parents' subjective reality. (Webster-Stratton & Spitzer, 1996, p. 11)

The empirical literature about the characteristics of these mothers has pointed to important features of their health, attitudes and behaviors which affect their children. The objective of the current narrative inquiry was to give voice to women who have been measured frequently, yet have also said that they have more to tell than can be expressed on a standardized measure (Tate, Lampard, Saayman, & Keyes, 2000). Perhaps by reading about their experience of struggling with their child's CP and engaging in PMT, the mothers can explain more about the role of key components of PMT as it occurred in their homes.

Participants and Procedures

Sample. Nine mothers whose children/adolescents were registered in the Home-Based Counselling Service (HBCS) at Queen Alexandra Centre (QAC) were invited to participate in the narrative interviews. A description of participants is found in Chapter 3. Mothers were selected consecutively, as the first nine of the overall 26 participants included in Study 2. No one declined to participate in the interviews; although, each was informed of her right to do so without any effect to her child's and family's counselling.

Interview procedure. The narrative interview begins with the general inquiry, "Could you tell me about what it has been like for you to parent ____?" The in-depth interview format was developed from Weiss (1994), Learning from Strangers: The Art and Method of Qualitative Interview Studies. Weiss's book explains how to help the respondent answer questions in a manner that is respectful of her personal experience, whilst it elicits prolific, dense data. Dense data, according to Weiss, yields information that is both broad and deep. In other words, the respondent who is appropriately interviewed will speak more openly about personally meaningful experiences, which in turn require further elucidation. It is then the interviewer's task to focus on individual segments of the response, in order to further expand the information generated by the interviewee. The process continues until the length of time agreed upon has been completed, with the productive interview yielding data relevant to the substantive frame or research question. Interviewers ask questions which are similar to those asked during initial counselling sessions, but the objective is to develop the information into the data upon which the research can be built, rather than to facilitate the speaker's insight or to enhance personal problem-solving (Weiss).

The interview process is meant to encourage the respondent to fully describe the context and perceived meaning of their experience; therefore, Weiss (1994) includes instructions about the content and structure of productive questions:

There are no magic questions. Any question is a good question if it directs the respondent to material needed by the study in a way that makes it easy for the respondent to provide the material. Sometimes the best question is one that in a very few words directs the respondent to give more detail or fill in a gap: 'What happened then?' Sometimes it is one that takes the time to tell the respondent just what is now needed: 'Could you give me a concrete instance of that, a time that actually happened, with as much detail as you can?' Anything that helps the respondent produce the material you need is good enough. (p. 73)

The interviewer guides the respondent to in-depth material by the specific phrasing and tense of the question. If one wants to know what occurred in the past, then questions are phrased in the past tense, and the respondent is requested to provide details about the events and feeling that occurred.

The initial interviews were conducted in the client's home, with arrangements made prior to the interview for child minding. The taped interview session was expected to take 75 minutes. The interviews were transcribed by the interviewer/counsellor. These interviews were also used as a source of direction in treatment, in that the interviewer could return the following week, and ask to confirm the list of treatment goals, referring to any statements within the interview that expressed goals.

Transcription of interviews was comprehensive but not literal. Respondents' use of "um," "you know" were omitted. The typed transcript included the interviewer's questions, as the tapes were shared at staff meetings, and the three counsellors could also refer to the list of themes developed from previous narrative interviews (Prette, 1999). Interviewer questions were only useful as a means of eliciting the mothers' stories. The important speaking part belonged to the mother, and her narrative account of parenting a challenging child was the objective of the interview process.

Each mother's series of three interviews is presented consecutively. By moving from the intense affect and the history of difficulties presented in the initial interview, to the second interview, the mother's personal experience of the effects of treatment are highlighted. The third interviews are presented as the opportunity to discuss the outcome of having had the treatment, and a time on their own again, so that mothers could describe what had stayed with them since their counsellor finished the home-visits.

Initial interviews. To introduce each of the nine mothers' stories, a summary of the child's presenting problem and a brief history of the previous community psychological and psychiatric services will precede her narrative. Through this clinical introduction a psycho-social context is drawn, and the process whereby social, educational and familial challenges are affected by the parent-child struggle will also emerge. When the mothers discussed their roles and attitudes towards their community, they also confirmed the insular nature (distressed and isolated) of their experience. Names have been changed to maintain confidentiality. An ellipsis was used to link statements which conveyed thematic meaning. All interviews initial interviews were

shortened, with representative quotes as excerpts used to illustrate the entire personal dialogue.

Posttreatment interviews. The mother was asked about the themes which had emerged from the first interview, which included her concerns about: (a) child temperament; (b) parent-child relationship; (c) spousal relationship and spousal parenting style; (d) parent child management style; (e) personal health and support network; (f) family of origin; (g) child's sibling relationships; and (h) future goals. In addition, mother's were asked about their child's success in school, if that topic had been discussed during the initial interview.

Follow-up interviews. The third and final interview was done on the telephone, and was completed in 30 minutes. The interviewer asked the respondent about how things have gone since the previous interview, usually an interval of four months. The general response varied; however, each respondent's statements were acknowledged, and then the focus was re-directed to issues and themes which had emerged during the previous interviews. The topics discussed were considered in terms of those which were relatively stable, such as child temperament, versus areas of reported successful change, such as parent's improved management of child behavior. Two new questions were introduced at the third interview dependent upon whether the mother had reported feeling better able to manage her child's CP at posttreatment: (a) How was the mother managing to maintain the improvements; and (b) What else would she suggest to improve the home-visit counselling service. If no improvement had been reported, mothers were asked how they were surviving, i.e. the kinds of self-care and support that kept them going, as well as what else the HBCS should have provided to be more helpful.

The Interviews

(Evangeline and Crystal). Crystal was seven years old when she was referred to Home-Based Counselling Service (HBCS) by her child psychiatrist. She had been diagnosed with both ADHD and CP, and was taking a combination of prescribed medications (ritalin and clonidine). Her mother, Evangeline, described her to the psychiatrist as unmanageable; however, reports from Crystal's teacher indicated that she had no problems with attention or hyperactivity during class, and was accomplishing the learning tasks of grade one well within the teacher's expectations. In addition, she had no tantrums or peer problems at school. Like many new clients, mother and daughter were a mystery—how was mother's experience related to the child's CP?

Initial interview. Interviewer: "Could you tell me about your experience of parenting Crystal?"

Evangeline: "I was a battered wife for 8 years. My 'ex' threw me out, into the snow when I was 8 months pregnant with Crystal. I had to get help from the ministry and move out here myself—my parents helped me a little when I arrived. But it was like they were put out. My dad said, 'oh, here comes the bad penny again.' My mom was some help, but her health was poor, and now she can't help at all since her amputation...Six weeks after Crystal was born I hemorrhaged, went back in the hospital. I was so depressed I wanted to die. I felt 90 years old. I moved to Sooke to start fresh. I am very intelligent, but I have no support, no back-up. It's just me 24/7. I have had no one else to help for 7 years. I can't get babysitters...Serena (other daughter) was only two when we left; now she is nine and she has taken over mothering me and parenting Crystal. She

feels sorry I have so much to handle. Every day before the girls come home (from school) I have to rest. Just having Crystal walk in the house makes my muscles tense and gives me nausea. She has fits, screams, hits, bites. The way she acts pushes people out...she has prevented friendships for me. She can frighten adults, and yet people say she doesn't need meds. She was always difficult to console and I just go overboard, trying to please her. It's very difficult to balance."

Posttreatment (exit) interview. Interviewer: "What has changed since HBCS treatment?"

Evangeline: "Well, she no longer has fits. When she starts to have a tantrum, I have time-out all set-up. She goes to her room for 5-10 minutes, and then she calms down. Instead of an hour, it's over in minutes, and we don't talk about it. We just go back to what we were doing."

Interviewer: "How did this change happen?"

Evangeline: "I am calmer. She just knows now that I am in charge. When the counsellor came to my house, she just observed and knew right away what I needed. So, we set-up this time-out in Crystal's room."

Interviewer: "What did you find helpful about the HBCS?"

Evangeline: "She was always there when she said. I could count on her. She listened, and I felt really supported. I knew my daughter and her problems, but the counsellor helped me decide what would work in our home. She was right-on the money for what she noticed. The charts we made were just what I needed for Crystal. The girls don't fight on the days I take naps; now that I have the injury I am more irritable. Plus I have all this stress about Crystal's heart rate and medications."

Interviewer: "So what else would be helpful to you at this time?"

Evangeline: “I need to keep everything in mind. After I was assaulted (during the fourth week of HBCS involvement), I have had some trouble remembering, so the lists are really important. The counsellor helped me organize all of my papers and bills. Having someone to help me while I was injured really made the difference. It’s still so hard being responsible 24/7. Respite would be ideal. I have no opportunity for a break, can’t even take time to go for my own counselling sessions unless I take them with me.”

Clinical summary. Here is a posttreatment need that had been addressed during the home-visits, but had come undone. The posttreatment interview elicits more advocacy chores for the Coordinator, as this mother has lost her MCF funded after-school support for the girls, which she had been able to schedule as overnight respite. Even though treatment is finished, phone calls were be made so that respite was available again.

Follow-up interview. Interviewer: “It’s been a while since we talked. How are things going?”

Evangeline: “Okay I guess. I have a new support person, S.P., who helps me organize all my meetings and tomorrow she’s coming over to help me with my papers.”

Interviewer: “Last time we talked, you mentioned that Crystal was much easier to manage. How is that now?”

Evangeline: “She very seldom has time-outs these days. She goes to a lot of after-school activities. I even have a child care worker who takes the girls skating. After S.P. finishes, then I am going to have a lifeskills coach to help me learn multitasking.”

Interviewer: One of the things you mentioned last time was the behavior charts. Are those still working?”

Evangeline: “Well that’s just it, I think they’re at the bottom of the drawer and S.P. is going to have to help me find them. The HBCS was helpful but much of last year is lost in a mist, ‘cause of my head injury.”

Interviewer: “So now you just need help to find what you lost ‘cause of the injury?”

Evangeline: “I guess so.”

Interviewer: “When we talked before, Crystal was back and forth to the doctor’s because of her reaction to medication. How is her medication now?”

Evangeline: “Well, she’s off just about everything. She’s only taking ritalin every morning, and Dr. S. has it scheduled so that she will be med free in two weeks.”

Interviewer: “Is there anything else we should talk about?”

Evangeline: “No, I think that I just have to keep re-learning what I forgot.”

Interviewer: “Sounds like you are doing pretty well, but that is a lot of extra effort, to re-learn everything that worked.”

Evangeline: “You’re not kidding.”

Summary. Psychiatric referrals are not always what they seem: From what this mother was reporting to the doctor, her child was always oppositional and out-of-control on a daily basis. As a psychologist doing an initial risk assessment in their home, this writer was concerned that the mother expressed so much fear and anxiety about such a diminutive child. Crystal’s teacher found her easy to manage. Mother had continued to ask the doctor to increase the medication dosages, to control acting-out behaviors.

Whom to believe? As the HBCS counsellor continued her work with Evangeline, this mother gained the confidence in her own skills to cope with her daughter’s noncompliance, and to recognize more of what Crystal could already do correctly at

home. When the family physician confirmed that the medication was adversely affecting Crystal's heart rate, this mother found the courage to trust herself and follow medical direction to reduce the dosages. When she asked the doctors for more help with Crystal, both psychiatrist and pediatrician thought a re-referral to HBCS was appropriate. The coordinator thought not, and helped the social worker connect with more appropriate support for mother through the Gorge Hospital head-injury program. Sometimes more PMT is not what is needed.

Shirley and Justin. Justin was 11 years old when his mother requested HBCS. He had been living in a foster home, and the MCF social worker thought it would help their reunion as a family if he had counselling. Shirley believed that most of his problems were due to his ADHD, and his frustration with school. His medications included ritalin, risperdal, and clonidine which were prescribed to address attention problems, impulsivity and aggression, and difficulty sleeping, respectively. From Shirley's perspective, his non-compliance and running away from home were a result of his being sent home from school to be disciplined. Despite his academic competence, and the better than average intellectual potential evidenced by his scores on psycho-educational assessments, he could not accomplish successful school attendance while living at home. Shirley agreed to PMT in order to help him cope with school expectations and both of their despair over his frequent and prolonged school suspensions. His psychiatrist, who had also supervised his inpatient treatment during his 2 month stay on the Child and Family program at Ledger, did not make the referral. Dr. T. did not believe that Shirley or Justin were "going to change."

Initial interview (Shirley and Justin). Interviewer: “Could you tell me about your experience of parenting a child with such challenging behavior?”

Shirley: “Justin was diagnosed at 9 with ADHD. I fought for 3 years, from when he was 6 to 9, trying to have him diagnosed. During that time I had a nervous breakdown. I had to accept Justin has ADHD—this illness—I had to calm down and learn to accept it. It’s not going to go away. Justin has it. He may get help with a lot of things, but he will still be Justin. I remember one of my breakdown days. Justin was acting up in school—everything had gone wrong at school—his older brother and he just seemed to act out in tandem. I was getting calls from their schools every day. It aggravates me. As a parent you feel embarrassed. Now I’m only half embarrassed, cause they mark the kids. Now I’m mostly on Justin’s side and not the other people’s side. When I first found out he had ADHD I was in denial. I didn’t want to accept it. I felt guilt, well what did I do? Now I’ve accepted his disability. His behavior is his behavior, nothing to do with me. The worst part is his school problem. He’s in denial about his ADHD. If he would just accept it, say ok I have this disorder, I got to handle myself, this is what it does to me, instead of saying I’m mentally retarded and putting himself down... If he was accepted you’d see a totally different kid, because he does have a sensitive side, a sense of fun and humour.”

Posttreatment interview. Interviewer: “Justin still has ADHD; what has changed with HBCS intervention?”

Shirley: “Some help with Justin, but mostly training is needed for teachers so that they can handle these children. These children may be unwilling to make transitions, try new things... These kids are used to negative attention. Their way of dealing with positives is

to turn it negative. Justin has low self-esteem. Every day is a trial...Feels like ¾ of the kids in the classroom hate his guts—why live? To be accepted by one teacher for one year will make a difference.”

Interviewer: “What else can HBCS do to make a difference?”

Shirley: “Listen to the kid.”

Follow-up interview. Interviewer: “How have you been doing?”

Shirley: “Justin is acting-out at school. He has mentioned guns to the school counsellor. He is out of control and thriving for negative attention. I try to ignore him, so I can speak to him positively when he’s more positive. It’s a power/control thing. His academics are ok, but his behaviour is still a problem.”

Interviewer: “How have you been able to take care of yourself?”

Shirley: “I’ve taken the leader training for Beavers. Justin won’t go anymore, but I just have a great time helping the kids, joining in with my friends at the camps.”

Summary. Where do professionals look to find the help that this mother and her son need? Despite Justin’s having been suspended from his grade seven behavioral school program last this past June, his mother, his step-dad, his social worker, and his HBCS team hope he will still attend one of the few school-based behavioral programs in Victoria in September for grade eight. Shirley’s parents are deceased, and her siblings are not involved in a way that supports family coping currently. Perhaps extended family relationships could support more than previously imagined; this would be an area of exploration if Shirley sought service through HBCS in future.

Providing ongoing support for the family—especially for Justin and his mother—needs to be a community based effort. This mother has learned advocacy skills, but will

need respite, and recognition of her efforts. She and her son will need all the relationships and support available to overcome the insular nature of their lifestyle. Her husband tries to support Shirley, but he does not really understand why his step-son cannot fit into school. Both parents have maintained their opinion, based on actual school staff behavior, that teachers were not always fair and consistent in their approach. Since his February to June placement was a failure, despite the well-trained staff who all met Shirley's criteria for understanding ADHD, mother has become less critical of her son's teachers. Justin is starting grade eight this September, old enough to be charged as a young offender if he continues to threaten people and damage property. Will he find his way in the less restrictive alternate school program?

Marsha and Eliot. Eliot was referred to HBCS by his grade two teacher. He could be managed by his classroom teacher and the resource room teacher, but he lacked social skills and acted out on the playground, with substitute and the student teacher. Disciplinary discussions between student and staff had precipitated his running away from school. Despite his academic abilities and his scholastic competence, his anxiety and impulsivity caused concern ranging from lack of productivity to life risk. His grade one teacher had documented his self-harm gestures and statements, as had his grade 2 teacher. His mother thought his school principal was overwhelmed her son, and that the previous school reports of his problematic emotional and behavioral responses were exaggerated. She was, however, willing to have HBCS involvement, because of his self-harm talk at home and at school.

Initial interview. (Marsha and Eliot) Interviewer: "What was it like for you to parent Eliot?"

Marsha: "He was always so easy going, so content. As a baby he was so easy to mind. When he was 3-4 (years) I had a lot of stress. Sharay (sister, 2 years older) was injuring him. He's taken a downhill turn since September, but Sharay was the one who had ADHD and behavior problems. He can't handle frustration, because then he gets angry. His response at the beginning of the year was to walk away, to the corner with his arms folded, in a very angry, pouty mood, closed up body and refused to speak to anybody, and that went from getting mad and running away and being lost to being mad, being out and out defiant, where he actually refused verbally to listen and actually said no and actually went underneath desks and had to be physically removed and that went to him saying he wanted to hurt himself. He does test you, and when you get really mad, he's shocked, upset how angry you are. He's pushed you to the limit. I guess to see what's going to happen. If you are in his face he freezes, just Eliot needs his personality corrected...He feels intimidated by the principal...

Now my older daughter, Serena (age 17 years) is having health problems too. Anyway, this year Eliot started having problems with every adult except me. He threatened to strangle himself last time Serena baby-sat him, so I am not going to my job anymore. It's too much stress for Serena to manage him on Saturdays...Eliot has a problem with communication and assertiveness. He's been choking himself at home and at school. Now I think he's quite serious...All of this about Eliot's problems, all my children's problems has been my responsibility. Larry (husband) can't take time off during work. I don't drive, I have to look after Kim (age 3) and I'm the only one who can handle Eliot in a crisis. I always have to have a talk with Eliot; meanwhile Sharay is

on the playground wondering where I am... When he tried to choke himself I didn't know what to do.

