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The Use of Stress Management in Combination with Parent Training: An Intervention Study with Parents of Preschool Children

Theresa L. Gunderson
Utah State University

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THE USE OF STRESS MANAGEMENT IN COMBINATION WITH
PARENT TRAINING: AN INTERVENTION STUDY WITH
PARENTS OF PRESCHOOL CHILDREN

by

Theresa L. Gunderson

A dissertation submitted in partial fulfillment
of the requirements for the degree

of

DOCTOR OF PHILOSOPHY

in

Psychology

Approved:

UTAH STATE UNIVERSITY
Logan, Utah
2004
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ABSTRACT

The Use of Stress Management in Combination with Parent Training: An Intervention Study with Parents of Preschool Children

by

Theresa L Gunderson, Doctor of Philosophy
Utah State University, 2004

Major Professor: Gretchen A. Gimpel, Ph.D.
Department: Psychology

Many preschool children exhibit a number of problematic, acting-out behaviors. Parents of preschoolers exhibiting behavior problems often experience a great deal of stress associated with these problem behaviors. Consistently robust improvements have been found in the use of stress management for adult stress, pain, and medical well-being. Likewise, studies have shown parent training decreases the severity of child behavior problems. However, only a few studies have examined effects of parent training on both child behavior and parent stress. Some studies have found that parents who complete parent training also report lowered stress levels commensurate with improvement of child behavior. It is unclear, though, whether adding stress management would provide additional benefits to parents and their children.
The purpose of this study was to look at effects of providing both parent training and stress management training to parents of preschoolers, and to look at the effects of providing treatment in a different order to two groups of parents. Parent volunteers completed seven weeks of parent training and four weeks of stress management training, with half of the parents receiving stress management first and half receiving parent training first.

It was found that overall improvements in measures of parent stress and child behavior were not significantly different between the two groups. Improvement in child behavior was attributed to parent training; improvement in parent stress was attributed to both parent training and stress management training, with larger improvements in parent-related stress generally attributed to stress management training and larger improvements in child-related stress attributed to parent training. However, child behavior temporarily worsened while parents received stress management training. Stress management did not enhance effects of parent training, but parents were better off on measures of stress and parenting efficacy after receiving both training components than they were after receiving only one treatment component. Parents felt more effective as parents after treatment and rated the overall treatment package highly; however, parents who received their preferred treatment first were slightly more satisfied than parents receiving preferred treatment second. Teachers reported general improvement in children whose parents received treatment and those whose parents did not receive treatment.
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Theresa L. Gunderson
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CHAPTER I

INTRODUCTION

Background and Problem Statement

Preschool children can exhibit a variety of behavior problems, typically in the form of externalizing (acting out) behaviors. Some children exhibit these behaviors for a short time, while others' problem behaviors are long lasting. The acting out nature of these problems can be particularly difficult for parents. Although behavioral parent training has been successfully used to treat child problems in the preschool years, little is known about what effects such treatments have on parents.

Many families report having a great deal of stress related to their interpersonal relationships. In particular, parents of children who exhibit problem behaviors report high levels of stress as well as other psychological difficulties (Anastopoulos, Shelton, DuPaul, & Guevremont, 1993; Mash & Johnston, 1983). For example, parents of children with problem behaviors associated with attention-deficit/hyperactivity disorder (ADHD) or conduct disorder (CD) often experience high stress, marital conflict, negative interactions with their child, and low involvement with their child (Barkley, 1996; Hinshaw & Anderson, 1996). This parent stress and negative parent-child relationship may lead to continuing problems for all involved. Thus, it is important to understand how to effectively address all difficulties that families are experiencing.

Behavior problems in children are often remediated through the use of behavioral parent training programs (e.g., Anastopoulus et al., 1993). For example, following parent training, improvements have been noted in such problem behaviors as
noncompliance, tantrums, and aggression. Not all children, though, are successfully treated with such methods. Some families drop out of treatment before improvements can be made. In such families, parents may be experiencing particularly high levels of stress or have other difficulties, such as depression or general psychological distress. Providing parents with a treatment component that addresses their specific problems may lead to more effective treatments for children with externalizing behavior problems and their families.

Stress, a common condition in parents, has been successfully treated in the general adult population through the use of stress management training (e.g., Fausel, 1995). In addition, stress management techniques have been used to successfully treat a variety of problems such as anxiety, headaches, and chronic pain (Lehrer, Carr, Sargunaraj, & Woolfold, 1994). It seems likely that stress management training may also decrease the psychological distress of parents of children with behavior problems.

It is largely unknown whether behavioral parent training alone or with an additional treatment component (such as stress management) reduces parental stress. Combining stress management training with behavioral parent training may decrease parents' levels of stress and lead to greater improvements in child behavior; however, no studies have looked at the effectiveness of stress management in conjunction with behavioral parent training. It would be important for such a study to be conducted to enable the comparison of the effectiveness of each treatment component as well as the cumulative effects of both treatments combined. This information would help in the ongoing quest to provide the most beneficial treatment for families. In addition, it would be important to measure parent variables (e.g., stress) before and after parent
training as well as before and after stress management training. Parents may experience a decrease in stress following parent training due to improved child behavior and/or increased parenting efficacy. Thus, stress management may not be needed. Alternatively, reducing stress may lead to parents feeling more confident in their parenting skills and parent training may be more effective following stress management training or not necessary. Of course, it may also be that both treatment components are necessary to reduce disruptive child behavior and decrease parenting stress.

Purpose and Research Questions

The main purpose of this study was to investigate whether adding stress management training to parent training positively affects parental stress levels, problematic child behaviors, and parenting efficacy. In this study, parents of preschool-age children received seven sessions of parent training and four sessions of stress management. Approximately half of the parents received parent training first and stress management second, whereas the other half received stress management first and parent training second. Because all parents in the study received both behavioral parent training and stress management training, a secondary purpose was to determine if there are any differences in outcome based on the order the treatments were received.

The study was designed to help to answer the following research questions.

1. Is there a statistically and/or clinically significant difference in changes in parent stress levels between the parent-training-first group and the stress-management-first group? It was anticipated that posttreatment stress levels would decrease equally
between the two groups, but that the stress-management first group would exhibit greater changes after the first phase of treatment.

2. Is there a statistically and/or clinically significant difference in feelings of parental efficacy between the parent-training-first group and the stress-management-first group? It was anticipated that posttreatment feelings of efficacy would increase equally between the two groups, but that the parent-training-first group would exhibit greater changes after the first phase of treatment because the first phase targets issues most related to parenting efficacy.