Posttreatment interview. Interviewer: "During your first interview, you said Eliot was not a difficult child to parent until September of 1998. How have things gone since you became involved (June, 1999) with HBCS?"

Marsha: "Eliot is in with Dr. Jenkins' special class. My assertiveness is out there...I now realize that options are generated by parents. I helped the learning assistance teacher plan the change from 11:30 am meds (for Eliot) to 12:30pm, just before he goes outside. I now need to be the school based team leader, but not too critical."

Interviewer: "How have things changed since you worked with HBCS?"

Marsha: "I found out that I could help plan guidelines and consequences (at home), and the schedule and structure helped reduce chaos. I also give feedback. When I first heard about the schedule and chart, I didn't see the value, but now I do. The structure and the points fit for Eliot and all our 3 youngest kids. Sharay and Eliot are getting along better. Would you phone Mr. Z. (school counsellor) and ask him if he wants _____ (HBCS counsellor) to work with Sharay? She is really having problems with being picked-on."

Follow-up Interview. Interviewer: "How have things been going since we last talked, when Eliot was getting used to his school program?"

Marsha: "Eliot is still overly sensitive. His meds are still changing. H still reacts to correction, consequences and change. He'll be in the Day Treatment program (Ledger school and youth and family counsellor). I like HB because it helped me & Larry make some changes at home which helped me to know what worked and helped all the kids. Larry and family life more organized and predictable. It helped Larry to realize that his

involvement is necessary. He takes time on the week-end for the family. He understands the children's medical and emotional needs and does not blame me. _____ (HBCS counsellor) helped us to be like minded. Our relationship has improved. He doesn't do those little twists and digs. Larry recognizes his effect—that his yelling was not helpful to the children. He uses play with Eliot to get close and soften things. He makes sure he does this before Eliot leaves the hours. The scheduled counselling, weekly, was important 'cause it helped focus our decisions about what we wanted to do with the children. _____ (HB counsellor) always came when he said, and did boy stuff with Eliot. Eliot felt important because his counsellor came. But Larry and counsellor were a good match, almost male bonding. The counselling has helped me to accept Eliot's good and bad days. The bedtime routines have made him much more willing to settle. When I met _____ (HB counsellor) Eliot was easier, but I was at my limit. Now he is more difficult, but I am more able."

Summary. This mother is preparing for a long-term commitment in her role as team leader for her children's school needs. She appreciated the HBCS support and skill development, but she knows that her son faces a difficult future. Despite the relative success of the HBCS intervention, Eliot still needed to attend an even more specialized school at QAC for several months, and move back to his special public school program in June, 2000. His mother is unsure about his school placement for September. She continues to work with the long term outpatient program at Ledger, as well as consulting with Eliot's teacher at Ledger from time-to-time. If his school placement in September is not able to cope with him, perhaps Marsha and Larry will ask Eliot's child psychiatrist to consider inpatient treatment. The QAC neuropsychiatry clinic could be a resource in

future, as Eliot's case is complex, and his diagnoses and medications do not yet work well for him.

Initial interview. (Brandy and Reese) Brandy is the single mother of an eight year old boy who was already a challenge for her when he injured his head in a bicycle accident at age six. He lost control of his bike and banged into a signpost. The initial injury has been treated medically, with surgery, and was considered mild to moderate in terms of future effects. The post-trauma diagnostics also included a neuropsychological assessment. The referral to Home-Based was made by the central intake counsellor at QAC, when Brandy phoned and asked for help for herself and her son. Previous reports from a child psychiatrist and the neuropsychologist indicated that medication had been suggested, as a way to help Reese manage his rages; Mother, however did not like the idea of medicating her son. She agreed to try HBCS; she reported that she had already learned the principles of positive parenting through a community-based PMT course.

Interviewer: "Could you tell me what it has been like for you to parent Reese?"

Brandy: "Well, I was pretty young when he was born, and his dad and I didn't agree on much. We split when Reese was still a baby. He only sees his dad from time to time, because he's up Island, and his dad has remarried, it's hard for Reese because his dad has a new baby. His dad really has no idea that Reese even has any problems in school."

Interviewer: "It sounds like you and Reese have been on your own for a while. Can you tell me what that was like; how did you manage when he was a baby?"

Brandy: "He was a colicky baby, so he was difficult to deal with right from the start...I thought he was a great toddler...he was pretty easy I guess. He would get into trouble as a little kid but that was just what kids do. His energy was a little bit high but mostly

typical and normal stuff that kids do. By the time he started into school he was much more difficult and even then was hard to get out the door. He never like school, not even in kindergarten. After his head injury, I think things got worse. From Grade 1 on the things that were hard got harder. The teachers weren't very good and he was getting bullied but he also had some learning problems that were worse after his injury. He had always been very strong willed and also physically sensitive to his clothing and different things. He seemed to get more physically aggressive after his accident...difficulty adjusting to transitions...difficult temperament...loses his temper easily. Once he is upset he becomes very fixated on things...Gets into fights...social problems. He's OK with mellow kids and plays really well with girls, but gets going with boys, especially if there's more than one, than more fights. He's the one that gets blamed. I'm the one that gets the worst of it from him. He is not as aggressive with other kids as he is with me. He has an individual learning plan at school...seems to be doing better now at his new school, it is smaller and more supportive. He blames his head injury for his problems...Sometimes I just don't know what else to do and I end up physically making him do things. Luckily he isn't getting as many time-outs now because he is getting too big to get him there...My dad was a rage-a-holic. I feel that I have a temper like my dad and I try not to be like him. I try hard to learn other ways of parenting."

Posttreatment interview. Interviewer: "You identified a number of goals that needed attention, and you sounded interested in parenting courses. How did the HBCS go for you and Reese?"

Brandy: "Well, I have full time employment for the last 3 months. Reese takes the school bus and does not give me such a hard time about getting out in the morning. ____

(HB counsellor) had a global view, and more understanding of Reese's behavior. _____ (counsellor) got to see Reese at his worst, and he pointed out times when I might be appeasing Reese."

Interviewer: "Were there any tools for handling Reese that came from the HBCS work?"

Brandy: "Yes, I learned not to get into power struggles, like the hold when he's acting out. Also in other situations at an Xmas rec. centre party, I ignored his misbehavior, and he stopped it and fit in. In public when he acts out I will "no" more firmly now, but it depends on the situation... I felt that some of _____'s (counsellor's) views were male."

Interviewer: "What would work better?"

Brandy: "Having _____ (counsellor) come into our home was a bit intrusive."

Interviewer: "What would have worked better for you and Reese?"

Brandy: "Meeting at a community centre. Talking during car rides was good. If there was a support group, or course for a half-day, I would like to have discussion and tips."

Follow-up interview. Interviewer: "How have you and Reese been doing since we last talked?"

Brandy: "Okay I guess. He's spent a lot of time with his dad this summer, I'm working full time and he was getting pretty hard. The after school and summer camp were just too much for him, and I had to work, so I'm glad that his dad could take him. I was even thinking that he might go to his dad's for the next school year, but I still am not sure if that will happen."

Interviewer: "Sounds like your job and Reese's problems are just not balancing right now."

Brandy: “Yeah. I really need to figure out a way to share my son without signing over custody to his dad. I just am not ready to let his dad make all the decisions, and what if he (Reese) hates it there. I won’t have the child support to take him home. I really need the help, but I hate having to give my son up to get what we need.”

Interviewer: “You are feeling kind of stuck with your ex-husband’s point-of-view if you want him to take Reese during the school year.”

Brandy: “I always thought if Reese got too hard for me to handle, we could try his dad before we tried medication or the hospital program. Then, when I came face-to-face with my choice, I don’t know if I can do it.”

Interviewer: “So his dad was like a last resort, and now that just doesn’t feel like the it should be so formal or so final.”

Brandy: “That’s right. I’ve been the one who’s been there for him all along, and now I have to give up his birth certificate and everything just because I can’t stop him fighting with other kids. I don’t know, it doesn’t seem fair.”

Summary. It is impossible not to feel sad for this single mother who is sounding defeated by her need for Reese to have appropriate parenting from two geographically separate homes. In the past, his mother has refused to accept the medication trial recommended for Reese’s rages, and gave a firm “not now, thanks” to the in-patient treatment program psychiatrist; however, it seems harsh for her to have to give him up. Perhaps she won’t—she hasn’t signed anything yet, and school starts next week. His school principal has said that this term, she will phone the Ministry for Children and Families as soon as he is aggressive. She can no longer protect Reese from the risk his

anger brings to himself and other students. The crisis will happen whether his mother agrees or not.

Initial interview. (Aemilia and Ricardo) Ricardo (age 12) was referred by his school counsellor for opposition and defiance in class, and a series of antisocial incidents on school grounds and in the neighborhood after school. None of the incidents had resulted in prosecution. This was Ricardo's second time through HBCS, but the school counsellor assured the Coordinator that this mother was really motivated to work with us this time.

Interviewer: "Could you tell me about your experience of being Ricardo's (age 12) mother?"

Aemelia: He was an easy baby, a busy, active toddler. I never found him too difficult until about two years ago. His father left us three years ago, and Ricardo has missed him something terrible. Sometimes, when his father didn't make any effort to see him, I'd feel so badly, but I refused to take the blame. His relationship with his dad has pretty much gone. The only contact they have had in the last year has been when Ricardo phoned him. On one hand, it makes me so mad, my daughter misses him too. But I know that the kids know who's there for them. It's me, on my own. We are doing the best we can...Ricardo never tried so many bad things around his father. Now, I have to keep matches out of the house, and lock away my purse...I think he's going to outgrow this, but I'm not giving up and he knows that, too. I've been getting up with him in the morning, so he does his paper route and then gives a good accounting when he collects. He and his friend—who is not a very good influence—threw all their papers away last week, but people complained and now they have to do it right. Anyway, no sense

whining, he's a handful but I love him... The good thing about being a single parent is I don't have to share the discipline with anyone. I think the kids are better off now, with one parent who always is just what they expect. And maybe it's easier for me because I don't have to ask anybody's advice. You know, I am my own boss in my home... School is a real problem for him sometimes, not because he can't do the work, but because he is lazy, oppositional. This year he has a man teacher and he's doing what he's told and causing fewer problems, but he likes Mr. ____ too. That's the problem, once he has an opinion about somebody he can make their life miserable. Like his sister, not me so much, but I do need help because he's just 12 and I want to nip the stealing, and you know, the next time he could be charged. I tell him and he laughs. What worries me is that things could get worse, and he could go to jail.

Summary. This mother works full-time as a nurse. She is used to coping in difficult, even life threatening environments, and Ricardo's school counsellor believes that she minimizes her son's role in school conflicts, and rescues him from consequences in the community as well. She feels like the school counsellor is supportive, but the HBCS looks like a good option to help her organize her approach to disciplining her son, and support her right to do so. She thinks her boy is going to change, but she is just not sure how long that will take, and whether she can stand the siblings' fighting until he does.

Posttreatment interview. Interviewer: "When you started counselling you had your hands full with Ricardo's behavior. Could you tell me what's improved at your house since HBCS started?"

Aemilia: “I have to be strict now, because Dave (boyfriend) is there for support. I can bounce ideas around with him now, just like I could with _____ (counsellor). _____ was very helpful, he gave ideas, and he validated my feelings and values. When Ricardo swears now, I ignore him and he stops because he loves attention and to be the centre. _____’s (counsellor’s) support implied my right to do what I did, justified me. I felt equal and relaxed, comfortable talking my frustrations out. Ricardo is still bitter about his loss of his dad, but he will come around. My former mother-in-law is dying, and I want to say good-bye, but my “ex” won’t allow it. That’s hard to take, but oh well, the kids have gone over to say theirs.

Interviewer: “Ricardo and his sister were getting pretty physical last time we talked. How will you handle aggression in future?”

Aemilia: “Rock Solid” phoned about Ricardo and five other boys being organized into a group, but even though I phoned some of the parents, none of the kids showed. I am going to work with the school to prevent future rumbles during and after school. I am more confident with giving consequences now, I take away the internet if the kids fight at home; bad language is consequence with loss of privileges. You guys made me feel good. I no longer feel overwhelmed. Oh yeah. Air Cadets has started, and he’s better when he’s busy.”

Interviewer: “That’s nifty. So many positive things have been happening. How did you do with his stealing at home?”

Aemilia: “Oh, I never have any cash for him to steal.”

Summary. This client knew what a helper needed to hear—she was coping, and she felt supported. Perhaps the school counsellor won’t phone us again next year.

Follow-up interview. Interviewer: “How have things been going since last time we talked?”

Aemelia: “Well Dave and I are getting married. Ricardo is getting better—for him, older is better, for me, there is still the issue of respect. But Dave is great with him, and he supports me. He still misses his own dad, but that guy has little contact with Ricardo. He answered an e-mail a couple weeks ago, and that’s about it. “

Interviewer: “How is Ricardo doing in school?”

Aemelia: Well, he has a woman teacher this year who is always on him. She’s not too bad. He wouldn’t be so bad if she wasn’t so fussy.”

Interviewer: “Is there anything else we should do to help—we talked about an inpatient referral, what do you think about the Adolescent program for Ricardo.”

Aemelia: “I think it’s OK for now. I don’t believe that place (Ledger) would be any use. My girlfriend’s son learned more bad stuff—he was worse after, than before he went in. No, I’ll just stick with what I’ve got. Dave is a great support.”

Summary. No news is good news.

Initial interview. (Monique and Stephanie) This mother had recently separated from her husband. She and the three children lived in the family home. Dad (Stefan) lived around the block, and came over every afternoon when he got off work and looked after the children until Monique got home. They did not tell us about the separation until we had been working with them for a month; because they believed that the professionals involved would put too much emphasis on the marital conflict, while the real problem was their eight year-old daughter’s difficult temperament and extremely disruptive behavior. This girl was referred to HBCS by her child psychiatrist with a diagnosis of

ADHD and CP. She had been taking stimulant medication since she started school. She was also given clonidine for settling at bedtime. Risperdal was successful at reducing her impulsivity and aggression, but was discontinued due to her weight gain.

Interviewer: "Could you tell me about your experience of being Stephanie's mother?"

Monique: "She was a manageable baby, lively, busy not hyper. Was a bit sensitive to change in routines, but really a fat, happy baby. Everything changed when she was about 18 months old. I went to pick her up, and she screamed. She had some kind of terrible abscess on her thigh, near her hip. No one ever told us exactly what it was. She had a very high fever and was in the hospital for ten days. My father noticed it too, that she was more irritable after she came home. Everything became a struggle. Toilet training was a battle; bathing was a battle. There may have been something different about her right from the start. Language and walking were also slower to develop. She would never take a nap, even as a baby.

I began to be concerned when Stephanie was around three. I remember picking her up from day care and she was hyper and aggressive. I have safety concerns both towards her aggression towards her siblings and for her own safety...i.e. going out on the roof, running away, climbing and jumping all over things, being very destructive...new things always get broken. She never admits to doing anything. It is never her fault. She ties string around stuffed animals and chokes them, drags things around. We don't have many tender moments; she's not affectionate. She doesn't deal with her emotions appropriately; she gets vengeful. Right now she's not involved in any activities outside the home, none of her activities have worked out...Depending on how wound up she is, things can become very ugly... When I have been really stressed out I phoned my mother.

Both sets of grandparents live in town. My parents are very involved, but Stephanie is so demanding that it just isn't fair to the other kids. We have to have a break. That's why Dr. S. said we should ask for respite."

Clinical summary. This mother had very high expectations and a very challenging child. She was insular and discouraged. Her descriptions were dramatic, occasionally contradictory—as if she herself were still unsure whether her daughter had always been a problem, or not. At school, her daughter did present with more of anxious demeanor than many children her age, but the overall impression was that it was toughest at home. Initially, her classroom teacher said that she was no problem except that she would not change into her swimsuit at school. Aggression was not a concern at school. Rather than being perceived as oppositional or impulsive at school, her teacher described Stephanie as competitive, as if desperate to achieve in class and to please. Her academic work was at grade level, with weekly learning assistance provided in language arts and arithmetic. MCF did provide week-end overnight respite twice per month, which began concurrently with HBCS involvement.

Posttreatment interview. Interviewer: "As you look back at the home-visits and counselling work you have done with HBCS, and the descriptions you gave of what your life with Stephanie was like, could you tell me what is the same or different now?"
Monique: "Well, she's (Stephanie) no different. She would act a little bit better when _____ (HBCS counsellor) came over, but she knows how to control herself if she has to. He was never here at supper time, which is when she was the worst. He really never figured out what we were trying to say, and our family didn't really benefit. We have

used those charts before, and we told him that, they just don't work for more than a few days. I am fed-up and frustrated."

Interviewer: "Okay, the home-visits and incentive charts weren't useful, and she's still very challenging. What about respite; how did that go?"

Monique: "That was very helpful. The woman who ran the special foster care placement just didn't take any guff. So even though Stephanie tried to have a fit about meals and taking a bath there, she got into the routine by the second week-end. That woman has been in the business for 20 years, and she said there is something else about Stephanie that's not quite normal. She asked me if we had had an MRI done, and what kind of complete neurological work-up she had. There are tests, brain scans, whatever, that a child with ADHD should have just to rule out other problems. I don't think anyone but Dr. ____ (developmental pediatrician) has thoroughly checked her out, and that was 2 years ago. He's the only one who takes the time to really listen. Dr. S. (child psychiatrist) just asks me about her, asks her one or two questions, and adjusts her meds."

Interviewer: "The neuropsychology report did not indicate that Stephanie had much interfering with her learning, but you seem to be asking about something else."

Monique: "Well I get all those tests and doctors confused, but I know there's something more that medical tests could tell about her brain."

Interviewer: "Dr. S. (child psychiatrist) doesn't think that there's a relevant test; he said something about there has to be a question, and he doesn't have one."

Monique: "Maybe not, but what if he's wrong and I feel so guilty if there's something we overlooked."

Interviewer: "You sound like you are convinced that ADHD is not enough of an answer. What else can we do to help?"

Monique: "I'd really like Dr. _____ (developmental pediatrician) to see her again, and send her for more tests."

Interviewer: "OK. How about we see if he'll see her, and then you can ask him your questions. Then, if he can't answer your questions, but has one himself, he can refer her to the neuropsychiatry clinic. The pediatric neurologist will be there, and any questions about the MRI should be put to him."

Monique: "That would be great."

Interviewer: "I'll phone you as soon as his secretary confirms the booking."

Clinical summary. This mother could be seeing something about this child that has not yet been diagnosed. She was not interested in PMT, but we were able to help her access the medical referral she requested. The developmental pediatrician saw her daughter within six weeks. He wrote a letter to the child psychiatrist, with a copy to HBCS stating that he was supporting the ADHD diagnosis. She required no further medical diagnostics (no question for the neuropsychiatry clinic). He was recommending no further in-home counselling; however, behavioral counselling was provided at school to Stephanie. Monique and Stefan were self-referring to their community mental health centre, seeking support for themselves and individual therapy for Stephanie.

No follow-up interview occurred. After several phone calls and one brief conversation, this mother said she appreciated the help having her daughter seen by the doctor, but she was too busy to talk further.

Initial interview. (Brenda and Nancy) Nancy was a petite seven-year old when she was referred to HBCS by her pediatrician, who also was querying a diagnosis of ADHD. She had been rated as having attention problems and learning disabilities in school by her teacher. Her mother did not agree to a trial of medication.

Interviewer: "Can you tell about your experience of parenting Nancy?"

Brenda: "She was an unhealthy baby, and this was the beginning of all my daughter's problem behaviors. She was very premature, her twin sister died at birth, and she had one health problem after another. She had allergies. She had asthma so bad she had to stay in the hospital, and I don't know how many times I've rushed her to the hospital with her asthma so bad I thought she was going to die. She is a little bit better this year. We haven't been to the hospital for months. But now, you see, she expects everything to be her way, and when it isn't, boy watch-out. She yells, cusses, screams, hits me and her dad and her dog, she steals things out of my room. She is always lying, and when I send her to her room she destroys the walls and door. She's worse with me, when I come home from work all I want to do is rest, and she's always on me."

Interviewer: "You're describing a lot of out of control behavior. How often do you think this happens?"

Brenda: "Oh, try every day. Especially if I go to work, or Joe (husband) and I are trying to talk... He usually just puts her on his lap, and says I'm making a big deal out of her behavior, but then he gets mad and spanks her."

Interviewer: "It sounds like you feel pretty much the target of her acting-out."

Brenda: "Oh, I am. I don't understand what she's so mad about. Maybe she has a split personality. It has to be more than just a behavior problem. There is something

psychologically wrong with her...It has nothing to do with how she gets treated. She intentionally wets her bed to get back at me when I make her go to her room and go to bed (at bedtime).”

Interviewer: “Can you tell me a little bit more about how you handle her behavior?”

Brenda: “I don’t always know what to do. I have tried everything, and nothing works. I have taken things away, I have tried telling her that this isn’t fair to me, but if I try to take her to her room she will attack me physically. Then, I try to hold her door shut but I end giving up out of sheer exhaustion. I feel attacked, invaded and violated by her...We are fighting constantly. She really gets on my nerves, but I keep feeling like I have this burden. She isn’t as mean to her dad, but then he can be too lenient or too harsh with her...He criticizes the way I am with her, and then we argue. Most of the fights we have are about her.”

Summary. This little girl was a source of intense distress for her mother and of conflict between her parents. Parents participated in in-home PMT, and a QACCH volunteer was recruited who helped Nancy with her reading and rewarded her with brief community outings. These were the main emphases of treatment. The volunteer was also linked to the classroom and learning assistance teachers. Mother was encouraged to make an effort to support Nancy’s involvement in gymnastics and to help her invite a friend to come over to play after school.

Posttreatment interview. Interviewer: “Could you tell me about what Nancy has been like since HBCS and your family started working together?”

Brenda: “The hitting and screaming are gone, but she still uses foul language. She still has to have some time-outs, but not as much...Her asthma is not too bad, she hasn’t had

to go to the hospital in almost a year. When I talk to her about things, she doesn't attack me. She is still a challenge at bedtime, but not as difficult. At bedtime, now, I have time to read her stories."

Interviewer: "Some of her behavior sounds much more manageable. How about the stealing and property damage?"

Brenda: "Oh, she is not as bad, she drew a little on her walls, but she didn't break her door or window again."

Interviewer: "Some of the other problems you described were to do with the differences between your husband's approach to disciplining Nancy, his permissiveness and over-reaction were a problem for you."

Brenda: "Oh, that's not too bad now. If he's disciplining her, I stay right out of it."

Interviewer: "Some things have improved a lot. What else still needs work?"

Brenda: "She still needs better bedtimes, and to be on time for school. But I can coax her now, and focus more on the good behavior because there's not so much conflict."

Interviewer: "What do you think was most helpful about the home-visit counselling?"

Brenda: "The chance to talk it out, to learn how to deal with it. And knowing that you're not the only one. It was also helpful that Nancy got the tutor (volunteer), this was stress relief for her and me, and she feels better about herself at school."

Clinical summary. From what mother reported, this was a successful intervention. Parents were feeling less stressed and more competent in dealing with their daughter. Nancy was benefiting from her parent's PMT practice, and through support and skill building experiences with the volunteer (who also helped mother register Nancy for gymnastics).

Follow-up Interview. Interviewer: "How have you been? Last time we talked things were going better for Nancy and you at home, and at school work was starting to improve."

Brenda: "It's still good. We can use fewer time-outs and her foul language is better. She still comes into my room sometimes, but not often. She knows that the rules are the rules. We still have the occasional screaming match, but mostly she's accepting my authority, and only argues sometimes."

Interviewer: "Sounds like you are all doing pretty well with the day-to-day routines that were impossible before. How about Nancy getting to school on time in the morning?"

Brenda: "That is no problem. She wants to go every day, so when I remind her about the time, there's no more conflict because she doesn't want to be late."

Interviewer: "What else could we have done to help?"

Brenda: "I have no suggestions, the most important part was having someone to talk it out with, and to know that I had a right to respect."

Summary. This mother thought that the service was what she needed in order to better manage her daughter's CP behavior. The positive effect of the volunteer was important for Nancy's social development and in support of her severe learning problems.

Initial interview. (Maryanne and Heather) This eight year old was referred to HBCS by the treatment team on the Child and Family program at QAC (Ledger), where she had been admitted following a five-day admission to the pediatric unit at Victoria General Hospital for out-of-control behavior (no room available at Special Care). The child psychiatrist had queried an early onset mood disorder, but CP was the primary

diagnosis. Her mother felt that inpatient treatment had been helpful, but that her parenting skills and child self-management were starting to wear thin.

Interviewer: "Could you tell me about your experience of parenting Heather?"

Maryanne: "Heather is a very tough kid to parent. Even as a young child she was very strong willed. It isn't just because I encouraged her to be strong, by eighteen months she had serious behavioral problems and tantrums and vibrated to the point where her daycare called me to the school because they thought she was having a seizure...she was so mad and it was so internalized. I got dealt a very tough hand. When I look at what I have done for her and where I have been with her and she isn't like this because of the way I raised her...she has components of course...environment of course influences her, but a lot of this stuff has nothing to do with what I have done. Things were better after she came home from being in foster care for a while, but she is starting to act-up, I am seeing it, the school is seeing it, and the after-school program is seeing it. She is getting a little more aggressive, she has pushed me; she has thrown things... Regardless of all the help we get, a lot of it comes down to what she wants...if she wants to control it she does, if she doesn't want to she doesn't, and it is that conscious of a choice and she will verbalize that, she will tell you 'I didn't want to get over it, I didn't want to move on'...even when she is calm and you back to it and say 'look you were really wanting this and you were doing this which was going to get you to this and not to her, what is going on?' and she will say 'I don't care.' A lot of her nature is very oppositional. I love her very dearly and I would do anything for her, but to be honest parenting Heather is like the worst thing that I have ever had to do in my life...it is like I have been deceived into thinking that parenting is rewarding. Even trying to do fun things together doesn't work-

out. She makes it so much work for me...it is draining. With Heather, it is lucky if I can find just 5 minutes that I have enjoyed with her and say that genuinely...It is the warm moments that help us to have the energy to do the things we have to do as parents and without it, it isn't there and compared to her brother that is what the big difference is...The thing I really have to do more of to help Heather is to take better care of myself. How I do that is that I work. If I just stayed at home I would go nuts. I need to be stimulated intellectually. As a young (age 18) unwed mom I think I had to put up with a lot of discrimination and social judgements and that didn't help. They rated Heather as being at high risk right from the start just because of my age and stuff. Basically her dad is a messed up guy...Let's say she comes by this naturally."

Clinical summary. This respondent required very little prompting. She had a lot to say about how distressed and restrictive she found her role as a mother. Also, there is more than one statement about the difficult child temperament, particularly pointing the difficult child behavior to the father's genetic contribution. Given the medication difficulty (risperdal had been effective but was causing weight gain and early onset of secondary sexual characteristics), this interview had every indication that it would be a challenging situation for PMT to be effectively taught.

Posttreatment interview. Interviewer: "Could I ask you to tell me about your experience of having the HBCS?"

Maryanne: "I think the most helpful thing _____ (counsellor) did was to support me. The charts and rewards were good, but the best part was when he told Heather that I was telling her what she needed to do. She hated him when he said that, but it worked. It's as if he backed-up my authority when she refused to listen to me."

Interviewer: "So basically, her temperament is still challenging, but you are more authoritative in your parenting."

Maryanne: "Yeah. I think we can manage like this for a while, but she always will be who she is. To tell you the truth, I'm not sure if I can continue to do this. I'm not sure I have it in me to struggle like this until she's 18 or whatever. I just have to take it one week at a time."

Clinical summary. This mother does not really feel confident about her ability to see this parenting job through. Her daughter is difficult, and very sensitive to mother's ease with the younger brother. Time will tell.

Follow-up interview. Interviewer: "It's been several months since we talked. How have you and Heather been doing?"

Maryanne: "Well, the summer didn't go too badly, but now that it's almost time for school to start, she been acting-out at her summer (day) camp. Around home, she stops short of hitting me, but last night I called the police because she kicked me and could not calm down. By the time the officer arrived, she had fallen asleep. I asked him to wake her up, so that she would know that I followed through. When she got up this morning, the first thing she said was, 'you never called the police.' I don't know if she didn't remember, or if she was just manipulating."

Interviewer: "Things are tense right now because school's coming?"

Maryanne: "Yes, every transition, when Christmas is coming, or when she has to go back to school after Christmas, all transitions are hard for her. This year isn't as bad as last year, but I don't want things to escalate and have her end up getting so out of control as she did last summer. I think it should be nipped in the bud, if you know what I mean."

Oh, yeah, the policeman told me to check and make sure that Heather is red flagged to go to Ledger from VGH. He said he took a kid into VGH the other night, it had taken the whole SWAT team to get the boy into the hospital, and they (ER staff) just discharged him. Can you check that for me? Also, I was thinking of asking for another go at HBCS.”

Interviewer: “Things are not as bad as they were last year before school, but you want to be sure she is taken seriously if you get to VGH. And you don’t want to wait too long for more help. I’ll check the Nurse-in-Charge book to make sure she is still red flagged to come here from VGH. I’ll call you tomorrow, at this time, OK? In the meantime, you know how to use the police to get her to VGH in an emergency, right? And to be very assertive if anyone tried to send her home tonight?”

Maryanne: “Oh yes, I can do assertive. Thanks, I don’t want to let her think that I will tolerate this physical stuff. I don’t want her brother to think that he has to live that way, too. How do I get another referral for Home-Based Counselling?”

Interviewer: “I can help you with that. I need to phone you next week, after I talk with ____ about the waitlist. Are you OK with that?”

Maryanne: “Yes. That sounds good, thanks.”

Clinical summary. One of the outcomes of follow-up questions is getting the kind of answers that indicate that more help is required. If this re-referral proceeds, the treatment strategy will include a female counsellor, as this mother seems to need a female role model who can help her find her own authority in the face of ongoing challenges.

Initial interview. (Julia and Ross) This boy was eleven years old when his school counsellor referred him to HBCS. He had no medical or psychiatric diagnosis except CP.

He was barely accomplishing the academic requirements of his grade six class, with no known learning problems. On the playground, he had several times succeeded at focusing group malice toward other children; children with disabilities were his particular victims. His attendance was sporadic: He punished his mother with non-attendance when he wasn't given pop for breakfast, or was refused extra money. His school counsellor believed that he was a boy with at least average abilities whose chaotic home life was dooming him to a future CP and school drop-out. His mother told the school she needed help, that he was totally oppositional and non-compliant at home, refusing to cooperate with rules and routines. His father thought the school was overly concerned.

Interviewer: "Could you tell me about your experience of parenting Ross?"

Julia: "As a baby he had a terrible time with colic. He's different than his older brother. He wants to be the centre of attention, he's less mellow than his older brother. When he gets an idea in his head, he doesn't let it go, he's going to push and push. His emotions go up as quickly as it goes (sic) down. He's like 12 kids rolled into one. He's got 12 times more energy than one kid—he's terrible to live with if he's in a rotten mood... I am disgusted by the language the boys use around me. Sometimes it gets to me. They wear me out. I'm dragging my butt around at 6 o'clock, and the kids are still going at midnight... I give and give. But I think what if I only had of bought that swing set we would not have lost Michele then (daughter who died at age 3). Ross was born a year after Michele died. I am afraid to say no to him, he threatens to run into traffic and to let himself be hit by a car. I feel so hopeless. I wonder, why am I here anyway, to take up space? Sometimes I think if my daughter was still alive, Ross wouldn't even be here."

Clinical summary. This mother is haunted by a memory of a child lost, and confused by one at risk. The boy who tries her patience and defies her authority was conceived to replace that daughter, and his mother cannot say “no” to him. She was unlikely to succeed at PMT, but she did welcome the HBCS weekly visit.

Posttreatment interview. Interviewer: “We’re at the end of our home-visit time. Could you tell me what it’s been like for you to have the HBCS?”

Julia: “Well, he’s a bit better.”

Interviewer: “What part of the service was helpful for you?”

Julia: “Having someone to come over and talk over my problems with, the support, knowing that I am not alone. _____ came up with some good ideas, he wasn’t too successful with my son (laughs). I think Ross is just going to have to be responsible for his own actions, and since the counsellor came, he at least admits when he’s done something wrong sometimes. He’s a good kid.”

Interviewer: Is there anything else we can do to help?”

Julia: “No, I think he’s just going to change or he’ll end up in juvenile hall. If he does, I’ve told him not to waste his quarter calling his mom. I’m not going to bail him out. We did that over and over for my 21 year-old son, and all he did was get in trouble. Theo (13 year-old brother) is the only prospect in this family. Just kidding...”

Summary. This mother was one for whom we had compassion and respect, yet the HBCS team seems to have had little success with teaching her PMT. The follow-up interview was not completed as she died four months after the posttreatment interview. The school counsellor said it well: “Julia was the parent who kept the communication

open with the boys' schools. Even though she couldn't always follow-through with Ross, she tried. With her gone, I don't know what's going to happen to Ross and Theo..."

When the families are struggling with every day life stresses, and facing such a loss as Julia's, the family would be both bereft and adrift. Perhaps the father will come forth and support his boys' schooling. That is the kind of question that is not answered by the interview data. Only mothers were interviewed, and this excluded important prospective data from father's (Webster-Stratton & Spitzer, 1996). In the case of Julia and Ross, the father's voice was absent from the treatment as well. Moreover, because dad was little mentioned in his own wife's interview, any indicators of his future effectiveness with the boys is missing from this interview process. Only time and his teachers will tell the true story of what happens in this situation during the next six years that Ross should be in school.

Cross-case Comparison of Initial Interviews

Webster-Stratton and Spitzer (1996) presented findings from a series of qualitative interviews with mothers and fathers of children with CP. These authors described the central theme of the mothers' initial interviews as "living under siege." For the mothers in the present study, this theme of the child being in control, and the mother "living under seige" is also prevalent. One mother, Evangeline, spoke of becoming tense and nauseated as the after-school time with her seven-year old approached. She also felt that her daughter's behavior alienated other adults: "She has fits, screams, hits bites. The way she acts pushes people out...she has prevented friendships for me. She can frighten adults, and yet people say that she doesn't need meds."

This sense of being the “victim” of her CP child’s acting-out behavior recurred throughout the initial interviews. Another mother, Marsha, described having to quit her job because her son had threatened to strangle himself when his older sister (age 17) was looking after him “He’s been choking himself at home and at school. Now I think he’s quite serious...” This mother felt that she had to be monitoring her son continuously, and that she was really the only person who could carry the burden of this responsibility: “All of this about Eliot’s problems, all my children’s problems have been my responsibility.” Indeed, most of the mothers did express a sense of being most responsible for their difficult child, on a daily and continuous basis, which also made them their child’s representative when s/he had a problem at school.