3. Is there a statistically and/or clinically significant difference in changes in severity of problematic child behaviors between the parent-training-first group and the stress-management-first group? It was anticipated that children of parents in the stress-management-first group would improve more overall at the time of posttreatment because lowering parents’ stress level would facilitate skill acquisition during parent training. However, it was hypothesized that the parent-training-first group would demonstrate greater improvements after the first phase of treatment. It was also anticipated that teacher measures of child behavior would reflect similar patterns.

4. Is there a statistically and/or clinically significant difference between groups (parent-training-first versus stress-management-first and preferred-treatment-first versus nonpreferred-treatment-first) in treatment satisfaction? It was anticipated that parents who received their preferred treatment first would be more satisfied with the overall treatment package. For example, parents who indicated that they were primarily interested in stress management would be more satisfied with the program if they received stress management training before parent training.
CHAPTER II
LITERATURE REVIEW

The study of childhood psychopathology has increased over the last few decades. The negative effects of childhood disorders often last throughout the person’s adult life and affect not only the child but also members of the child’s immediate family, such as siblings and parents (Mash & Dozios, 1996). Better understanding of childhood disorders may lead to more effective intervention and prevention techniques. Of particular importance is understanding what factors increase effectiveness of prevention and intervention techniques for the child and his/her family.

Child Behavior Problems

Although it may be difficult to recognize problem behaviors during the preschool years as indicative of more serious and long-term problems in later childhood and adulthood, it is the case that adolescents with serious disruptive behaviors show a long history of such behavior starting in the preschool years (Campbell, 1995). Richman, Stevenson, and Graham (1982) found that mild to moderate behavior problems during these early years occur in 10-15% of the preschool population. Typical problem areas as reported by parents, preschool teachers, and daycare providers include behavior management issues, overactivity, inattention, and poor relationships with siblings and peers (Campbell). In one study, children at age 13 who were identified as “hard-to-manage” at age 3 showed more externalizing symptoms and were more likely to meet criteria for a disruptive behavior disorder than children not initially identified as
“hard-to-manage” (Pierce, Ewing, & Campbell, 1999). In addition to being stable across the years, these problem behaviors are also associated with later internalizing and academic problems (Campbell, 1990). Another interesting finding is toddler and preschool-aged boys with especially high levels of early hyperactivity and aggression, along with high levels of negative parenting and family stress, are most likely to have continued problems when they are ready to enter school (Campbell, Shaw, & Gilliom, 2000).

Three common behavior disorders in childhood are ADHD, CD, and oppositional defiant disorder (ODD). The initial symptoms of these disorders are often seen during early childhood. Many of these symptoms (e.g., inability to follow instructions, defiant toward adults) are presenting complaints when parents seek help from professionals in managing their child’s behavior.

*Overview of ADHD*

ADHD is characterized by activity levels, attention problems, and impulsivity, which are in excess of those in the child’s age group. Attention problems include an inability to respond to tasks or to follow through with instructions, being disorganized, distracted, and forgetful. In school these difficulties are evident in the appearance of being off task and in the failure to complete assignments. Hyperactive and impulsive behaviors are exhibited, for example, in frequently being out of seat, frequently talking and interrupting others, being unable to wait in line or take turns, and being less able to delay gratification (Barkley, 1996).

Children with ADHD experience problems in social, cognitive, academic,
familial, and emotional areas, as well as in general adjustment. These problems are thought to arise early in life and to persist throughout the individual's development. Specifically, hyperactive and impulsive problems (and in some, oppositional and aggressive behaviors) have been shown to arise earliest, at about the ages of 3 to 4 (Barkley, DuPaul, & McMurray, 1990; Loeber, Green, Lahey, Christ, & Frick, 1992; Taylor, Sandberg, Thorley, & Giles, 1991). Inattention problems tend to arise somewhat later (between the ages of 5 and 7) and often are noticed with the beginning of formal schooling (Loeber et al.). If significant ADHD symptoms arise during the preschool years and persist for at least a year, children are likely to continue to have problems throughout their years in elementary school (Beitchman, Wekerle, & Hood, 1987; Campbell, 1990; Palfrey, Levine, Walker, & Sullivan, 1985), especially if there is a great deal of conflict, maternal directiveness and negativity, and child defiance during parent-child interactions (Campbell, March, Pierce, Ewing, & Szumowski, 1991). During the early elementary school years, oppositional and socially aggressive behaviors develop in at least 40-70% of children with ADHD (Barkley, 1990), and these behaviors develop into symptoms of conduct disorder in up to 50% of children with ADHD (Loeber et al.; Taylor et al., 1991). Further, Mannuzza and Klein (1992) have found the disorder to persist into adolescence in 50-80% of children in clinical samples.

Childhood ADHD is also associated with other psychiatric disorders, as well as medical risks. In childhood ADHD is associated with both oppositional defiant disorder and conduct disorder (Barkley, 1990), as well as with anxiety disorders (Biederman,
Medical risks associated with ADHD include sleep disturbance (Kaplan, McNichol, Conte, & Moghadam, 1987), chronic health problems such as asthma and sinus infections, accident proneness (Hartsough & Lambert, 1985), and reduced life expectancy (Weiss & Hechtman, 1993).

Although research on continuation of ADHD symptoms into adulthood is limited, Barkley (1998b) noted that 11-70% of children with ADHD continue to have significant symptoms of ADHD as adults. This wide variability may be due to the difficulty of diagnosing ADHD in adults and the resulting inconsistency between studies in diagnosing the disorder in adult subjects (Faraone, 2000). It may also be due to the possibility that adult self-reporters, used in many studies as one source of diagnostic information, underestimate the persistence of ADHD into adulthood (Barkley, Fischer, Smallish, & Fletcher, 2002). In adulthood ADHD is associated with antisocial personality disorder (Biederman et al., 1992; Mannuzza & Klein, 1992; Mannuzza, Klein, Bessler, & Malloy, 1993; Mannuzza, Klein, Bessler, Malloy, & LaPadula, 1998) as well as histrionic, passive-aggressive, and borderline personality disorders (Fischer, Barkley, Smallish, & Fletcher, 2002). Studies also show some association with mood disorders in adulthood (Biederman et al.), including major depressive disorder (Fischer et al.). Further, some studies have found that adults with ADHD receive more mental health treatment than do community controls (Fischer et al.). Adults with ADHD have also been found to have a higher prevalence of illegal substance use and substance abuse disorders (Mannuzza et al., 1993, 1998; Murphy & Barkley, 1996).
As with children, adults with ADHD experience difficulties in various life areas in addition to the psychological and medical risks associated with the disorder. Adults with ADHD report more driving risks, more frequent changes in employment, poorer educational performance, higher likelihood of multiple marriages (Murphy & Barkley, 1996), and are more chronic offenders of the law (Lynam, 1996). Adults with ADHD have also been found to complete less formal schooling than controls and held jobs of lower occupational ranking (Mannuzza et al., 1993).

**Overview of CD and ODD**

Although conduct and oppositional defiant disorders show some overlap with ADHD, they are quite distinct disorders. CD and ODD are characterized generally by aggression, acting out, and disruptive behaviors. Aggression takes a variety of forms. It can be characterized as verbal (e.g., name calling, swearing) or physical (e.g., fighting), goal directed or hostile (intent is the infliction of pain), direct or indirect (e.g., spreading rumors to “get even”), proactive (e.g., threatening) or reactive (e.g., retaliating), and overt or covert (Hinshaw & Anderson, 1996). Diagnostic symptoms of ODD include arguing with adults, losing one’s temper, defiance or noncompliance towards adults, deliberately annoying others, and being angry. Diagnostic symptoms of CD include such behaviors as physical aggression toward people or animals, destruction of property, lying, theft, and serious violations of rules (American Psychiatric Association, 1994). Children with CD are at risk for peer rejection and academic failure, and the disorder tends to persist throughout childhood and adolescence (Hinshaw & Anderson).
Young children with conduct problems are more likely to engage in oppositional behaviors, such as arguing and defiance, whereas older children are more likely to engage in covert behaviors, such as stealing (McMahon & Wells, 1998). The developmental progression of aggression and antisocial behaviors is varied. While an individual may persistently show patterns of such behaviors, the behaviors themselves vary in their topographical expression depending on whether the individual is a toddler, child, adolescent, or adult. For instance, an irritable and overactive toddler may become an argumentative and defiant preschooler, then a physically aggressive and stealing child, and finally an adolescent who turns to sexual assault and substance abuse (Hinshaw & Anderson, 1996).

Multiple research studies have shown that the presence of conduct problems is relatively stable (Egeland, Kalkoske, Gottesman, & Erickson, 1990; Yoshikawa, 1994), indicating that many children with conduct problems are likely to exhibit problems into adulthood. It is estimated that 50% of preschool children who display significant externalizing problems continue to have problems at school age, and of those who continue to have problems, 67% meet diagnostic criteria for ADHD, ODD, or CD by age 9 (Campbell & Ewing, 1990; Webster-Stratton & Hancock, 1998). Early onset of behaviors associated with CD and ODD has been shown to predict antisociability and adjustment problems later on. In fact, the developmental progression appears to be that children who display conduct problems early begin with more benign behaviors, such as temper tantrums and noncompliance, and progress to more serious behaviors, such as fighting and stealing. In addition, the change in repertoire appears to be additive,
expanding to include not only the original problem behaviors (e.g., noncompliance), but also the more serious and newly acquired problems (e.g., stealing; Hinshaw & Anderson, 1996).

Children who do not display conduct problems until adolescence ("late starters"; Patterson, DeBaryshe, & Ramsey, 1989) have a much better prognosis, generally not having chronic problems throughout adulthood as do the "early starters" with a long history of conduct problems (Webster-Stratton & Hancock, 1998). In their study of a sample of fourth-grade boys, Patterson, Forgatch, Yoerger, and Stoolmiller (1998) found that 76% of early-onset boys became chronic juvenile offenders, whereas for late-onset boys that figure was only 19%. Enough research supports this type of finding that, in his review of literature, Yoshikawa (1994) stated "a consensus exists that the chronic juvenile offender has a particularly early age of onset of antisocial acts" (p. 532).

Other problems have been found to be comorbid with CD and ODD. These include ADHD (Biederman, Newcorn, & Sprich, 1991), academic underachievement (Egeland et al., 1990; Hinshaw, 1992), learning disabilities (Hinshaw), and the internalizing disorders of anxiety and depression (Zoccolillo, 1992).

Family/Parent Variables Associated with Child Behavior Problems

The parent-child relationship during the preschool years has a great impact on the onset and persistence of externalizing problems (Campbell, 1990). Parental behaviors that are important to the developing child include, among others, parent-child
attachment, limit setting and control, and involvement with the child as both teacher and play partner (Campbell, 1995). Insecure attachment has been described as a risk factor for antisocial behavior in childhood, while a secure attachment is thought to be essential for active exploration of the environment and, subsequently, optimal child development. Arbitrary, inconsistent negative, and uninvolved parenting has been associated with noncompliance and defiance in children. Authoritative parenting, consisting of warmth and firm control, has been associated with child compliance. Finally, children who are hard to manage during play interactions with parents have parents who are more negative and controlling during the interaction than parents of well-behaved children (Campbell, 1995).

While parent variables affect children, child variables also affect parents. Ralph, Haines, Harvey, McCormack, and Sherman (1999) surveyed 40 parents of children ages 1-8 in a suburban area, and almost half reported clinically significant levels of child behavior problems. Parent characteristics of overreactivity, anxiety, depression, and dissatisfaction with parenting style were highly correlated with severe behavior problems.

An interesting study by Egeland et al. (1990) looked at child behavior problems over time (in the absence of treatment) and associated family factors (e.g., maternal depression). Families of children who were identified as having behavior problems in preschool and continued to exhibit behavior problems during elementary school had significantly more maternal depression, and unorganized and unpredictable environments as compared to families in which children improved. Similarly, families
of children who were identified as competent (lacking behavior problems) in preschool but had significant behavior problems in elementary school had significantly more maternal depression and unorganized home environments as compared to families of children who were competent both in preschool and elementary school. Similarly, Campbell and Ewing (1990) found that the presence of an externalizing disorder at age 9 could be predicted by earlier problem behavior and maternal negative control as first measured at age 3.

In an extensive review of the epidemiological literature, Lahey, Miller, Gordon, and Riley (1999) found that disruptive behavior disorders correlate with low socioeconomic status, parental psychopathology, family and marital dysfunction, and atypical parenting. According to Dodge, Bates, and Pettit (1990) and Emery (1982), the onset and maintenance of antisocial behaviors in children are associated with family variables such as marital conflict, divorce, and child abuse. Family variables related to aggression in children include parental lack of availability, negativity with the child, and parental diagnosis of antisocial personality disorder. Children’s aggressive and antisocial behavior has also been linked to low parental involvement in the child’s activities, poor supervision, and harsh and inconsistent discipline practices. The relationship between such parent behavior and aggression in children has been found to be bidirectional in that parental behavior affects the child and vice versa (Hinshaw & Anderson, 1996).