Mothers described feeling isolated and angry with judgements made by extended family, their children’s school and community resources. As Maryanne described her daughter, “Things were better after she came home from being in foster care for a while, but she is starting to act-up, I am seeing it, the school is seeing it, and the after-school program is seeing it.” Not only is their CP child different than other same age peers outside of the home, but s/he is also described as being more difficult than siblings: “He’s different than his older brother. He wants to be the centre of attention, he’s less mellow than his older brother. He’s like 12 kids rolled into one” (Julia). Mothers feel betrayed and helpless, as Maryanne said, “It is the warm moments that help us to have the energy to do the things we have to do as parents and without it, it isn’t there and compared to her brother that is what the big difference is.” Again, Julia described how she felt as “hopeless”, wondering “why am I here anyway, to take up space?”

Mothers perceived themselves as being most responsible, and vacillated between feeling the person most able to control their child's acting-out, and the person most targeted and helpless in the face of their child's aggression, as described by Brenda: "I have tried everything, and nothing works. I have taken things away, I have tried telling her that this isn't fair to me, but if I try to take her to her room she will attack me physically. I feel attacked, invaded and violated by her... We are fighting constantly... She isn't as mean to her dad." Those mothers who were married to the child's father, described conflicts with their spouse about the best way to cope with their child's behavior. Brenda described her solitary struggle in terms of feeling unsupported by her husband. "He criticizes the way I am with her, and then we argue. Most of the fights we have are about her." Another example of feeling most abused would be Brandy's description of her son's aggression: "I'm the one that gets the worst of it from him. He is not as aggressive with other kids as he is with me." Aemelia described her children's absentee father and her lonely role: "It's me, on my own. We are doing the best we can... Ricardo never tried so many bad things around his father. Now, I have to keep matches out of the house, and lock away my purse... Anyway, no sense whining, he's a handful but I love him... The good thing about being a single parent is I don't have to share the discipline with anyone. I think the kids are better off now, with one parent who always is just what they expect."

For mother's who had other children who also had behavior problems, the weight of responsibility and sheer volume of their children's needs were consuming. As Marsha described an afternoon when she had to respond to her son's school, "I'm the only one who can handle Eliot in a crisis. I always have to have a talk with Eliot, meanwhile

Sharay is on the playground wondering where I am... When he tried to choke himself I didn't know what to do." Once again, the mother reported vacillating between being the only person who could handle the crisis, to feeling overwhelmed and not knowing what to do. Not only were these mothers "under siege" in the face of their child's aggression at home, but school became another source of overwhelming stress and ongoing struggle. As Shirley said, "I remember one of my breakdown days. Justin was acting up in school—everything had gone wrong at school—his older brother and he just seemed to act out in tandem. I was getting calls from their schools every day. It aggravates me. As a parent you feel embarrassed. Now I'm only half embarrassed, 'cause they mark the kids." Although this position of being on her child's side, and against the school, was not as overtly expressed by all the mothers as it was by Shirley and Marsha, responding to teachers and principals was an onerous task for Brandy, Aemelia, Monique, Brenda, Maryanne and Julia, too.

From their initial interviews, these mothers provided information about their lives which demonstrated that their child's CP had left them feeling angry, helpless, and isolated. Moreover, when the phone rang during a school day, they did not expect good news, and mothers expressed hostility toward school personnel for what they perceived as a lack of understanding about their child's CP. As Marsha reported, "The worst part is his school problem... If he was accepted you'd see a totally different kid, because he does have a sensitive side, a sense of fun and humour." These mothers were insular, surrounded by a sea of difficulties with little hope of reaching calmer shores.

Cross-case Comparisons of Posttreatment Interviews

One of goals of Home-Based intervention was to reduce each mother's insularity, and to improve the relationship with her child's school. In the posttreatment (exit) interviews, the mothers talked about what had changed since they participated in HBCS. Although two of the mother's did comment on improvements for their children at school posttreatment, most did not. Despite the team effort to help school and family to connect, only two reported feeling better about their relationship with their child's school personnel. Marsha said that she learned, "I now need to be the school based team leader, but not too critical." Brenda reported that her daughter's school situation had improved: "It was helpful that Nancy got the tutor (volunteer), this was stress relief for her and me, and she feels better about herself at school." For Shirley, HBCS was made only a small difference (if any). She found that the counsellor provided "Some help with Justin, but mostly training is needed for teachers so that they can handle these children."

The themes that emerged most frequently across the posttreatment interviews were the mother's appreciation of the support and skill development provided by the home-visit counsellor. In response to the question of what she found helpful, Evangeline spoke for many when she said: "She listened, and I felt really supported. I knew my daughter and her problems, but the counsellor helped me decide what would work in our home. She was right on the money for what she noticed. The charts we made were just what I needed." Evangeline's comments were echoed by Marsha, who learned said, "I now realize that options are generated by parents...I found out that I could help plan guidelines and consequences, and the schedule and structure helped reduce chaos. I also give feedback. " The other kind of support that single mothers, such as Maryanne, found

helpful was when the counsellor told their child that they need to listen and comply: “I think the most helpful thing _____ did was to support me. The charts and rewards were good, but the best part was when he told Heather that I was telling her what she needed to do. She hated him when he said that, but it worked.”

Criticism of the in-home approach was forthcoming from two of the mothers.

Monique felt that the counsellor did not come at the right time to see her daughter act out:

“He was never here at supper time, which is when she was the worst. He never figured out what we were trying to say, and our family didn’t really benefit. We have used those charts before, and we told him that, they just don’t work for more than a few days.”

Another mother, Brandy, found the HBCS staff too “male” in his perspective, and having a counsellor in her home felt intrusive. She preferred discussion to PMT practice or role play: “Talking during car rides was good. If there was a support group, or course for a half-day, I would like to have discussion and tips.”

For the most part, mothers appreciated the convenience and support of having the intervention in their own homes. Aemelia described her feeling of being validated by the HBCS staff, and how she “felt equal and relaxed, comfortable talking my frustrations out...I am more confident with giving consequences now... You guys made me feel good. I no longer feel overwhelmed.” While the more positive commentary about HBCS intervention was focused on mothers perceiving themselves as more capable, and better able to cope with their children’s behavior, only one mentioned how much more they played with their child: Brenda described having time to read at bedtime because her daughter was less challenging. What appeared to be a basic approach to building positive mother-child relationships, play and positive attention, was really only remarked upon by

one of the nine mothers. Brenda commented that, "I can coax her now, and focus more on the good behavior because there's not so much conflict." That sounds something like a PMT strategy, but the more important changes in mother's attitudes regarding play and positive engagement with their children seemed to be missing. More of the comments related to parent-child play (recreation) activities surfaced during the follow-up interview.

Cross-Case Comparison of the Follow-up Interviews

There were meaningful changes and maintenance of posttreatment gains reported by several of the mothers during their follow-up interviews. One mother, Marsha, reported that she perceived her son as more difficult, but herself as more capable: "When I met _____ (HBCS counsellor) Eliot was easier, but I was at my limit. Now he is more difficult, but I am more able." Other examples of mothers' reports of their increased ability to cope with their challenging children included comments from Brenda that tardiness to school was no longer a problem for her daughter, because "She wants to go every day, so when I remind her about the time, there's no more conflict because she doesn't want to be late."

The mother who had the most positive responses to report, however was Marsha because she felt that the HBCS intervention had helped her husband to participate more fully in family life: "He understands the children's medical and emotional needs and he does not blame me. _____ (counsellor) helped us to be like minded. Our relationship has improved. He doesn't do those little twists and digs. Larry recognizes his effect—that his yelling was not helpful to the children. He uses play with Eliot to get close and soften things. He makes sure he does this before Eliot leaves the house." That kind of

relationship improvement was also reported by Aemelia, who felt that her son was easier because he was older, and because her fiance was involved, "But Dave (fiance) is great with him, and he supports me." Although Evangeline had no significant other to support her, she found that she was able to manage her daughter without medication because she had the intervention, but that she was constantly re-learning the parenting techniques due to her own head injury: "I think I just have to keep re-learning what I forgot."

Of the seven mothers who completed that follow-up interview, however, there were few comments about play and positive relationship with their children beside Brenda's and Marsha's. Shirley reported that she had decided to ignore provocative but small misbehaviors, in order to be more positive: "He has mentioned guns to the school counsellor. He is out of control and thriving for negative attention. I try to ignore him, so I can speak positively when he's more positive. It's a power/control thing." For the other mothers, play, praise and positive interaction were less remarkable than their own abilities to have some authority and more compliance on their children's parts. As Brenda noted, "We can use fewer time-outs and her foul language is better... She knows that the rules are the rules. We still have the occasional screaming match, but mostly she's accepting my authority, and only argues sometimes."

For Maryanne, there has been some improvement during the four months since her posttreatment interview, but her daughter (age nine years) remains difficult: "Around home, she stops short of hitting me, but last night I called the police because she kicked me and could not calm down." This kind of small improvement with a probable prognosis of more struggles to come was also reported by Brandy, who thought that she should share more of the parenting with her former husband: "He's (Reese) spent a lot of

time with his dad this summer, I'm working full time and he was getting pretty hard. The after school and summer camp were just too much for him, and I had to work, so I'm glad that his dad could take him." However, her hope that she could remain guardian of her eight-year-old would remain her stumbling block to getting him consistent care from his dad: "I really need to figure out a way to share my son without signing over custody to his dad... I won't have the child support to take him home. I really need the help, but I hate having to give my son up to get what we need." Brandy had always hoped that she could avoid having to medicate or hospitalize her son for his rages by sending him to his dad when he became too difficult. When the moment of choice came, she could not accept the loss.

Summary

Narrative interviews tell the counsellor/reader the mother's story of parenting a child with CP, from her perspective (Weiss, 1994). She is both the narrator and the protagonist of her own story (Wahler, 1996). Her role is that of the heroine who struggles to cope daily with very difficult, dramatic encounters with her overbearing child and an often hostile environment. The important theme for the collection of interviews with these women was the effort which they invested on their children's behalf.

Whether they getting up at 5:00 a.m. to deliver newspapers with a son, as Aemelia did with Ricardo, or sitting in hospitals with their daughters, as several reported, these were women who parented in difficult circumstances. Through the narrative interviews, these mothers told the history and outcome of their children's CP and whether or not HBCS was effective.

The effect of the intervention was reflected in their posttreatment and follow-up interviews. On one occasion, the mother stated dissatisfaction with treatment, and refused to respond to phone requests for a follow-up interview (Monique and Stephanie). In this situation, her disappointment and frustration with the ineffective in-home treatment has precipitated her ending any dialogue with HBCS. These are difficult children, and sometimes a reduced number of hospital stays is not exactly the outcome that a parent envisioned when asking for help. Whether or not they acknowledged having learned PMT, the intervention was designated helpful in some cases and not in others.

Mothers who found the intervention helpful often responded as expected to questions about changes in their children's CP at posttreatment. They spoke in terms of their experience of support and skill building. Sometimes they were saying that the intervention was supportive, yet was not effective in making a change in their child's CP, as in the case of Marsha and Justin. Whilst Marsha acknowledged the support and work with her son (age 12 years), she was also reporting that he had been suspended repeatedly from his school-based behavioral program during the third month after he was discharged from treatment. In most mothers' views, HBCS was a positive and worthwhile experience during ongoing difficulties with troubled children, but had not solved the chronic, long-term nature of their children's CP.

One of the more difficult longer-term problems was medication effects. For many of the mothers, the interview was a context for their reporting ongoing frustration with the imperfect medications. The question of medication side effects and how to survive the medication regime was attended to during treatment; HB staff made visits to the child psychiatrist with the family, but again, support did not always yield a medical success.

Weight-gain, and early onset of puberty were adverse enough side effect that two girls' use of risperdal was discontinued (reported by two mothers in the narrative sample). In the absence of meaningful medication, supportive, in-home PMT remained the intervention. Repeated follow-up interviews would be required to know how these children and their mothers will cope. Continued anecdotal reports from mothers could stimulate further research to develop medication that targets impulsivity and aggression in girls without such unacceptable side effects.

The narrative interviews presented in this study were dense descriptions of difficult child behavior, with only occasional reference to empowered parenting. Parents in previous studies of this population had asked for their experience in the treatment process to be recognized and heard in posttreatment interviews (Tate, Lampard, Keyes, & Saayman, 2000). The current study attempted to include this element of parents' participation through the narrative interview process. That data emerged as descriptions of a treatment process which was often perceived as successful in helping parents to feel supported, but less often mentioned as something that changed the child's CP. This lack of reported dramatic clinical improvement was consistent with the expectations of the study, that mothers' narrative reports of their experiences of their children's CP treatment would vary across cases.

For some of the mothers, the in-home PMT was helpful in bringing relief through improvements to their own ability to cope with their child's aggression and non-compliance; however, their understanding and acceptance of the chronicity of their child's CP brought an additional burden. These mothers knew how much more parenting effort their children would require in future. Among those who were apprehensive about

their ability to sustain this extra effort, several reported having learned to support themselves through recreation, friendships, and vocational challenges. Self-care and continued social support were important features of a hopeful outlook on a difficult future.

Chapter 5

Summary and Implications for Research

This study examined the outcome of Parent Management Training (PMT) (Kazdin, 1996; Webster-Stratton, 1996) administered individually to mothers in their homes, in order to treat their child's/adolescent's CP effectively. The PMT was embedded within the context of multisystemic therapy (MST), which focusses on the total social and operational needs of the identified client and his/her family (Henggeler et al., 1999). The four basic components of PMT taught to mothers were: (a) play; (b) praise and rewards; (c) effective limit setting; and (d) handling misbehavior (Webster-Stratton, 1994). Although elements of family behavioral therapy (FBT) are subsumed within MST (Achenbach, 1988; Henggeler et al.), family counselling was provided to clients only as mothers were able to master the elements of PMT which foster positive communication. In other words, family meetings were not scheduled unless mothers were able to demonstrate the abilities to both perform the first two components (play, praise and rewards) of PMT and to remain comparatively neutral during limit setting and the handling of misbehavior.

The Home-Based Counselling Service (HBCS) PMT was called Positive Parenting; this was done to emphasize the importance of using play, praise and rewards as the building blocks of the mother-child relationship upon which behavior management techniques must be based (Patterson, 1982; Patterson, Reid, & Dishion, 1992; Webster-Stratton & Herbert, 1993). The curriculum followed the Basic and Advance Parenting Programs, as described by Webster-Stratton (1987; 1994) with mother's learning the components through videotape modelling, role play, and discussion. Children and

adolescent clients were engaged in Problem Solving Skill Therapy (PSST) with their HBCS counsellor. The language and curriculum were adapted to their cognitive abilities, as youngsters twelve years and older have demonstrated more proficiency at learning the PSST concepts (Crowley & Kazdin, 1998; Kazdin, 1996) than their younger counterparts. Children and adolescents engaged in recreation, arts and crafts as part of relationship building with their HBCS counsellor before PSST sessions. The counsellors also used anger management training and individual videotape modelling with identified clients and their siblings (i.e., Anger Commandos). The goal of cognitive behavior therapy (CBT) was to help youngsters to develop self-monitoring and affect regulation skills. Children who had been identified as having been sexually abused were treated concurrently at the Mary Manning Centre for the Prevention and Treatment of Child Sexual Abuse.

Summary of Research Problem and Method

Objectives of the study. The purpose of the study was to evaluate treatment outcomes for children and their mothers, who were provided an on-going program of home-based PMT. The study was also an attempt to close gaps in the current practice and research in the PMT outcome literature. There have been few studies of the effectiveness of teaching parents PMT in their homes. The preponderance of in-home treatment outcome studies have been focussed on home preservation (Lindblad-Goldberg, Morrison, & Stern, 1998; Kutash & Robbins, 1996). Evaluation specific to the individual child/adolescent as evidenced by parent and teacher ratings, and improvements to mothers' level of distress and perceived parenting agency, were the foci of the current outcome study. The provision of in-home counselling service to children and adolescents

with CP who have had psychiatric hospitalization has developed as an important area of investigation since the inception of the current study (Henggeler et al., 1999). Henggeler and colleagues (1999) have demonstrated that multisystemic therapy (MST) is an effective approach for treating child/adolescent CP in-home. The MST approach emphasizes the social ecology of each family context, and the authors reported significant improvements to individual child/adolescent CP as measured by teacher and parent ratings (Henggeler et al.). In-home PMT and individually administered videotape modelling (IVM) (Webster-Stratton, Kolpacoff, & Hollinsworth, 1988), however, are approaches which were unique to the current study.

Whereas previous studies have demonstrated the efficacy of clinic-based PMT in a group context, the current study examined the effectiveness of PMT taught individually through individually administered videotape modelling (IVM). Previous studies (Webster-Stratton, 1990; Webster-Stratton, Kolpacoff, & Hollinsworth, 1988) have indicated that IVM plus counsellor discussion were effective in reducing the frequency and intensity of children's CP. The current study examined the effectiveness of IVM and PMT in the context of a home-visiting MST intervention.

Hypotheses of the study. There were three hypotheses which shaped the study. First, it was hypothesized that children's and adolescents' behavior, as evaluated by their parents and teachers, would show a decrease in psychopathology from pretreatment to posttreatment. It was expected that this improvement would be maintained at the follow-up measurement. An expected ancillary outcome was that there would be a modest correlation between mothers' and teachers' ratings of the corresponding child's/student's behavior. The second hypothesis was that mothers would report both an improved

perception of their own ability to cope with their children, and less personal distress from pretreatment to posttreatment. Again, it was expected that gains would be maintained at the follow-up measurement. The third hypothesis was that mothers' narrative accounts of their experience of parenting a child with CP would both overlap and complement the information provided by them on standardized measures of parenting distress and parent self-agency.

Methods and measures. Twenty-six children/adolescents registered in HBCS and their mothers or female caregivers participated in the study. Child and adolescent improvement were measured by parent ratings on the Child Behavior Checklist (CBCL) (Achenbach, 1991a), as well as teacher ratings of their school behavior on the Teachers Report Form (TRF; Achenbach, 1991b). These measures were completed pretreatment, posttreatment and after a four-month follow-up interval. Mothers' rated their ability to manage their child's/adolescent's behavior by completing the Parenting Self-Agency Measure (PSAM) (Dumka, Stoerzinger, Jackson, & Roosa, 1996) at the same measurement intervals. Mothers also completed the Parenting Stress Index (PSI) (Abidin, 1995) at these same times.