ADHD behaviors specifically have also been found to negatively affect interactions between children and their parents. For example, mothers of children with
ADHD have been found to be less responsive, more negative and directive, and less rewarding of their child's behavior (Danforth, Barkley, & Stokes, 1991). Patterns of negative parent-child interactions are found in preschool populations of children with ADHD, and at this age the interactions may be most negative to the parent due to younger children with hyperactivity having more observed behavior difficulties than older children with hyperactivity (Mash & Johnston, 1990). This pattern of negative parent-child interactions is predictive of and when the child is an adolescent (Barkley, Fischer, Edelbrock, & Smallish, 1991). Interestingly, this pattern does not necessarily just involve the child with ADHD. Negative interactions are also found between the parent and siblings of the child with ADHD as well as between the child with ADHD and his/her siblings (Taylor et al., 1991). Although the aforementioned researchers spoke of these results in relation with children with ADHD, Barkley et al. (1991) asserted that most of the negative interactions and conflict are present when the child with ADHD has comorbid ODD. Nevertheless, the presence of ADHD appears to contribute significantly to the detrimental effects of child behavior on the family relationship.

Additional family correlates of ADHD include decreased sense of parenting competence (Mash & Johnston, 1990), and increased marital conflict and maternal depression (Barkley et al., 1991; Taylor et al., 1991). Whalen and Henker (1999) hypothesized that the link between ADHD and maternal depression is because mothers take more responsibility for parenting than do fathers, and there are many unsuccessful parenting interactions on a daily basis with children of ADHD. Mash and Johnston
found an inverse relationship between parents' sense of efficacy and the age of their child with hyperactivity, with parents of younger children reporting higher efficacy than parents of older children. The authors propose that this is due to parents of older children with hyperactivity having a longer history of unsuccessful attempts to modify their child's behavior. Interestingly, these findings of increased mental health problems in families is supported by Hechtman's (1996) finding that there is marked improvement in family mental health after the child with ADHD moves out of the home.

Parental characteristics have also been related to poor outcome of interventions for conduct problems as well as poor attendance and dropout in treatment programs. These characteristics include negativity, maternal and paternal depression, low education level, experience of negative life events, maternal history of childhood antisocial behavior, and maternal report of psychopathology, low marital satisfaction, low socioeconomic status, and maternal insularity, as well as low social support and the associated stresses (Clark & Baker, 1983; Dumas, 1984a, 1984b; Graziano & Diament, 1992; Knapp & Deluty, 1989; McMahon & Wells, 1998; Webster-Stratton, 1985a, 1985b; Webster-Stratton & Hammond, 1990). Better outcomes are found for parents who were married (Clark & Baker; Webster-Stratton, 1985a; 1985b; Webster-Stratton & Hammond) and were experiencing good marital adjustment (Webster-Stratton & Hammond), those who had attained a higher level of education (Clark & Baker), and those of higher socioeconomic status (Clark & Baker; Dumas, 1984a, 1984b; Knapp & Deluty, 1989; Webster-Stratton, 1985b). Worse outcomes have been found for insular
mothers (Dumas, 1984a, 1984b) and those who were depressed (Webster-Stratton & Hammond).

Parental Stress

As one looks into the research, the reciprocity of child and parent behavior becomes more and more apparent and one sees more clearly the impact children have on parent wellbeing. Researchers have shown that parents of children who exhibit various problem behaviors report a great deal of stress (Anastopoulos et al., 1993; Mash & Johnston, 1983). Mash and Johnston also report that while parenting is generally stressful, mothers of children with hyperactivity or conduct problems "participate in transactions with their children that are more stressful, are less rewarding, and provide considerably less positive feedback" (p. 87) than do mothers of children without hyperactivity or conduct problems. These researchers administered the Parenting Stress Index (PSI) to both mothers of children with hyperactivity and mothers of children without hyperactivity. Mothers of children with hyperactivity reported significantly higher stress levels than did mothers of the comparison children, especially in the area of child characteristics (e.g., "There are some things my child does that really bother me a lot"). These researchers also found strong, positive correlations between parental perceptions of child deviancy and the degree of maternal stress reported. Similarly, in a study of 104 clinic-referred children with ADHD, Anastopoulos, Guevremont, Shelton, and DuPaul (1992) found that parents of children with ADHD commonly experience a great deal of stress in their parenting roles. In the study by Ralph et al. (1999), previously described in this section, the parent characteristic of stress was also highly
correlated with severe behavior problems. Looking at studies such as these, one can see
the intuitive relationship between child behavior problems and parental stress.

In the study by Egeland et al. (1990), which looked at child behavior problems
over time and associated family factors, families of children with behavior problems in
elementary school also had significantly more family stress than families whose
children did not have problems during elementary school. Campbell and Ewing (1990)
also found that the presence of an externalizing disorder at age 9 could be predicted by
ongoing family stress as first measured at age 3.

Family factors correlated specifically with ADHD include higher parental stress
(Mash & Johnston, 1990) and increased alcohol consumption (Pelham & Lang, 1993).
The increased alcohol consumption has been shown to, in part, be a direct function of
parents' stressful interactions with their children (Pelham & Lang). Mash and Johnston
have proposed a model of stress in parent-child interactions in which parent
characteristics, child characteristics, environmental characteristics, and parent-child
interactive stress all influence each other. They state that, with children with
hyperactivity, child characteristics are the “major and direct contributor” to the
interactive stress experienced by parents.

Previously, parental characteristics associated with poor intervention outcomes
were discussed. Another influential parent characteristic is high stress, with parents
experiencing more stress having greater nonresponse to behavior training programs and
poor treatment outcomes (Webster-Stratton, 1985b; Webster-Stratton & Hammond,
1990). Therefore, not only do parent and child behavior negatively affect each other, but
the presence of parental stress also negatively affects whether treatment for child
behavior problems is successful.

Treatment of Childhood Behavior Problems

Treatments for childhood behavior problems are varied. Here treatments will be
discussed for ADHD and also for CD and ODD (under the general heading of conduct
problems), and outcomes will be reviewed.

_Treatment of ADHD_

ADHD has been treated primarily through the use of medication, parent training
in contingency management methods, and the application of these methods in the
classroom. Treatments that have shown the greatest efficacy include these methods,
academic interventions, and educating the child’s family and teachers about ADHD.
However, none of these methods used alone address all of the problems a child might
have because of the disorder (i.e., problem behavior at home, problem behavior at
school, parents’ and teachers’ lack of knowledge of behavioral techniques, and
physiological causes of child symptoms). A combination of these approaches has long
been thought to be most beneficial because the various issues are addressed (Barkley,
1998a).