Nine of the 26 mothers who participated in the study also completed three narrative interviews, with the same pre-, posttreatment and follow-up schedule. The initial interview was audiotaped, lasting between 75 and 90 minutes. This was the mother's opportunity both to tell her story without interruption and to allow the counsellor to understand how her child's CP had affected the family's life. The post-treatment interview was scheduled for 45 minutes, and mothers were asked to talk about their experience of receiving the HBCS intervention. The third interview was completed

over the telephone. The focus was to re-examine any statements about unresolved problems or progress made during the previous interview, and to ask how gains had been maintained. The interviews were compared within and between subject's narratives. Many of the themes which were found in PSI items were repeated in the interview, i.e. themes of feeling hopeless, helpless, isolated, stressed, depressed, anxious, unsupported and dissatisfied with their parenting role were present throughout the interviews. In addition, unique information about their feeling "under siege" and experiencing their child's CP as a personal and overwhelming attack helped to flesh out the phenomenon of parenting a child with CP. The narrative interview allowed mothers to voice their resentment and sense of loss in a way that the standardized measure may have not.

Summary of Findings

The standardized measures provided more objective profiles of parent and child functioning. Mothers' ratings of child behavior on the CBCL, their self-reports of their parenting distress on the PSI, and their self-reports of their parenting capabilities as measured on the PSAM, were analyzed through SPSS 8.0.

As regards the PSAM and the PSI, mothers in the treatment group had scores which changed significantly across time in the appropriate directions. For the PSAM, the change was an increase in mothers' scores which represented a significant improvement to their perception of their own parenting abilities. For the PSI, the decrease in mothers' reported level of child domain stress (PSI-C) was statistically significant. The PSI-C scores remained above the clinical cut-off. The corresponding decrease in mothers' parenting role stress (PSI-P) was also statistically significant, and brought their levels of

stress below the clinical cut-off. More comprehensive descriptions of PSAM and PSI outcomes are presented in the implications section of this chapter.

The first group of analyses were conducted to test the hypotheses both that treatment group parent scores improved and that control group parent scores did not change. A 2 X 2 mixed design analysis of variance was conducted for each of the three broadband scales of the CBCL (parent and teacher), the PSAM, and the two domains of the PSI (child and parent). The Time by Group interaction effect was used to test the hypothesis that mean scores for the treatment group indicated improvement across time, while mean scores for the control group remained constant.

The results for CBCL (parent) did not support the hypothesis that change across time differed by group. The absence of change was also true for the teachers' scores (TRF). Due to the small size of the control group ($n = 5$), the absence of significant changes should be interpreted cautiously.

There was a significant interaction effect for Time by Group on the PSAM, with the mean for the treatment group significantly higher at Time 2 than at Time 1. For PSI-C and PSI-P, the relationship between PSI and Time was dependent on Group. Although no change was reported for the control group for PSAM, PSI-C, or PSI-P, the same caution about the control group size ($n = 5$) needs to be mentioned in interpreting the findings for the difference between the group means. That being said, the treatment group mean scores for PSAM, PSI-C and PSI-P did change in the expected direction and confirmed the hypothesis that the parents in the treatment group reported improvements in their ability to parent their CP children with less duress and more confidence. These findings confirmed the hypothesis that Home-Based PMT was a probably effective

intervention in families. Like other outcome studies of PMT (Webster-Stratton, 1987, 1992, 1994), the current study yielded results that favored mothers and children in the treatment group, but had no corresponding effect on teachers' ratings.

The lack of consistency between mothers' ratings of their children's behavior problems on the CBCL and teachers rating of these same students has been a consistent finding in the CP outcome literature (Kazdin, Esveldt-Dawson, French & Unis, 1987a; Webster-Stratton, 1994; Webster-Stratton & Hammond, 1997). In their 1997 study, Webster-Stratton and Hammond found that teaching parents PMT and concurrently teaching their children PSST yielded significant changes to observed child deviance as well as decreased problem behavior as reported by mothers on the CBCL broadband scores at posttreatment and at one year follow-up. Teacher ratings did not reflect the same clinical levels of child behavior problems at pretreatment, and their posttreatment ratings did not reflect significant change. At the one-year follow-up measurement, however, teachers did report significant improvements in children's CP behaviors. Whilst some researchers have reported similar discrepancies between mothers' and teachers' ratings (Patterson & Forgatch, 1995), others have reported similarities in parents' and teachers' ranking of children's CP behaviors (Loeber, Green, Lahey, & Stouthamer-Loeber, 1991).

Despite the apparent discrepancy between mother and teacher ratings, there were modest but significant correlations between these sources ($r = .30$, $p = .05$), as reported by researchers such as Webster-Stratton and Hammond (1997), and Kazdin and his colleagues (1987a). For children in the current study, there were no significant correlations between mothers' and teachers' ratings on the Internalizing broadband scale

of the CBCL and the TRF. For Externalizing, however, there were significant correlations between mothers' and teachers' scores at Times 1 and Time 3, but not at Time 2. The correlation at Time 1 was moderate ($r = .447, p < .05$), and at Time 3 it was stronger ($r = .632, p < .05$). For Total problem behaviors, there was a significant correlation between mothers' and teachers' ratings at Time 3 ($r = .542, p < .05$).

Correlation coefficients were reported in Table 2.

Implications

CBCL (parent). The hypotheses that participants in the treatment group would report improvements to their children's/adolescents' CBCL broadband scale scores was rejected. The CBCL confirmed the clinical nature of the HBCS client population. These were children/adolescents with behavior problems and co-occurring psychiatric disorders; however, their high mean scores ($M = 69.05$ for Total problem behaviors) at pre-treatment, supported the validity of the CBCL use. The decrease in mothers' ratings posttreatment and at follow-up (64.5 and 63.25 respectively) was consistent with the previous findings of the HBCS pilot study (Appendix A). It is meaningful to note that children and youth referred to HBCS, who participated in either the pilot or the current study, had similar pretreatment scores on the CBCL. This would confirm the appropriate nature of the referral, with clients scoring at the 97th percentile before treatment and the 90th percentile at follow-up. This high level of difficulty is noteworthy because other researchers have indicated that extreme levels of problem behavior (as measured on CBCL externalizing scores) are very stable over time (Dishion, French & Patterson, 1995; Verhulst & Althaus, 1988). Without therapeutic intervention, such behavior persists. Verhulst & Althaus similarly reported that for total problem scores "It was rare

for children in the disturbed category to move into the low-scoring or normal category...” (p. 24).

Whereas typical developmental change in “normal” children over a 2-year period yields a decrease of about 3 points (Verhulst & Althaus, 1988), children in the clinical range have scores which are resistant to change. For example, in their (1997) study, Webster-Stratton & Hammond found that their control group of CP children showed virtually no change over a six-month time span. Thus, the children in the control group of the current study were similar to other control group samples. Without appropriate intervention, CP behaviors do not desist in either outpatient populations (Kazdin, Siegal & Bass, 1992) or for inpatient populations (Kazdin, Esveldt-Dawson, French & Unis, 1987a).

CBCL (parent form) and TRF. Researchers have suggested that there could be a problem with children’s ability to transfer PSST skills practiced in the clinic setting with PMT-trained parents to their school setting (Kazdin et al., 1987a; Patterson & Forgatch, 1995; Webster-Stratton & Hammond, 1997). Other researchers have pointed to the stability of peer judgements about their fellow students with CP (Coie, 1993). On the other hand, the home-based study by Henggeler et al. (1999) of an MST intervention provided to youth with CP and emergent psychiatric behaviors, a significant treatment effect for CBCL Externalizing was demonstrated between Time 1 and Time 3, with significant improvement reported by parents/caregivers and teachers. Means for TRF Externalizing decreased from 71.1 at Time 1, to 64.8 at Time 3 ($n = 57$; $p = .048$).

In part, the statistical significance of the improvement to Externalizing TRF scores in the Henggeler et al. study might have been helped by the larger sample size of

the treatment group. In terms of differences in model of treatment, the number of clients per counsellor was substantially lower than those of the HBCS counsellors (3 vs. 6). This would be consistent with the high number of hours of direct client contact reported in the Henggeler et al. (1999) study. This client population was older (age 10 to 17 years; average age = 13 years) than that described by Webster-Stratton & Hammond (1997) (age 4 to 8 years), and was similar to the average clients in the current HBCS study (mean age = 10.6 years). The question of why children's scores on the CBCL and TRF, as reported by mothers and teachers, do not appear to consistently reflect similar perceptions of the same child remains somewhat unclear.

Perhaps variation across CBCL/TRF scores could be due to inter-rater variability. Even teachers, who are trained and experienced observers of child behavior, vary in their ratings of special needs children (Achenbach, 1991b; Cutchen & Simpson, 1993). Mothers are thought to be susceptible to over-inflating child problems pretreatment, while over-estimating improvement posttreatment (Dumas & Serketich, 1994; Forehand, Furey & McMahon, 1984; Patterson, Dishion & Chamberlain, 1993; Patterson & Forgatch, 1995; Richters, 1992; Webster-Stratton & Hammond, 1990). Difficulties with interpretation should not disqualify the use of this measure as it has reflected changes in mothers' perceptions of their children's CP, which were similar to in-home behavior observations at posttreatment and follow-up in other studies (Webster-Stratton & Hammond, 1997). In addition to the diagnostic utility of the CBCL (Maruish, 1994), this measure was significantly correlated with mothers' reported levels of stress on the child domain of the PSI as reported on other studies of child CP (Kazdin, 1990; Webster-

Stratton, 1994). This feature has added to its concurrent validity in the CP outcome literature.

Moreover, the meaning of numerical changes could not be directly inferred from the CBCL analyses. Rather, the improvements (or not) to individual children's behaviors were more clearly articulated in the mothers' narrative interviews. The relationship between improved scores and mothers' narrative interviews is explored in the summary section of this chapter, as it is an important piece of the whole context of mothers' perception of their children's/adolescents' CP.

PSAM. The current HBCS study explored the use of the Parenting-Self Agency Measure (PSAM) (Dumka et al., 1996). The brief, 10 item Likert-type scale appears to have significant implications for this study and for other studies of mothers' perceptions of their parenting abilities because of (a) its role as an effective measure of treatment outcome; (b) its positive tone; and (c) its inexpensive and quick administration. The ten items queried parental attitudes about their confidence, competence, and perseverance in solving on-going problems with their children. Positive parenting variables have been noted as important to identify and investigate (Kazdin & Weisz, 1998; Webster-Stratton & Spitzer, 1996; Webster-Stratton, 1997). In other words, now that clinicians and researchers are aware of the risk factors which may exacerbate and potentiate child CP, measures of parents' perceived success merit further inquiry.

The PSAM was useful as a measure of a construct which has been identified as parenting self-agency, that is parents' perception of their ability to act successfully in the parental role. This construct is less specific than parenting-efficacy, but it is another way to tap into parents' perceptions of their ability to (a) manage their CP

children's/adolescents' behavior; and (b) resolve problems with their children/adolescents.

For the current study, the PSAM was compared with mothers' scores (collapsed across treatment and control groups) on the PSI at pre- and posttreatment. For Time 1, there was a significant correlation between PSAM and PSI-C ($r = -.476, p < .01$); for Time 1 PSAM and PSI-P, the correlation was also significant ($r = -.490, p < .01$). At Time 2, the coefficients were larger, $-.574$ and $-.631$, respectively (see Table 3). This inverse relationship between perceived parenting capability and parenting stress supported the utility of the construct of parenting self-agency, when measuring treatment outcome for mothers of CP children and adolescents. Whereas parenting self-agency, as measured by the PSAM was a self-report, when it was so strongly (inversely) associated with parent stress as measured by the PSI, the arguments for its concurrent and construct validity were enhanced.

PSI (child and parent domains). The treatment group mothers in the current study reported high levels of parenting stress as it pertained to their experience of their children/adolescents. Pretreatment mean scores ($M = 144$) were at the 99th percentile—well above the clinical cut-off of 116. At posttreatment means decreased, and at follow-up the trend to decrease continued ($M = 128$), to the 94th percentile. Mean scores were still above the clinical cut-off of 115 (Abidin, 1995), but the change was significant statistically and a shift from the extreme level that was reported pretreatment.

In terms of their reported parenting stress, the treatment group mothers reported a similar pattern of improvement, with means decreasing on PSI-P from 144 to 127. This decrease represents a shift from the 83rd percentile, at the clinical cut-off on the PSI-P, to

the 60th percentile and well below the clinical cut-off. It would be fair to represent mothers as having had a significant improvement to their perceptions of their parenting roles, despite the ongoing challenges a future with CP youngster might hold.

Retention of gains. One of the more encouraging findings of the study was that treatment gains were maintained from posttreatment to follow-up. This confirmed a study hypothesis, and was consistent with similar findings in the literature (Webster-Stratton & Hammond, 1997). On the other hand, for the control group in the current study, scores at Time 2 indicated a potential trend toward worsening. Perhaps mothers/caregivers in the control condition were experiencing the effects of cumulative stress. Without the treatment their children required, their own attributions would be consistent with those of mothers in other studies, such as Patterson and Forgatch (1995), wherein mothers' ratings of their children's CP behaviors were more closely related to their own reported levels of distress than to the ratings of neutral observers. The implication for practice is that more timely intervention could reduce parent distress, and prevent further escalation of perceived child CP.

Limitations. The current study was limited by two design features. First, the small size of the control group limited the surety of the lack of change in the control group (type II error). Second, the measures on which change was reported were maternal reports, and subject to their biases. Replication of this study with a larger control group and collaborative information from teachers would help to support the generality of the findings.

Future research

Current research with CP children/adolescents and their families has continued to

explore the issue of effective treatment generality across home and school environments (CPPRG, 1992; Webster-Stratton & Reid, 1999). The models for the current research have featured programs that include a PMT component taught to parents in clinics/community centers that links to school-based programs (Briesmeister & Schaefer, 1998; McMahon & Slough, 1996; Webster-Stratton, 2000). School-based programs that address the needs of high-risk populations such as children who live in poor, urban or rural neighborhoods have been funded, usually, through large national grants and called “demonstration projects” (Bierman, 1996; CPPRG, 1992; Webster-Stratton & Reid, 1999). The research has often had a longitudinal design. The authors of these programs have collaborated with teachers and administrators to target social problem solving in the classroom, playground and anywhere in the school where children may come into conflict. The mother’s role, as agent of child behavioral change, has been assigned to the teacher because of the large amount of time and opportunity that teachers have had to spend with children (Webster-Stratton, 2000). As with any other school-based project, the programs have depended on teacher support, and the participation of each school site has been contingent on teachers’ agreement (McMahon & Slough, 1996). Parents have been linked to teachers through regularly scheduled meetings, and on a day-to-day basis through conversations via phones conveniently installed in teachers’ classrooms. Treatment/prevention teaching components have been consistently applied across home and school, allowing children, families, and teachers to share a common language of social problem solving (McMahon & Slough, 1996).

Future research which focusses specifically on how types of CP behaviors are related to parenting behaviors could provide much insight for clinicians and parents. For

example, a recent study by Stormshak, Bierman, McMahon, Lengua, and the CPPRG (2000) examined parenting practices in relation to particular disruptive behaviors on the part of the children. These researchers demonstrated that lower levels of parental warmth were associated with higher levels of child oppositional behavior. Physically aggressive parenting, on the other hand, was more specifically linked to children's aggression. The ongoing need for parents to understand the predictable effects of their parenting practices continues to motivate researchers to develop models of parent-child interactions that demonstrate the outcome of both positive and negative parenting practices.

In the specific area of home-based interventions, the relationship between client and therapist interactions requires further evaluation (Cunningham, Henggeler, Brondino & Pickrel, 1999). What are the characteristics of the effective working relationship for counsellors and parents who support the treatment of CP children/adolescents? Patterson et al. (1993) cited the qualities of enthusiasm (not being burned-out), warmth and caring as those which parents preferred in their counsellors. With the challenge of fitting into the family's environment, physically and cognitively, successful home-visit counsellors are probably a distinct type of therapist. The therapeutic relationship requires further elucidation in order to better test the assumptions of family-centered care which suggest that the family provides leadership in home-based MST (Cunningham et al., 1999).

Future research should also investigate the psychometric properties of the PSAM. With further study, this instrument could become an effective measure of PMT outcome. Given the high standards for executing empirically supported treatment studies, the current study was only a beginning exploration.

Defining Empirically Supported Therapies. Empirically supported treatments are generally, but not exclusively, cognitive behavioral therapies (CBT) (Chambless, 1996, 1999). Therapists are urged to adhere to specific standardized and demonstrated protocols, especially as described in a treatment manual format, in order to provide consistently effective treatment (Chambless & Hollon, 1998; Kazdin & Weisz, 1998; Lonigan, Elbert & Johnson, 1998). The pursuit of treatment integrity, how to attain and maintain it, is the penultimate goal of EST therapists and researchers alike. Among the utilitarian applications of social learning theory, is its role as the contextually sensitive framework upon which Parent Management Training (PMT) and Social Problem Solving Skills (PSST) are built (Bandura, 1997; Brestan & Eyberg, 1998; Kazdin, 1998). Parent and family based interventions include PMT, PSST, and MST (Kazdin & Weisz). The most promising treatments for CP must engage parents in the intervention (Prinz & Miller, 1996).

As an applied CBT, multisystemic therapy (MST) has become the humanistic, ecologically relevant approach for treating children and adolescents with clinical level CP in their homes (Henggeler et al., 1999; Kazdin, 1998; Kutash & Robbins, 1998; Lindblad-Goldberg et al., 1998). MST is an effective alternative to more expensive hospitalization for self-harming, acting-out, and aggressive youth. Future research in this field should attempt to define the best model of ecological validity. For whom and under what circumstances is MST most effective? Present studies have typically served clients within the low SES range (Henggeler et al., 1999). The question of how MST fits for more advantaged families has not yet been addressed.

The Chambless criteria. Empirically supported treatments are defined by Chambless and Hollon (1998) as “clearly specified psychological treatments shown to be efficacious in controlled research with a delineated population” (p. 7). The emphasis of the Chambless criteria is on the effects of treatments as independent variables. The effect of the therapeutic alliance is assumed to be both basic and very important (Chambless, 1996, 1999). Rather, evaluators need to consider:

- (a) Has the treatment been shown to be beneficial in controlled research;
 - (b) Is the treatment useful in applied clinical settings and if so, with what patients and under what circumstances?
 - (c) Is the treatment efficient in the sense of being cost-effective relative to other alternative interventions?
- These questions are addressed by studies on efficacy (including clinical significance), effectiveness (or clinical utility), and efficiency (or cost-effectiveness). Chambless & Hollon, 1998, p. 7.

In experimental research, empirical evidence can only be derived by comparing treatment and control groups (Brestan & Eyberg, 1998; Chambless & Hollon, 1998). The next challenge is replication of the study. If replication is not done by an independent research team, then the treatment is relegated to a slightly lower level of surety and deemed to be “probably efficacious” (Chambless & Hollon). There are additional Chambless criteria such as (a) adequate sample size; (b) sample description; (c) selection of instruments with demonstrated reliability and validity; (d) uninformed (as to treatment or control group) observers/interviewers; (e) multiple methods of assessment; (f) avoidance of solely self-reported data; and (g) follow-up.

The next challenge is to move the research out of the controlled setting into the field (Weisz, 2000). In order to facilitate this transition, Weisz suggests that research be developed as a “Clinic-Based Treatment Model” (p. 1). In addition, information about beneficial psychosocial interventions, or EST’s, needs to be disseminated beyond scholarly journals and out to the public. Finally, practitioners need both the opportunity for training in EST’s and the opportunity to participate in research and practice concurrently. All of these professional practice and research goals are standard expectations for the advancement of improved mental health treatment. What seems exciting are the opportunities to learn and discuss the prodigious number of new EST’s in community, university, and through electronic communications, such as the internet.

The current study demonstrated “probable effectiveness.” It was not, however, definitive; nor, was it an EST. Future HBCS research should attempt to meet the Chambless criteria in research projects within the homes and schools of CP children and adolescents.

Conclusion

The present study attempted to integrate information from two methods, quantitative and qualitative inquiry, in order to measure and explicate the effects of a Home-Based Counselling intervention. Mothers reported significant reductions in their children’s psychopathology and in their own parenting stress. In addition, they reported significant increases in their parenting capabilities. In their narrative descriptions of their experience of parenting a CP child, many mothers told the story of their youngsters’ progression from infancy to the hour of

the interview. While their narratives varied in the details (i.e., whether or not the “baby” had colic), the themes of their stories validated their perceptions of their children’s behavior. These were not easy children to parent.

Mothers’ reported levels of stress and their own reported level of self-agency on the standardized measures corresponded to the changes that many of the mothers described in their narrative interviews. For these parents, the best features of the Home-Based Counselling intervention were: (a) personal support and validation through the in-home counselling sessions; (b) improved parenting skills (behavior management); (c) access to additional services such as respite, tutoring and allied helping/health professionals; (d) improved relationships with significant others; and (e) more comfort in their children’s schools. As expected, the narratives allowed unique data about the mother’s experience to educate us about her needs. After all, if her stress was ameliorated, if her insularity was diminished, and if she perceived her skills as enhanced, then the HBCS team effort was useful. The children/adolescents will remain challenging, but with improved coping skills the mothers said that they could be stronger contenders in the future struggles.

The current study confirmed the work of previous CP studies by demonstrating that PMT was an effective means of helping mothers to cope with the ongoing challenges inherent to parenting a child/adolescent with CP. This study also added to current knowledge about counselling for CP children and adolescents, by providing data to support the effectiveness of in-home Individually Administered Videotape Modelling (IVM, Webster-Stratton, 1990).

Moreover, the use of the Parenting Self-Agency Measure (PSAM) as a meaningful outcome measure supported its future development through use by practitioners and researchers.

In addition, the current study extended the previous HBCS pilot study findings by demonstrating the relationship between in-home counselling and decreases in mothers' reported levels of parenting stress and ineffectiveness. The positive effects of mothers' perceptions on the reciprocal relationship between them and their CP youngsters was confirmed by this study: That is, if mothers believed that they were more capable, and less distressed, they were likely to be more able to maintain their PMT practice with their CP children. Finally, although this study did not include number of psychiatric hospital admissions (or length of stay) as an outcome variable, the study did demonstrate that a multisystemic intervention, which included in-home IVM plus PMT, was effective in helping both children and adolescents with extreme acting-out behaviors to remain in their mothers' care.

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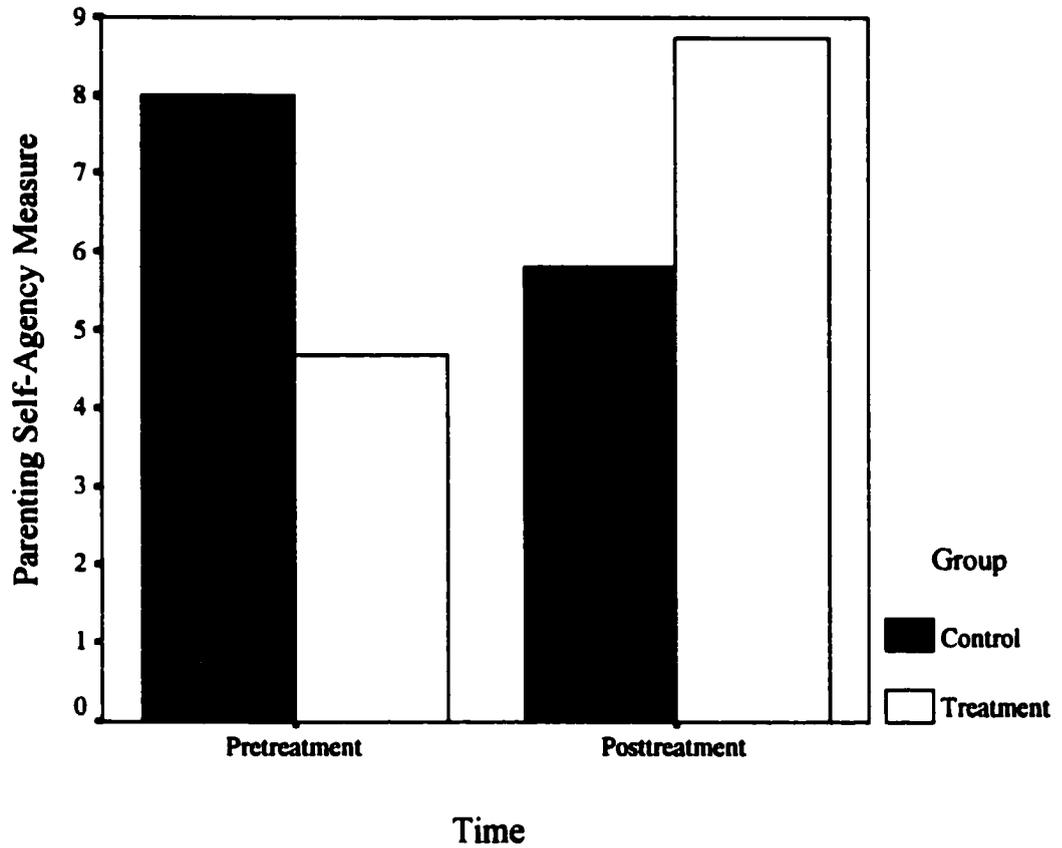


Figure 1. Mean Parenting Self-Agency Measure (PSAM) scores for treatment group ($n = 26$) and control group ($n = 5$) at pretreatment and posttreatment.

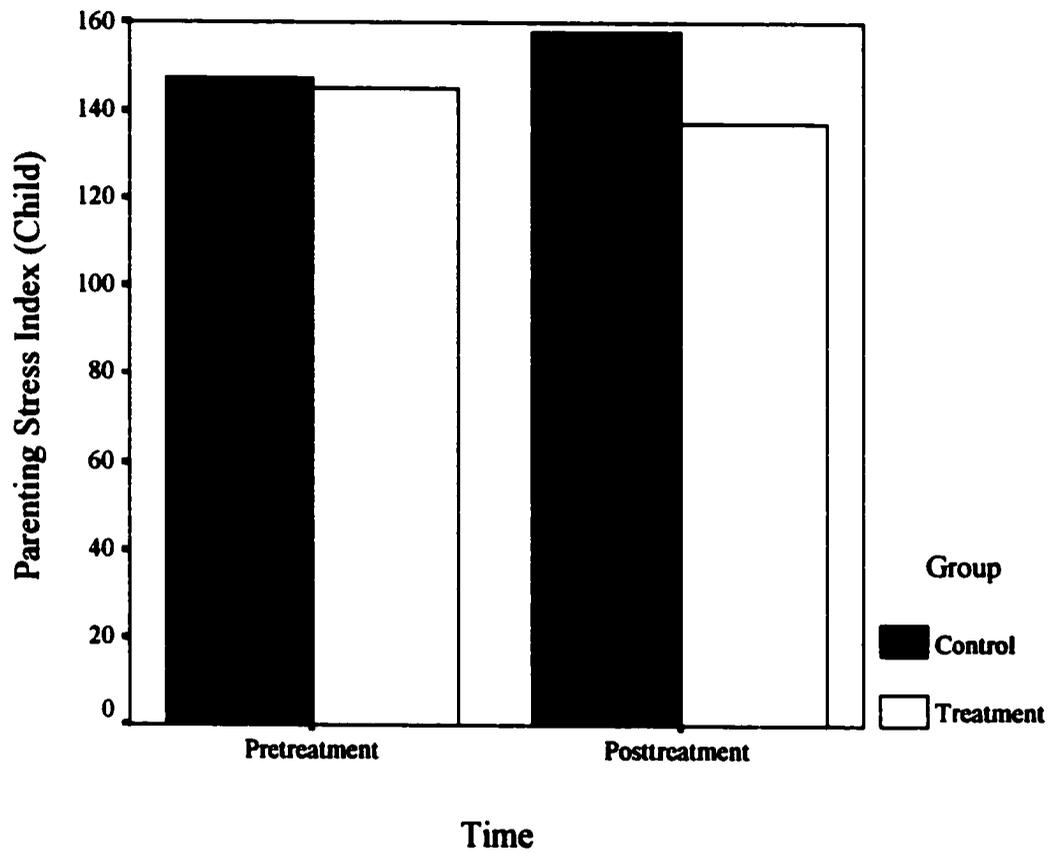


Figure 2. Mean Parenting Stress Index Child domain (PSI-C) scores for treatment group ($n = 26$) and control group ($n = 5$) at pretreatment and posttreatment.

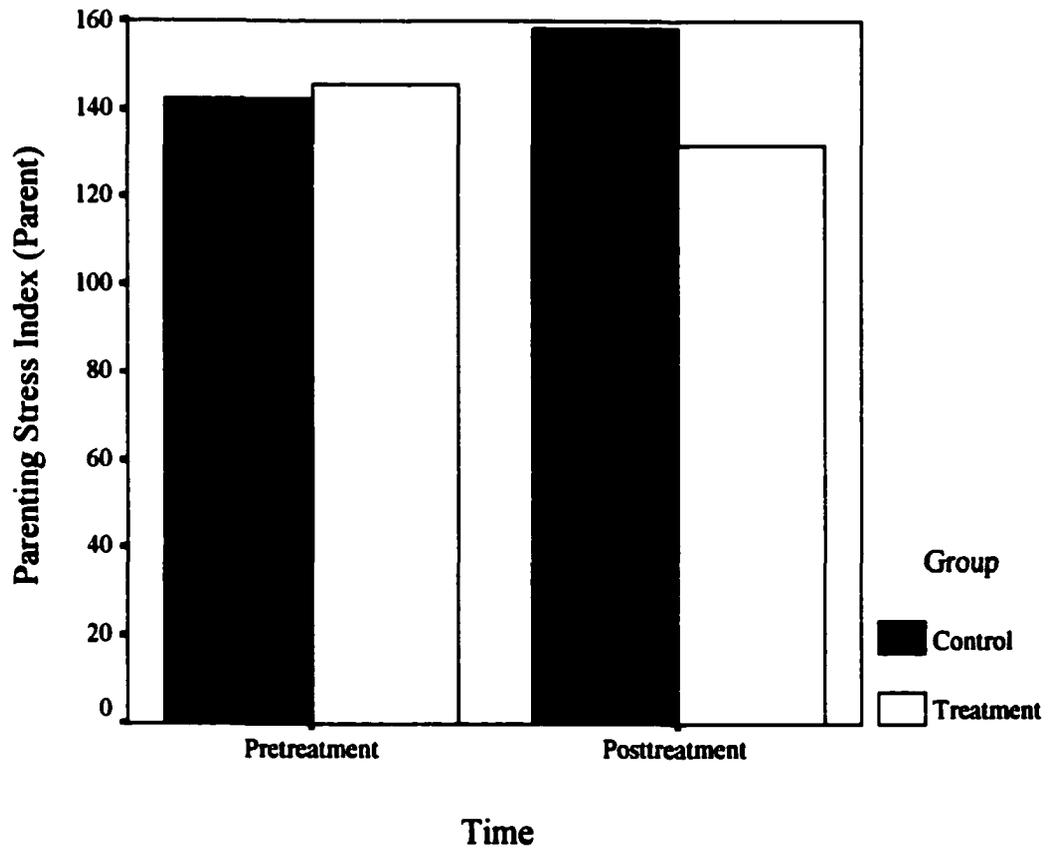


Figure 3. Mean Parenting Stress Index Parent domain (PSI-P) scores for treatment group ($n = 26$) and control group ($n = 5$) at pretreatment and posttreatment.

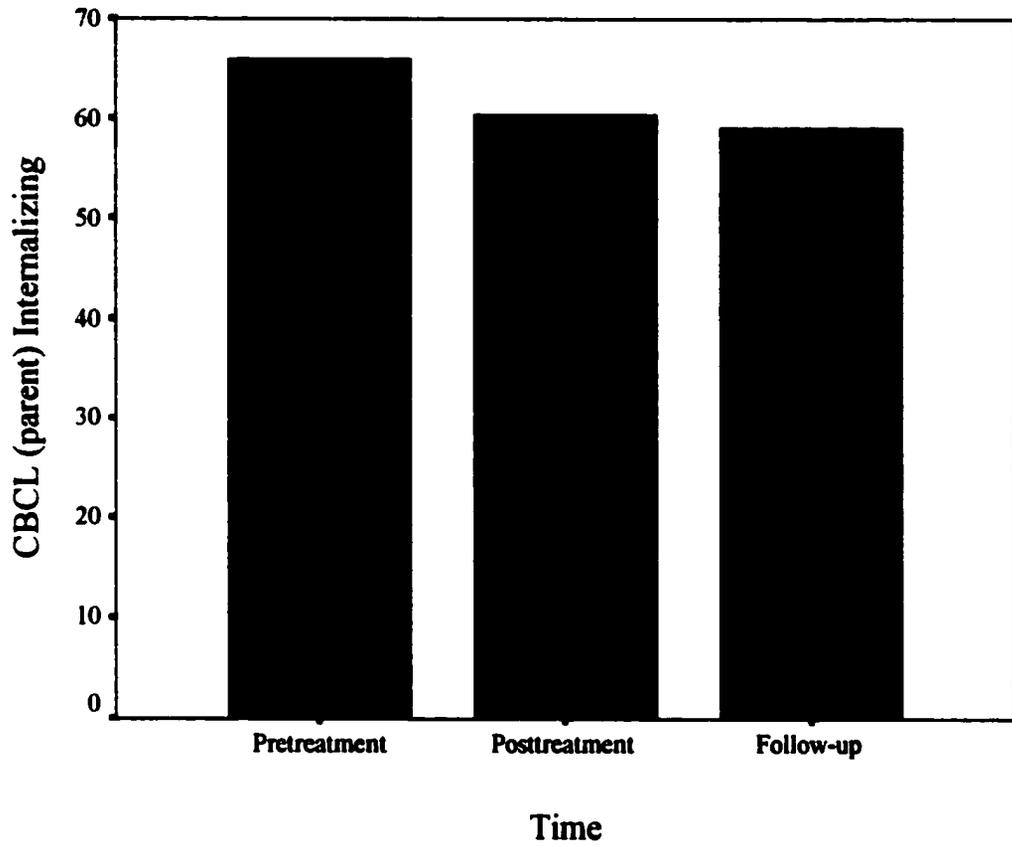


Figure 4. Mean Child Behavior Checklist (CBCL, parent) Internalizing scores across three times (pretreatment, posttreatment, and follow-up).