Of the various pharmacological treatments, stimulant medications are the most
commonly used. Rapport and Kelly (1993) found, following treatment with stimulant
medications, that improvements in the children’s behaviors included increased
attention, better impulse control, and diminished disruptive behavior. Swanson (1993)
and others have found clear evidence for short-term efficacy of stimulant medication, and some consider stimulants to be the treatment of choice for ADHD (Klein & Abikoff, 1997). However, there are disadvantages to the use of stimulants. Only 70-80% of children with ADHD who try stimulants respond positively to them, and the remaining experience either no response or adverse side effects (Swanson, McBurnett, Christian, & Wigal, 1995). Of those who do respond positively, many still fall outside the normal range of functioning. Additionally, stimulant medications, when effective, do not affect the full spectrum of ADHD symptoms. Attention, activity, and impulsivity are affected (Conners & Erhardt, 1998), as are associated conduct problems (McMahon & Wells, 1998), but academic achievement and peer relationships are typically not impacted (Pelham & Hinshaw, 1992; Swanson et al., 1995). Weiss and Hechtman (1993) asserted that there is little long-term evidence that stimulant medications alter the course of ADHD into adulthood, although a recent article in a national periodical alludes to the presence of data that suggests children with ADHD, when treated appropriately, are at lower risk for later substance abuse than children who are not medicated properly (Jensen, 2003). The most common side effects of stimulant medication include decreased appetite, insomnia, stomachaches, and headaches (Christophersen & Mortweet, 2001). Other medications used for ADHD are tricyclic antidepressants, which produce increased vigilance, sustained attention, decreased impulsivity, and lower disruptive and aggressive behavior (Barkley, 1998a), and antihypertensives, which produce a reduction of hyperactivity and overarousal (Hunt, Caper, & O'Connell, 1990).
Parental objection to medication has, in part, been spurred by the various side effects of medications, however minor. Many parents, therefore, are receptive to learning behavior management techniques. However, a combination of these two treatments has been recommended by many professionals (e.g., Carlson, Pelham, Milich, & Dixon, 1992) to not only improve the child’s behavior but the pattern of parent-child interactions as well. Barkley (1998a) described the research on parent training as supportive, but with “cautious optimism.” Parent training generally consists of teaching contingency management techniques, as in applying contingent reinforcement or punishment for appropriate or inappropriate behaviors. Reinforcement is typically in the form of praise or tokens, whereas punishment has typically taken the form of time out from reinforcement and loss of tokens.

Barkley's (1997) ADHD treatment program is designed for children ages 2-11 and is presented to families either individually or in groups. It addresses both ADHD and associated ODD behaviors. The program trains parents in behavioral techniques that are used contingently for compliance and noncompliance. Session topics include review of information on ADHD, causes of oppositional defiant behavior, developing and enhancing parental attention, attending to child compliance and independent play, establishing a home token economy, implementing time out for noncompliance, managing noncompliance in public places, improving child school behavior from home, and managing future misconduct. Studies using this training program report significant improvements in child behavior (Anastopoulos et al., 1993; Pisterman et al., 1989).

Review articles have endorsed parent-training programs such as that developed
by Barkley as an effective treatment for many types of behavior problems (Danforth et al., 1991; Frazier & Merrell, 1997). Danforth et al. described several studies that successfully used parent training to improve hyperactive behaviors in children, and Frazier and Merrell concluded in their review that the behavioral intervention techniques, such as those taught in parent training, are one of the effective treatments for ADHD.

Both in individual (e.g., Anastopoulus et al., 1993) and group settings (e.g., Dubey & Kaufman, 1978), parent training has been effective in improving various parent and child behaviors. Pisterman et al. (1989) found that parent training not only increased child compliance in 3- to 6-year-olds, but also increased the number of parental rewards given, the number of appropriate parental commands given, and amount of positive parental behavior, and decreased the number of inappropriate parental commands and parental directive behavior. Similarly, Pollard, Ward, and Barkley (1984) found an increase in positive parental attention following child compliance after parent training was complete. Dubey and Kaufman (1978) found that knowledge of behavior management skills among parents of children age 3 through 18 also improved significantly.

When parents are taught to effectively manage a child's ADHD symptoms in the home, similar improvements in the child's behavior are typically not seen in the classroom unless that setting is specifically targeted and the child's teachers receive training in behavior management procedures (Forehand et al., 1979). Therefore, many of the effective treatments discussed thus far incorporate a school behavior component.
A common treatment for problematic child behavior at school is a daily behavior report card, which is primarily managed by the parent, and consultation with teachers regarding the teacher’s responsibilities for the daily report card, behavior management strategies in the classroom, and helpful changes that can be made to the classroom environment (Barkley, 1997; Pelham & Sams, 1992). Implementing a daily report card involves the psychologist working with the parent and teacher to define the behavioral goals, choose three to five target behaviors to track (e.g., completes seat work), and decide how to record the behavior, where to set the criteria for success, and daily home-based rewards for successful school behavior.

In addition to using parents to target school behavior, classrooms can also be the primary target for intervention. Meta-analysis of classroom behavior management programs reveals effect sizes of 0.60 to 1.40 (DuPaul & Eckert, 1997). Interventions that were the most effective included manipulation of the curriculum, antecedent conditions (environmental variables), and peer tutoring. Typical manipulations to the curriculum include reducing task length, “chunking” tasks into smaller units, and setting quotas for the child to meet within a short time (DuPaul & Stoner, 1994; Pfiffner & Barkley, 1990). Another strategy involves providing rewards contingent on increased attention and on-task behavior in the classroom, although the expected positive result on increased work completion and accuracy is questionable (Barkley, 1998a).

In 1999, the results of the largest and most well-controlled ADHD treatment study to date were made available (MTA Cooperative Group, 1999a, 1999b). Subsequent papers that analyzed these data have been published (e.g., Conners et al.,
The researchers followed 579 children ages 7 to 10 who were diagnosed with ADHD, combined type, over 14 months of randomized treatment. The four groups received medication only (MED), behavioral treatment only (BEH), a combination of the two (COMB), or routine community care (CC). Children in the MED group received Ritalin at varying doses within a closely controlled design. Those in the BEH group received parent training (similar to programs discussed above, especially that of Barkley, 1997), school-based intervention (including consultation with teachers on behavior management and use of a daily behavior report card), and a summer treatment program (consisting of the use of point system, time out, social reinforcement, modeling, social-skills training, group problem solving, and sports-skills training). Children in the CC group were referred to community resources, which meant they did not receive the intensive treatment those treated internally received and were typically treated medically by their family physician. Approximately 67% of the children in the CC group received medication (Wells et al., 2000).