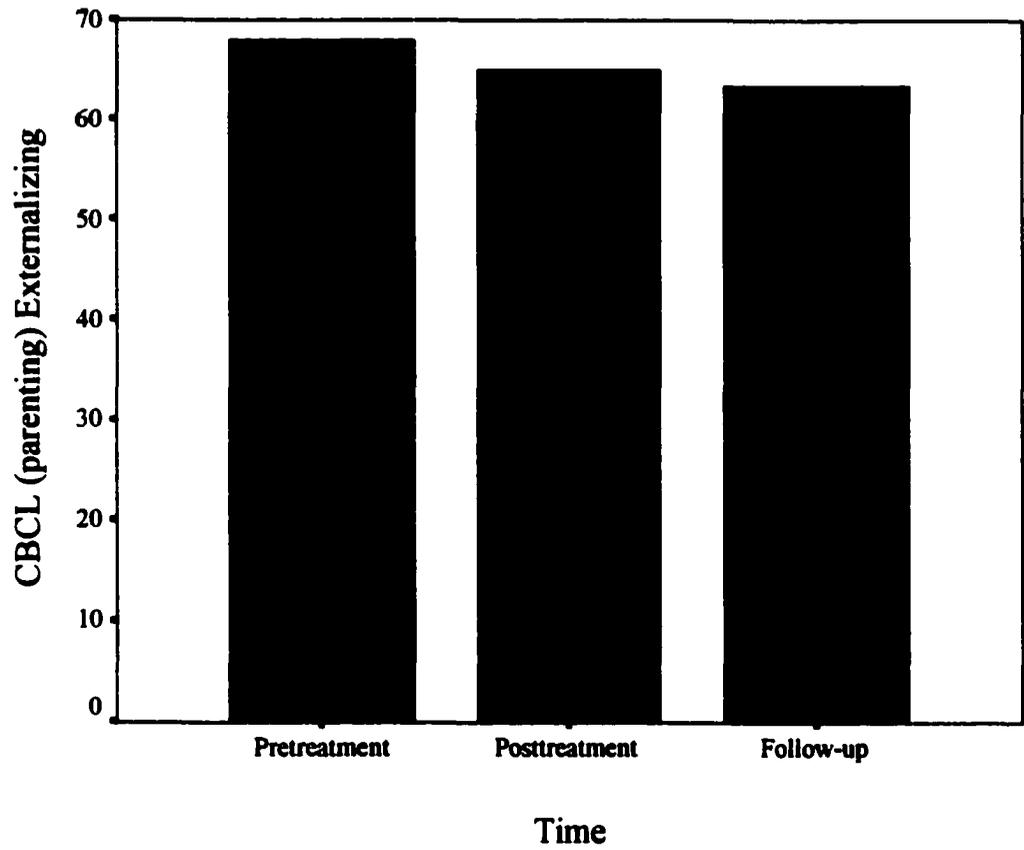


Figure 5. Mean Child Behavior Checklist (CBCL, parent) Externalizing scores across three times (pretreatment, posttreatment, and follow-up).

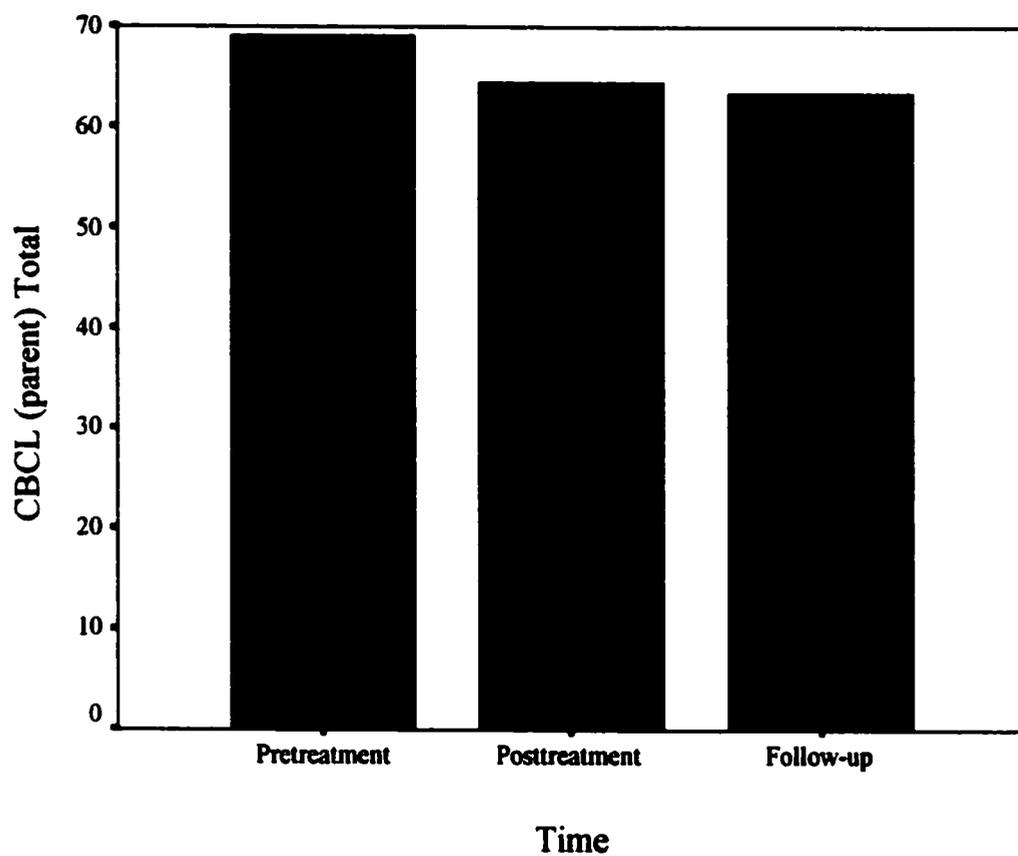


Figure 6. Mean Child Behavior Checklist (CBCL, parent) Total scores across three times (pretreatment, posttreatment, and follow-up).

Appendix A

The Pilot Study

Objectives

The purposes of the HBCS pilot study were both to determine if the intervention was effective, and to assess if children, youth, and their families perceived an improvement in the identified youngster's psychological well being. Consistent with contemporary mental health evaluation, the tests and variables utilized were those common to both treatment diagnostics and outcome evaluation in child and youth mental health (Maruish, 1994). In addition, the program was evaluated by all of these participants in terms of each of their satisfaction (or not) with the services provided. The final objective of the pilot was to provide information about useful methods to be employed in ongoing program evaluation efforts. This model of evaluation, which included focus group consultation, as well as staff feedback, was derived from Eash's (1985) approach.

Design

Model of evaluation.

Program evaluation provides important information to clinicians and administrators about the effectiveness of service provided (Lyons, Howard, O'Mahoney, & Lish, 1997). Among recent models of child mental health program evaluation, the process of deciding what to evaluate, and how to measure the identified outcomes is a combination of prudent use of diagnostic and interpretative inquiry (Eash, 1985). The process is developed among various stakeholders and clinicians. Choosing relevant parameters requires involvement of many direct and indirect participants in the service

(Maruish, 1994). The evaluation is envisioned as one that includes feedback loops to staff and stakeholders (Eash). The HBCS pilot included (a) consultation with staff and colleagues; (b) an initial focus group to share the concepts and measures with clients; (c) discussion of the results with staff/colleagues and; (d) focussed group discussion to share the results of the evaluation with parents and caregivers who participated. According to Eash, it is the feedback loops which really bring the evaluation findings out of the office, and into more timely, relevant social contexts.

The Home-Based pilot study relied on client satisfaction forms from four stakeholder groups to query child, youth, parent, and colleague satisfaction with the services provided by the program. Information derived from each of the participant groups included rated responses to Likert-type-scaled item statements about improvement, and respectful and timely treatment services. All participants also answered open-ended questions, about their experience in the program. The results were presented in a previous report (Tate, Lampard, Keyes, & Saayman, 2000). Despite the social validity of these data and the high levels of client satisfaction reported, the client satisfaction forms are not discussed. Stakeholders' responses to the summary results of the client satisfaction questionnaires will be discussed in the focus group section.

Model of treatment.

Home-Based Counselling consisted of two visits per family per week, over the course of approximately four months. Counselling hours were shared between the identified child and the parent, with each receiving at least one hour each per week of direct contact. The first visit was focussed on obtaining client consents for treatment and release of information, as well as being a goal setting dialogue between family members

and the counsellor. The treatment adhered to an SLFI format. The core elements consisted of Multi Systemic Treatment (MST), counselling and social problem-solving, were made available to the family in the context of all members' social environments. Since all parents consistently requested a treatment plan aimed at improving their child's behavior, PMT was offered to the parents or to the caregivers. Selected vignettes from the Webster-Stratton BASIC videotapes (1987) were introduced in the family home, with the video vignettes providing springboards for discussion and role play. The Webster-Stratton (1987) pyramid, which identifies parents as the foundation of child behavioral improvement, was photocopied and shared with all parents (Figure 2). Thus, the importance of parent's role as an effective agent of change was emphasized in all aspects of treatment. Parental well-being was also identified as an important factor in the parents' attaining their goals for their children's improvement. Parents' feelings about their own health were queried and appropriate support and referrals were provided to adult programs. Self-regulation, self-care, and the importance of social support and problem-solving were emphasized every week during separate sessions with parents and their children.

Children and adolescents were offered similar guidance in affect regulation and social problem-solving, with an added recreation component specifically designed to fit their interests. Cognitive behavioral treatments (CBT) for anxiety, depression and anger management were provided as necessary to individual children through the use of workbooks and videos. Appropriate peer and recreation activities in the community were actively sought out on behalf of child/adolescent clients. When an appropriate level of self-regulation was accomplished, children and their parent(s) were more able to spend

time listening to one another's concerns, and family problem-solving (FBT) was initiated. If talking was not an effective means of communication, due to interpersonal conflicts, then family sessions were re-directed to more experiential modes, such as arts and crafts (i.e., family collage of members' hopes and dreams), or non-competitive board games (such as Pictionary).

Family members re-evaluated their perceptions and values about education, including responsibility for homework and other class assignments. Better working relationships with each youngster's classroom teachers were developed. Community case coordination was managed by the HBCS counsellor, with parents practicing the responsibilities of organizing and recording the outcome of meetings. For example, a parent's request for respite could be facilitated by the family's support from the HBCS counsellor, but it was the parent's goal of having respite that directed the search. As the time for home visits concluded, a discharge summary was written by the counsellor, and edited by the parent (clients age 15 years and older were encouraged to read and edit the final report as well). Recommendations were problem-solved with the family, so as to introduce necessary ongoing resources in a timely and meaningful manner.

Methods

Participants.

Children/youth (and their parents/caregivers) who were consecutively admitted to HBCS between September 12, 1995 and February 19, 1997, and who were between the ages of 8 and 18 years were eligible participants. Although 52 children/adolescents were registered in the program, data were collected from only 42 because of parent's/caregiver's choice. Of the 42 youngsters whose families participated, 30 were

male, and 12 were female; 25 were under 12 years of age, and 17 were ages 13 to 17 years. Parent demographics were not considered. Child/adolescent diagnoses included conduct problems (CP), parent-child conflict, adjustment disorder, post-traumatic stress disorder and post-sexual abuse trauma. Children/adolescents also had co-occurring problems such as Tourette's syndrome, attention deficit/hyperactivity disorder (ADHD), as well as anxiety and obsessive-compulsive disorders, which were addressed in the context of their receiving treatment for CP. Only one adolescent participant had been previously diagnosed and treated for early onset schizophrenia, and his CP was addressed at his mother's request. Substance misuse was not pervasive in this sample. For the two youth whose families identified a drug or alcohol problem, referrals to community agencies such as the Dallas Society were made.

Sample and data collection.

This was a clinical sample: Children and adolescents were referred for treatment by doctors and mental health professionals. Participation in the pilot study was voluntary, and no initial incentives were offered. Participation was not uniform across families; data sets were complete for some parents, and for some children/adolescents—but they were not always from the same family. Although 21 of the 42 parents completed pretreatment and posttreatment outcome measures, six (6) of their children did not complete the appropriate outcome measures. Of the 21 children who completed pretreatment and posttreatment outcome measures, there were seven whose parents did not complete theirs. The same held true for the adolescent sample, which yielded only 7 complete data sets, with two parent sets missing. Given the variation of data set completion, as well as the high level of attrition, the data were analyzed for possible

differences between “completers” and “non-completers”. Using paired sample T-tests, mean baseline scores for children and parents who completed both pretreatment and post-treatment measures were compared with mean baseline scores of parents and children who had no second measure. There were no significant differences among either the child or parent baseline scores between “completers” and “non-completers.” Although follow-up measurement was intended, due to poor return by mail, these results will not be discussed. However, data collection and attrition were identified as important areas of concern for future evaluation/research projects.

Measures and procedures.

At the first home-visit, parents completed intake information and consent forms to participate in program evaluation. Upon receipt of parent permission, the identified child/adolescent was also invited to participate. Parents completed the Child Behavior Checklist (CBCL, parent form) (Achenbach, 1991) before the second visit, when treatment began. Among two parent families, parents were requested to collaborate. The social competence and behavior rating items were completed at the pretreatment measurement; parents completed only the 112 behavior items at posttreatment.

The CBCL is considered a reliable measure of parents' perceptions of their child's social competence and behavioral problems (Achenbach, 1991). Amongst its strengths are its sound psychometric properties, its comprehensive coverage of child and adolescent behavior problems, its extensive empirical basis, and its use of both broad-band (e.g., Externalizing vs. Internalizing) and narrow-band (e.g., withdrawal, aggression) syndromes (Achenbach; McMahon & Estes, 1997).

Children aged 8 through 12 years completed the Coopersmith Self-Esteem Inventory (SEI) (Coopersmith, 1981) at pretreatment and posttreatment. The test has 50 items (plus an 8 item lie scale that was not scored). The SEI is a pencil and paper self-report measure of self-esteem. Tests were read aloud, and children circled “like me” or “unlike me.” The SEI has been demonstrated to have good reliability (Kokenes, 1978). Scores are normally distributed, with means for special needs students somewhat lower than those of the general population (Stark, Reynolds, & Kaslow, 1987). It has been used as a measure of effective outcome among youth referred for mental health treatment (Maxwell, 1992) and school-aged children treated for moderate to severe levels of depression (Stark et al.).

Youth aged 13 to 17 years completed the Symptom Checklist-90 Revised (SCL-90-R) (Derogatis, 1992), a pencil and paper self-rating scale of global mental distress, at pretreatment and posttreatment. The SCL-90-R queries youth’s perceptions of their physical and mental health during the last week. Youth read the questions and circled a number between 0 and 4 to indicate whether a particular item was bothersome or not. Although this test has wide use in adult mental health as a measure of treatment effectiveness (Maruish, 1994), it has been used less extensively with adolescents (cf., Alford & Jaremko, 1990). The limits of its use among adolescent clinical populations will be discussed in the results section below.

Results.

Test scores were analyzed through the Statistical Package for the Social Sciences (SPSS), using paired samples T-tests. For the CBCL, (parent form) (N = 21), the results of the analysis indicated a significant decrease posttreatment on both of the broad band

scales (Internalizing [INT] and Externalizing [EXT]), as well as on the total deviance scores (TOT). Means for children/adolescents' affective symptoms (INT) decreased from 70.19 to 64.61 ($SD = 8.5$), $p = .007$; means for problematic behaviors (EXT) decreased from 72.10 to 66.14 ($SD = 8.4$), $p = .004$; means for overall symptoms (TOT) decreased from 73.67 to 67.52 ($SD = 7.8$), $p = .002$.

Among the children who completed the SEI ($N = 21$), overall scores of self-esteem increased. Pretreatment mean scores increased from 58.95 ($SD = 16.51$) to 68.29 ($SD = 12.90$) at posttreatment, $p = .015$. For adolescents who completed the SCL-90-R ($N = 7$), pretreatment means on the global symptom index (GSI) did not change significantly from pretreatment to posttreatment.

The focus group.

Parents and caregivers of all children and adolescents who had been admitted during the evaluation period were mailed invitations to attend an evening discussion of the results of the pilot evaluation (approximately 300 invitations were mailed). Refreshments were provided, and an incentive of \$15.00 was offered to any of the parents who stayed after refreshments to contribute to the discussion of what else could be evaluated in future projects. All of the 15 parents/caregivers chose to stay for the entire meeting, which took 2 hours. Their children had attended various programs at QACCH-MHS, including HBCS (4 out of 15 parents/caregivers). Parents' comments and recommendations included: (a) Evaluation should be done by program, and where possible, by child's diagnosis; (b) QACCH should sponsor a focus group with their youngsters, to inquire about their view of how we should evaluate Mental Health Services; (c) Parents wanted face-to-face exit interviews in addition to the standardized,

more impersonal questionnaires; (d) Standardized measures of pre- and post-treatment effects be completed by children's and adolescents' teachers, and other referring professionals; (e) Children should be interviewed about the course of their treatment during and after service interventions; (f) Parents want to be asked what they have done to sustain change at 6-month and one-year follow-up measurements; (g) Parents want to keep in touch with the QACCH through on going communications such as newsletters, drop-in groups and educational events; and (h) Parents want to be recognized as needing help during their children's times of crisis--support, including parent support groups should be offered.

Comments c, g, and h had arisen in previous focus group discussion, and were highlighted for management, at their twice monthly operating group. The request for newsletters and education were addressed by managers, with emphasis on parenting courses for families of children with various developmental disabilities, as well as with specific disorders, such as obsessive-compulsive disorder, autism, and conduct problems. Parents' suggestions about future research/evaluation were incorporated into the next generation of research. For example, the face to face (exit) interviews were explored as narrative components of the second HBCS evaluation, which also included the teacher information requested, and addressed parents' perceived stress. In addition, an attempt to survey parents' perceptions of how they sustained change was included in the follow-up interviews. Youth focus groups would be useful projects in the future, as these clients need to have an opportunity to inform future outcome research, too.

Discussion.

The pilot study lacked a control group, and had a considerable problem with attrition. However, even if data had been more consistently collected, the quasi-experimental nature of the study limited the interpretation of the findings. Including the use of a control group, and random assignment to groups would be desirable design features. Although some statistically significant results emerged for the CBCL, the clinical significance requires further scrutiny. While the average child's mean scores indicated that s/he had dropped below the overall (TOT) clinical mean score of 70, these children and youth were still averaging mean scores that were indicative of some adjustment difficulties. Families of children and adolescents who have CP need to feel hopeful about the results of any given treatment; yet, the reality of continued challenging behaviors despite best parenting practices is one which counsellor and family need to anticipate. The long-term plan for these youngsters needs to include check in points, and support for their parents to consult and enhance their roles, as well as additional clinical care for the children/adolescents.

Although there was a significant improvement in the mean level of children's reported self-esteem, self-esteem is a nonspecific variable (Kohn, 1994), which renders meaningful interpretation difficult. Despite its consistent use as a measure of treatment effectiveness in studies of child/adolescent depression and anxiety (Kaslow & Thompson, 1998), self-esteem is not considered to be as predictive of longer term outcome or relapse as is self-efficacy (Bandura, 1997). Unfortunately, when parents (and a few adolescents) identified self-esteem as a treatment goal, clinicians assumed that the goal/construct could be a useful outcome measure. However, the behavioral indicators of such an

improvement occurring were not documented by the staff or families. Rather, the construct was assumed to be identical to an SEI global score. Thus, the meaning for the improvement requires further study: For example, the behavioral correlates of self-esteem could include comments about the youngster's social and academic functioning during and after service concluded. Neither longer term outcome measures, nor teacher reports were collected, and these would have corroborated the reported increase in self-esteem (Coopersmith, 1967).

Parents and caregivers had some cogent comments to make about the pilot evaluation. From their perspective it provided useful information about the effectiveness of service provided to the average client, but it lacked specificity in terms of particular child and adolescent disorders and individual program effectiveness. Subsequent program evaluation/research has attempted to include the parent/caregivers suggestions by including: (a) measures of parent stress; (b) narrative interviews with parents/caregivers about their experience; (c) information from child/adolescent clients' teachers; (d) the examination of a specific psychological disorder as treated within a particular program (i.e. conduct problems within HBCS program); and (e) a dialogue with parents to ask how they have sustained gains.

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Available: <http://www.fmhi.usf.edu/cfs/policy/rtc/11thProceedings/11thchap7.htm>

Appendix B

Parent Information and Consent to Participate in Research:

Child Conduct Problems and Parent Support: A Home-Based Counselling Intervention

Candace Tate, graduate student, Phone: 721-6800

Dr. Brian Harvey, Supervisor, Phone: 721-7856

Dear _____,

At Queen Alexandra Centre (Q.A.C.) we are using our clients' comments to help improve the quality of service we provide to children, youth, and their families.

Professional researchers and supervised graduate students require training and education about your family's experience of having a child with special emotional and behavioral needs. At this time, I am requesting your participation in a research project which is aimed at improving counselling provided to children who have conduct problems. This particular research project would be part of my doctoral studies. Your participation is entirely voluntary. None of the information would be available for public access; if the anonymous information or results contained within this study were to be considered for use in further studies, your permission would be required. Your name will not appear on or within any of the summary reporting. For the protection of your confidentiality and anonymity, all of your responses will be coded, and personal identifiers will be removed.

During this research project, we will be asking you to take 3 paper and pencil tests, the Parenting Stress Index, the Parenting Self-Agency Measure, and the Child Behavior Checklist, three times each over the course of about 6 months (a total of 9 tests). Each test will take you about 20 minutes to complete, and we will be able to offer you \$20.00 to complete the last set. We would also like you to allow us to tape record three interviews with you: The first one will be part of how we get to know you, and learn your goals for our counselling work, and it will take about 1.5 hours; the second one is at the end of our homevisit time, to hear what the experience was like for you, and it will take about one hour; the third one is 4 months after the homevisits have finished, to hear how you are doing, and it will take about 45 minutes. We will be able to offer you another \$10.00 to participate in that final interview. We would like to ask your youngster's teacher to complete 3 brief (20 minute) behavior rating scales, so that we can find out if our service is helping your child in school. We are not asking your son/daughter to complete any tests during this project, but we are asking their permission to use the adults' ratings. If you agree to participate, your identity, and your child's, remain confidential. I am also asking permission from you and your child to use his/her teacher's ratings of classroom behavior in this research. If you choose not to participate, you will still receive the ordinary service to which you are entitled. Only the principal investigator (C. Tate), your child's teacher, and your Home-Based counsellor will have access to the paper and pencil tests before your name and your child's name are removed, and given a number to conceal your identity. All tests and tapes will be kept in a locked cabinet. The paper tests will be shredded as soon as they are entered into the password protected computer by me or your counsellor, or the Q.A.C. psychometrician. The computer is kept in a locked research area at Queen Alexandra Centre. Audiotapes are coded, and transcribed by Q.A.C. medical typists. Only your Home-Based counsellor, and C. Tate, will have access

to the audiotapes, and the tape will be numbered, with no name. All audiotapes are erased as soon as they have been transcribed. By the conclusion of this project, all tests will have been shredded and all audiotapes erased. This conclusion is scheduled to occur within one year of your participation in the first interview of the research project.

You, or your child, or their teacher, may drop-out of the study at any time without any consequence or loss of service. If you do drop-out, all of your information will be shredded and erased. If you choose not to participate in the audiotaped interviews, but would like to fill-out only the questionnaires, we will respect your choice. If you have any concerns or questions about this study or your participation, you may phone C. Tate, or the counsellor who visits you from Home-Based, at 721-6800.

The results of this project will be shared with you. If you would like to know the results of this study, but prefer to hear them privately, this will be arranged, and your identity and your child's will remain both anonymous and confidential. If you prefer to come to a group presentation, you will be invited to attend by putting a check mark next to that option on the attached consent form. Any findings presented at the group presentation will not be identifiable, and your individual confidentiality will not be compromised. The information will be grouped to present themes related to the research questions about service to children, youth, and families.

Please sign below if you agree to participate in this research project, and if I may ask your child's teacher to participate, please sign the attached "Teacher Consent" form—if you don't return it signed, we will not involve your youngster's teacher. If you wish to participate in the research, but do not wish to have your child/youth's teacher do so, your choice be will accepted.

(parent/guardian's signature)

(date)

I want to participate in the research project, without any audiotaping.

Do not contact my youngster's teacher, please.

I would like to be invited to a group presentation to participants of overall results of this research project (all information is numbered and modified to protect each individual's identity).

I would prefer to hear about the results privately.

You may change your mind at any time about how you wish to be informed about the results of the study.

Appendix C

Child/Youth Consent

Title: Child Conduct Problems and Parent Support: A Home-Based Intervention

Candace Tate, graduate student, Phone: 721-6800

Dr. Brian Harvey, supervisor, Phone: 721-7856

Dear _____,

In order to better help children and youth who have special needs, we would like your permission to ask your parent and teacher to answer some questions about how things are going for you at home and school. Please read this, and sign below if you agree that they may fill out some forms which ask about your behavior at home and school. Your anonymous scores will help us improve our service to other youngsters and their families. Your participation is worthwhile, and we would like encourage you, so if you do agree that we may include your scores, we will give you \$7.50. To keep your identity secret, all of the forms will have a number; none will have your name on them.

No one but the researcher, and your Home-Based counsellor will see the forms before they are numbered. They will be kept in a locked cabinet until the numbered scores are entered into a password protected computer by Candace or your counsellor, or the Queen Alexandra Centre (Q.A.C.) testing person. Then, the forms will be shredded. The computer in which the scores are entered is kept in a locked research area at the Queen Alexandra Centre for Children's Health.

Your permission is entirely voluntary, and if you choose not to give it, the counselling for you and your family will be just the same. Your parents and your teacher will receive an overall summary of the information, with all names kept secret. If you wish, your parent/caregiver or your counsellor will explain the results to you. Please sign below if you understand and agree with the following statements:

I agree that my parent/caregiver and my teacher may complete checklists about my behavior at home and school. I understand that my name will be numbered to keep my name secret and private. If I choose not to participate, or to withdraw my permission, my counselling service will still be available. If I drop out of the study, all of my parent and teacher's checklists will be shredded. I can phone 721-6800 and speak to a counsellor if I want to know anything else about this project.

(child/youth's signature)

(date)

___ I would like my parent/caregiver or counsellor to explain the results of the research to me.

Appendix D

Teacher Consent to Participate in Research

Title: Child Conduct Problems and Parent Support: A Home-Based Intervention

Candace Tate, graduate student, Phone: 721-6800

Dr. Brian Harvey, supervisor, Phone: 721-7856

Dear _____,

At the Queen Alexandra Centre (Q.A.C.) we are using our clients' comments to help improve the quality of service we provide to children youth, and their families. Professional researchers and supervised graduate students require training and education about the effectiveness of treatment services which are offered to children with special emotional and behavioral needs. At this time, I am requesting your participation in a research project which is aimed at improving counselling provided to children who have conduct problems. This particular research project would be part of my doctoral studies. I would be asking you to complete 3 brief behavior checklists about this student over the course of about six months. No one but the counsellor who works with your student, and Candace Tate, will have access to the questionnaires which you complete. The questionnaires will be immediately coded, and stored in a locked cabinet. As soon as the scores are entered into a password protected computer, the paper tests will be shredded. The coded data entry is done by the principal investigator, your student's counsellor, or the Q.A.C. psychometrician. All tests will have been shredded by the conclusion of the project, which should occur within one year of your participation. The anonymous electronic scores will remain in the password protected computer in a locked research area of the Queen Alexandra Centre for Children's Health until the conclusion of the project.

This student and her/his parent have given us permission to ask you to participate in this study. If you are willing to allow us to include your ratings of this student's behavior, please sign below. We have asked this student's parent to indicate their agreement with your choice to participate by their signature, as below. If you have any questions or concerns regarding this research project, please phone C. Tate or the counsellor working with your student at 721-6800. If you drop out of the research, all of your information gathered for this project, about this student, will be destroyed.

I agree to participate in this research project by completing three behavior rating scales. I understand that test scores will be coded, and that student and teacher identities will remain confidential. In the event that I choose not to participate, or if I choose to drop out of the study at any time, service on behalf of this youth will not be compromised.

(teacher's signature) (parent's signature) (child/youth signature)

(date) (date) (date)

___ I would like a written summary of the results of this study.

Appendix E
Script to Introduce Child/Youth Consent

The interviewer is a Q.A.C. research assistant, a graduate student who has completed all relevant background checks, and the oath of confidentiality. She/he will help with the reading and collection of the child/youth consents, but will not have access to any data.

Interviewer: We are doing a big project, and we would like to tell you about it. I am going to read a letter about the project to you. Please read along with me, in your head, while I read out loud. Since there are a lot of big words in this letter, I am going to tell you the meaning of a few of the important ones, like “shredded” and “overall summary”, but you can ask me to stop reading at any time, so that you can ask a question. Let’s begin. (Reads consent, pausing to explain “shredded” and “overall summary; as well as inserting a pause at the end of each sentence and double length pause at the end of each paragraph). Interviewer stops as asked to explain any other words or concepts, and at the end of the reading, asks whether youngster has any more questions. After she/he has finished, the interview ends as below:

Interviewer: Whoa. That was a lot of words. Thank you for your patience. To encourage your participation on this project, we can offer you \$7.50 as an incentive. Would you like to earn that reward by allowing us to use your anonymous scores?

Appendix F

_____, 2000

Dear Parent/Caregiver,

By now you will have heard that your youngster has met the criteria for admission to the Child and Family Program in the Ledger Building at Queen Alexandra Centre. Although we cannot give the exact date that this admission will occur, we do want to confirm that your youngster is "waitlisted." While your youngster is awaiting his/her admission to a program here, could you complete the attached forms as soon as you receive them? This information will help staff to understand your youngster's treatment needs. None of this information will affect your child's status on the waitlist, but it will help the staff to plan service, so please be as accurate and direct as possible. We will arrange to pick-up the forms at a time convenient to you.

In the next week or two, you will be contacted by the Queen Alexandra (nurse) Evaluation Project Coordinator. She will ask you if the information which you are giving us about you child's needs can also be used anonymously for Program Evaluation and research. We want to be able to compare the information that you give us to the responses of other mothers who have children with emotional and behavioral problems. Your ratings of your child's behavior will help us to evaluate the effectiveness of services we provide to families and children.

Children, youth and families who were registered in these programs in the past, have made a good start at helping staff to improve services by participating in our previous Program Evaluation. In an effort to respond to client feedback from the previous project, we are extending our evaluation to include information about parent and caregiver's levels of stress, as well as teacher's reports of how youngsters' behavior does (or doesn't) improve after their treatment. Your participation is entirely voluntary, and will not affect your child's status on the waitlist. Your identity and your youngster's will be confidential.

If you are willing to participate, please sign the attached consents. Would you also encourage your youngster to give us permission, too? We are offering an incentive fee (\$10.00) to youngsters whose parent/caregiver participate in this project, to be paid after you have completed the second set of checklists. In the event that you decide that your child should not be admitted for treatment, we would still pay the fee immediately following your completion of the second set of questionnaires. Thank you in advance for your assistance.

Sincerely,

Shirley MacEachern, R.N., BSN
Candace Tate, Evaluation Coordinator

Appendix G
Waitlist Recruitment Script

Interviewer: Hello, my name is _____. Do you have a few minutes?

I'm calling to ask if I could enlist your cooperation in a project we have just begun at Mental Health Services, here at the Queen Alexandra Centre. In order to evaluate the service we provide to youngsters and their families, we are asking parents/caregivers to complete 3 brief questionnaires. Your information would be coded, and your identity, as well as that of your child, would remain private. Your choice to participate will in no way affect your child's status on the admission waitlist. When your youngster is admitted, you may be asked to fill out the tests again at the end of treatment. This would require only about one hour of your time. If you are willing to participate, we would like to make an appointment to come to your home to pickup the checklists. Could you tell a couple of times that would be convenient for our student research assistant to come to your home? I will call you back and confirm which time works for our student to pick-up the forms. Thank you for your help.

Appendix H

Child, Youth and Family Mental Health Services
Queen Alexandra Centre

CONSENT FOR RESEARCH AND PROGRAM EVALUATION

Mental Health Services, at the Queen Alexandra Centre for Children's Health, is doing Program Evaluation as a way to improve treatment for children and youth. Would you and your child be willing to help? You would only need to fill out three brief self-reports now, and then once again before your youngster has received service (about four months from now). The information will be coded and kept confidential. Neither your identity nor your youngster's will be revealed. Only the anonymous test scores would be used in this project. This information is stored on a password protected computer for research. In recognition of your participation, your child will receive a check for \$10.00 when you have completed the first and second set of checklists. Please sign below if you agree to participate, and if we may contact your youngster's teacher for a behavior update.

Signature of Parent/Guardian

Child/Youth's Signature

Name of Child's Teacher

Name of Child's School

Date

Date

Yes, you may contact my child's school.

Thank you in advance for your family's support in this research. Please phone us if you have any questions or concerns about this project. Our number is 721-6769.

Sincerely,

Shirley MacEachern,
Candace Tate
Project Coordinators

Appendix I

Queen Alexandra Centre for Children's Health

Client Information Sheet

Client ID:

Birthdate:

Last Name:

First Name:

Middle Name:

CONTACTS:

Parent/caregiver names

Address

School Name

Address

Event ID

Start Date: Dec. 10, 1999

Program: children

Coordinator:

Status: waitlisted

Referral Source: (child psychiatrist)

Program Note: Recent discussion with Dr. _____ suggesting that child be considered for an in-pt admission. There remain concerns about aggression, non-compliance and symptoms of ADHD. This child has had a # of assessments and community professional involvement. Parents conferred last week with Dr. _____ and have agreed to in-pt admission.

Appendix J

Parent Questionnaire

This information is requested for research purposes only. Confidentiality within this the study is guaranteed. Please respond as openly as possible.

Parent name: _____ Marital status _____

Child ID # _____

Are you currently receiving income assistance?

Are you employed? _____ How many hours per week are you working? _____

What is your income per year? Please circle the appropriate response.

\$10,000+ \$20,000+ \$30,000+ \$40,000+ \$50,000+

If you are married, or have a partner who contributes to your family income, please continue to the next question.

What is your spouse or partner's income per year?

\$10,000+ \$20,000+ \$30,000+ \$40,000+ \$50,000+

Appendix K

Table 3

Correlations Between Parent Variables Across Treatment and Control Groups (n = 31)

	1	2	3	4	5	6	7	8	9	10	11	12
1. CBCL INT_1		.315	.713**	-.298	.318	-.022	.419*	.002	.178	.049	.093	-.178
2. CBCL EXT_1			.762**	-.294	.609**	.174	-.050	.648**	.418*	-.289	.581**	.060
3. CBCL TOT_1				-.254	.552**	.035	.234	.466**	.507**	-.064	.432*	-.063
4. PSAM_1					-.476**	-.490**	-.073	-.308	-.170	.527**	-.495**	-.348
5. PSI C_1						.480**	.323	.620**	.560**	-.198	.700**	.121
6. PSI P_1							.278	.364*	.303	-.370*	.352	.582**
7. CBCL INT_2								.211	.619**	.098	.183	.197
8. CBCL EXT_2									.821**	-.548**	.757**	.415*
9. CBCL TOT_2										-.289	.611**	.352
10. PSAM_2											-.574**	-.631**
11. PSI C_2												.539**
12. PSI P_2												

*p < .05, **p < .01

Appendix L

Narrative Interview Questions

Initial Interview

1. What has it been like for you to parent _____ (child's name)?
2. Could you tell me about your experience of parenting _____?
3. Could you tell me about your experience of parenting a child with such challenging behavior?
4. Could you tell me about your experience of being _____'s mother?

Posttreatment Interview

1. What has changed since Home-Based Counselling treatment?
2. _____ (child's name) still has ADHD; what has changed?
3. How have things gone since you became involved with Home-Based Counselling?
4. Could you tell me what's improved at your house since Home-Based started?
5. As you look back at the home-visits and counselling work you have done with Home-Based, could you tell me what is the same or different now?
6. Could you tell me about what _____ has been like since Home-Based Counselling and your family started working together?

Follow-up Interview

1. It's been a while since we talked. How are things going?
2. How have you been doing?
3. How have things been going since we last talked, when _____ was getting used to his school program?
4. It's been several months since we talked. How have you and _____ been doing?