The original MTA results showed children in all four treatment groups improved over 14 months (MTA Cooperative Group, 1999a). The MED group improved more than the BEH group, but there were no statistically significant differences in improvement between the COMB and the MED groups. However, outcome measures in the COMB group were consistently superior to those in the MED group and children in the COMB group required lower dosages of medication. Both the COMB and MED groups were statistically superior to the CC group, and the COMB group was statistically superior to the BEH group. Parents in the COMB and BEH groups reported
higher treatment satisfaction than did those in the MED group. In Connors and others’ (2001) reanalysis of these results, it was found that when only parent and teacher-completed measures were used (direct observations, child-completed measures, and peer reports were excluded), the COMB group was statistically superior to all groups, including the MED group.

*Treatment of Conduct Problems*

Overall, family-based interventions (e.g., parent training, behavioral family therapy) have been the main interventions investigated for preadolescents with conduct problems. In their review of family-based interventions, McMahon and Wells (1998) report favorable outcomes for changes in parents’ and children’s behavior as well as in parental perception of the child’s adjustment, and these changes were shown to be maintained at follow-up. In addition to effecting change in the home environment, generalization of these favorable outcomes extended to untreated siblings, and untreated behaviors. In his review of treatments for conduct disorders in children, Kazdin (1997) found parent training to result in positive changes in parent and teacher reports of deviant behavior and direct observation of behavior at home and school, and he noted that treated children tended to fall within normal limits compared to peers and tended to maintain gains years later. Similarly, Patterson (1974) found that children’s deviant behaviors significantly improved after family-based intervention, and the group’s mean deviant behavior fell within the normal range. Other specific problems improved by parent training include tantrum behavior, aggressive behavior, sibling fighting, and everyday home problems (O’Dell, 1974). Outcomes also show that parent training
increases child compliance in children ranging from age 3 to 8 (Forehand et al., 1979; Forehand & King, 1977; Kelley, Embry, & Baer, 1979). Interventions for conduct problems that are implemented early in childhood (i.e., before the age of 5) have been found to be more effective than those implemented later in a child’s life and may have better long-term effects (McMahon & Wells).

The family-based interventions outlined for conduct problems are essentially the same as those for ADHD and reflect a social-learning-based parent training model. This approach has been widely used (e.g., Kazdin, 1995; Miller & Prinz, 1990) and its procedures vary, but core elements include: (a) training conducted primarily with parents; (b) emphasis on prosocial goals; (c) training in prosocial techniques; defining, monitoring, and tracking child behavior; training in applying positive reinforcement through methods such as parent attention and token systems; training in extinction and mild punishment procedures; training in giving clear commands; training in problem solving; and (d) use of didactic instruction, modeling, role playing, behavioral rehearsal, and structured homework exercises.

One such parent-training program that has a great deal of empirical support is parent-child interaction therapy (PCIT; Hembree-Kigin & McNeil, 1995). PCIT is a short-term intervention originally designed for children with conduct problems. PCIT has two phases, child-directed interaction (CDI), and parent-direct interaction (PDI). During the CDI phase, parents learn to provide positive attention contingent on appropriate play behavior while strengthening their positive relationship with their child. The PDI phase consists of helping parents improve child compliance by giving
effective commands and providing consistent consequences (e.g., praise or time out) for compliance and noncompliance. Currently, PCIT is a widely used treatment for children ages 2-6 with externalizing behavior problems, such as ODD and ADHD.

Empirical research supports both statistically significant and clinically significant changes in problem behaviors following PCIT (Eisenstadt, Eyberg, McNeil, Newcomb, & Funderburk, 1993; Eyberg, Boggs, & Algina, 1995), as well as long-term maintenance of treatment effects (Eyberg et al., 2001; Hood & Eyberg, 2003). For example, Eyberg et al. (1995) found statistically significant improvement in maternal report of child problem behavior and observed maternal praise, negative talk, and child compliance following PCIT for children ages 3-6. Significant improvements were also found in siblings of the target child, and parents reported high satisfaction with the treatment. Eisenstadt et al. found statistically significant improvement in parent report of problem behavior, child report of self-esteem, and observed child compliance, parent-initiated negative touch, and parent-child physical closeness in parents of 2.5 to 7-year-olds following PCIT. In their study of 1 and 2-year maintenance of improvements following PCIT, Eyberg et al. (2001) found that of 13 children ages 3-6 who met criteria for ODD, ADHD, or CD prior to PCIT, only two met criteria for those diagnoses at posttreatment. At 1-year follow-up, five children met criteria, and at 2-year follow-up three children met criteria. Parent report of problem behavior at posttreatment was significantly lower than at pretreatment, and remained so at 1- and 2-year follow-up. Also maintained were observed low incidences of child deviant behaviors and low incidences of parent physical and verbal negative behavior. Parent satisfaction
regarding the treatment program was also maintained after two years. In fact, the most recent follow-up study found that treatment gains have been maintained 3-6 years after treatment, and mother-reported severity of disruptive behavior has decreased with time (Hood & Eyberg, 2003).

Webster-Stratton developed a similar type of treatment program called BASIC (Webster-Stratton, 1981, 1982a, 1982b, 1984). This program is designed for parents of children ages 3-8, and uses videotaped examples to model parenting skills. Components include child-directed play used in PCIT, strategic use of differential attention, and effective use of commands, discipline, and consequences (Webster-Stratton, 2000). The program promotes parent self-efficacy by using parent group support, mutual problem solving, self-management, and a collaborative relationship with the therapist.

Research on the BASIC program has revealed significant improvement in parental attitudes and parent-child interactions, as well as significant reductions in child conduct problems (Webster-Stratton, 1982a, 1984, 1989, 1990, 1994; Webster-Stratton, Hollinsworth, & Kolpacoff, 1989). Other research on the program (Webster-Stratton, 1985a, 1985b) found that child participants experienced a significant reduction in noncompliance, deviancy, and severity of behavior problems as reported by mothers.

In 1987 Webster-Stratton added a supplement to her BASIC parent training program, ADVANCE, to improve parental interpersonal skills and impact family risk factors, such as depression and marital distress (Webster-Stratton & Hancock, 1998). In the late 1990s, Webster-Stratton developed a program called PARTNERS to be used with parents and teachers of 4-year-old children enrolled in Head Start (Webster-
Stratton, 1998), and later the program name was changed to Incredible Years (Webster-Stratton, Reid, & Hammond, 2001). The program was very similar to BASIC, with the addition of teacher-focused materials and changes that included designing the intervention to be preventative in nature and incorporating treatment components that take into account the multiple risk factors Head Start families have (e.g., low income). Children whose parents receive treatment have been found to have significantly fewer conduct problems and less noncompliance than control children, and teachers who completed the program had better classroom management skills (Webster-Stratton; Webster-Stratton et al.). Treatment gains were found to have been maintained 1 year after treatment (Webster-Stratton et al.).

Specific parenting skills have also been found to improve following parent training. Forehand and King (1977) found that, following parent training, mothers significantly increased the number of rewards given during interactions with their child (e.g., verbal praise and positive physical contact). Other researchers have found significant increases in maternal attention statements (verbal description of the child’s activity) and rewards provided during parent-child interactions following parent training (Forehand, Wells, & Griest, 1980). Significant decreases in beta commands (commands with which the child does not comply) and increased attention contingent on appropriate behavior has also been noted (Forehand et al., 1979, 1980). Similarly, Kelley et al. (1979) found improvements in the parent variables of appropriate instructions, attention to appropriate and inappropriate behavior, and interparental consistency following parent training. In her BASIC and ADVANCE programs, Webster-Stratton has found

Studies of parent training cited thus far have been delivered in either group (e.g., Webster-Stratton, 1998; Webster-Stratton et al., 2001) or individual (e.g., Eisenstadt et al., 1993; Schuhmann, Foote, Eyberg, Boggs, & Algina, 1998) format, and the effectiveness of both methods of delivery has been demonstrated. In addition, a few studies have specifically compared the effectiveness of group and individual delivery methods (Pevsner, 1982; Webster-Stratton, 1984). Webster-Stratton found that both individually treated families and group-treated families improved more than nontreated controls, and there were no significant differences in improvement between the individual and group formats. She did find, however, that the group format was more efficient and cost-effective (e.g., therapist time was 251 hours for the individual format and 48 hours for group format). Pevsner, in a parent-training program for child behavior problems, also found the group format to be more efficient. Parents in the group condition also changed problematic child behaviors more quickly than those in the individual condition and scored higher on a post-test measuring knowledge of behavioral principles as applied to children.

In their review of treatments for conduct problems, McMahon and Wells (1998) outlined several effective psychosocial interventions for overt conduct problems in addition to the family-based interventions (parent training) already discussed. These
include: community-based programs, school-based treatment, and skills training.

Effective psychosocial interventions for stealing, lying, and fire setting (covert conduct problems) included social-learning-based family therapy, combinations of response cost and positive reinforcement, and contingency management, among others. The community-based services of day treatment programs have also been shown to successfully treat preadolescent children with conduct problems. Important components of treatment include providing multimodal services such as contingency management and parent training.

School-based treatments for conduct problems have included classroom and playground behavior management programs, home-based reinforcement programs, and interventions for specific problem areas such as homework problems, noncompliance, and school bullying. One specific classroom behavior management technique involves praising appropriate behavior, such as the child raising his/her hand to speak, and ignoring inappropriate behavior, such as talking out of turn. Another technique involves establishing clear rules for expected behavior and providing concise directions to the children. Programmed instruction, pacing learning of new concepts or skills at the child’s own pace, is also widely used. Another effective technique is a combination of positive feedback (e.g., specific praise) and corrective feedback (e.g., informing the child of errors and how to correct them). Token economies, reprimands, time out, and response cost have also been used effectively. For example, Proctor and Morgan (1991) effectively used a response cost raffle procedure to reduce inappropriate behavior (talking out, out of seat, noncompliance, aggression, noise, and off-task) and increase
appropriate behavior (e.g., attending, working, volunteering, reading aloud, responding to questions, questioning the teacher). The procedure involved providing identified students with five raffle tickets at the beginning of each class and removing a ticket for each inappropriate behavior. Five minutes before the end of the period, remaining tickets were pooled and one was chosen. The student whose ticket was chosen was then able to choose a reinforcer that the entire class could enjoy (e.g., rest time, bubble gum). Each method heretofore mentioned, when used alone, has been demonstrated to be effective in changing child behavior, although there is more support for using a combination of treatments. A combination of treatment strategies is most likely to bring about change, and more specifically a combination of positive and negative techniques has been shown to work most effectively (McMahon & Wells, 1998; Shores, Gunter, & Jack, 1993).

Home-based reinforcement programs have also improved conduct problems at school (e.g., Kelley, 1990). With the home-school note, target behaviors are identified and monitored by the teacher at school. The child is then responsible for bringing the note home to receive prearranged consequences from the parents. The efficacy of this type of system has been shown over a variety of ages from kindergarten-aged through adolescence and over a variety of behaviors encompassing academic performance and classroom behavior, such as rule following, disruptive behavior, and discipline referrals to the principal (Rosen, Gabardi, Miller, & Miller, 1990; Abramowitz & O’Leary, 1991).

Skills training approaches have also been used to reduce conduct problems.
These methods, as outlined by McMahon and Wells (1998), emphasize changing skill deficiencies in children and have been constructed to reflect child development, in that behavioral skills are targeted in younger children and cognitive skills are targeted in older children. Whereas skills training programs in the past have stressed either behavioral skills (e.g., Michelson et al., 1983) or cognitive skills (e.g., Arbuthnot & Gordon, 1986), programs have more recently become more complex. For instance, multicomponent systems such as EQUIP for adolescents (Gibbs, Potter, Barriga, & Liau, 1996) may include social skills training, moral reasoning (knowing what one should do in a situation), and problem solving (e.g., generating alternative solutions), and use behavioral methods to monitor progress. Multicomponent interventions such as this have been found to be more effective in both the short and long term than those with single components. For example, Leeman, Gibbs, and Fuller (1993) researched the effectiveness of EQUIP in a sample of incarcerated 15- to 18-year-old male offenders and found significantly higher gains, lower recidivism rates 12 months after release from the facility, and improved social skills in institutionalized youth who completed the EQUIP program as compared to both no treatment and attention placebo control conditions.

However, Kazdin, Siegel, and Bass (1992) concluded that skills training treatments yield results that are not always replicated with across studies, do not bring the children's behaviors into normal levels compared to peers, and are not maintained over time. These researchers concluded that effects of skills training programs could be enhanced by combining such programs with parent management training (PMT).
Kazdin et al. evaluated the combination of problem-solving skills training (PSST) with PMT. The PSST package targets the child’s cognitive-behavioral skills in different interpersonal situations (e.g., social skills, problem solving), and Kazdin et al. found that the combination of PSST and PMT as compared to PSST or PMT alone produced a more marked impact on measures of child aggression, antisocial behavior, and delinquency. More children in the PSST + PMT condition were also considered within the normal range of functioning following treatment. However, children in all three conditions improved significantly in overall child dysfunction, prosocial competence, and aggressive, antisocial, and delinquent behavior. These improvements were also maintained at 1-year follow-up.

**Treatment Impact on Parent Mental Health**

In addition to child behavior and parental behavior management skills being improved by parent training, parents’ mental health (including stress) can also be affected. Anastopoulus et al. (1993) found that parents who completed a 9-week parent-training program for school-aged children with ADHD experienced a significant decrease in parenting stress and increase in parenting self-esteem, along with improvement in child behavior problems. Pisterman et al. (1992) also found reductions in parenting stress and increased parenting self-esteem (in addition to improved child behaviors) following a parent-training program. Kazdin others’ (1992) study on combining PSST and PMT yielded marked improvements in parental stress, depression, and other symptoms of parent dysfunction, in addition to improvements found in child
behavior. Parental improvements were maintained at 1-year follow-up, along with child improvements.

Parents who complete PCIT also report decreased stress following treatment (Eisenstadt et al., 1993; Eyberg & Robinson, 1982; Eyberg et al., 1995, 2001; Schuhmann et al., 1998). In their study of 64 families of 3 through 6-year-olds with a diagnosis of ODD, Schuhmann et al. found significant improvement in parent-related stress commensurate with significant improvements in child problem behavior after completion of PCIT. Eyberg et al. (1995) found similar results in a different sample of parents of children ages 3 through 6, as did Eisenstadt et al. in children ages 2.5 to 7.

Long-term maintenance of stress relief, however, does not appear to fare as well as long-term maintenance of improved child behavior. Eyberg et al. (2001) found that although there was a significant improvement in mother-reported stress associated specifically with the child (child-related stress) as well as stress not related to the child (parent-related stress) after PCIT, only parent-related stress remained statistically significantly lower at a 1-year follow-up. Moreover, neither measure of parental stress was statistically significantly lower at 2-year follow-up. However, due to a small sample size (13 families), these researchers also calculated effect sizes. Examination of effect sizes shows large improvement in both child-related and parent-related stress at post-treatment, 1-year follow-up, and 2-year follow-up. Finally, Webster-Stratton’s ADVANCE program, has been found to be effective in reducing maternal depression (Webster-Stratton, 1994).
In recent years, there has been a resurgence of comprehensive school-based programs for disruptive behavior disorders that take a public health and evidence-based perspective (Hunter, 2003). They have in common a team approach to intervention and the targeting of school-wide behavior rather than behavior of individual children.

One example of a comprehensive school intervention for general disruptive behavior is called Positive Behavioral Interventions and Supports (PBIS), which is team-based and comprehensive, targeting child functioning in multiple settings and situations within the school (Scott, 2001). The process typically involves training school personnel in identifying, teaching, and reinforcing school-wide behavioral expectations (Horner, Sugai, Lewis-Palmer, & Todd, 2001). Research indicates this approach has resulted in decreased office discipline referrals, fewer problem behaviors in less structured settings (e.g., cafeteria, hallway), and increased performance in academics. For example, an Oregon middle school implemented a school-wide PBIS intervention they called the High Five Program and saw a 47% decrease in office discipline referrals after 1 year and a 68% decrease after 5 years (Taylor-Greene & Kartub, 2000).

A similar approach called Responsive Advocacy for Learning and Life in Youth (RALLY) has been used for ADHD. The program targets all youth and stresses early detection and prevention, but does include additional intervention for targeted youth (Hunter, 2003; Noam, Winner, Rhein, & Molad, 1996). Those children receiving individualized intervention in addition to the general prevention intervention are assisted with organizational skills. Their teachers receive assistance in maintaining
consistent behavior management plans, and communication between the child/family and an outside physician is facilitated. Initial results indicate that children receiving this individualized intervention have decreases in truancy and increases in time spent on homework (Noam et al.). Additional evaluation of the program is currently underway (Hunter).

One school-based program for conduct disorder is Linking the Interests of Families and Teachers (LIFT; Reid, Eddy, Fetrow, & Stoolmiller, 1999). This intervention program provides treatment on a school-wide level, and targets antecedents of conduct disorder both at home and school. Students are instructed by LIFT staff in social skills and practice these skills in groups as well as during free play. Reid et al. conducted a study in which students were randomly assigned to either treatment with LIFT or no treatment. Those receiving treatment were observed to behave more appropriately on the playground and were rated more favorably by teachers than those who did not receive treatment.

Stress Management Training

As discussed earlier, stress is a common complaint among parents of children with behavior problems. Although parents of preschoolers in general experience a great deal of stress related to parenting, parents of children identified as having behavior problems report higher family stress than comparison families (e.g., Egeland et al., 1990). Mothers of children with ADHD report significantly higher levels of stress than mothers of children without ADHD (e.g., Anastopoulos et al., 1992; Mash & Johnston,
1983; Ralph et al., 1999). Stress management techniques have been developed to counteract stress in a variety of populations. The purpose of stress management, according to Cotton (1990), is to balance external stress of the individual and his/her ability to cope.

According to Brantley and Thomason (1995), stress manifests itself in three main areas: biology (e.g., physiological arousal), behavior (e.g., smoking or overeating), and cognition (e.g., thoughts that one is not able to cope). There are a variety of stress management techniques that target different outcome areas. Methods commonly used include progressive muscle relaxation (PMR), EMG biofeedback, autogenic training (AT), meditation methods, and cognitive methods (Lehrer et al., 1994).

Progressive muscle relaxation (PMR) was developed by Jacobson in the 1930s to improve hyperarousal and muscular tension. PMR consists of systematically tensing and relaxing muscle groups throughout the body while observing the sensations of tension and relaxation. Biofeedback was added to PMR in the 1980s to provide individuals with feedback regarding their physiological state.

In EMG biofeedback training, the trainee alters covert muscle activity and observes changes in a public (observable) stimulus that parallels the private event. Thermal biofeedback training consists of providing the trainee with a public signal that reflects small changes in peripheral temperature, and then instructing him/her to control the signal, and hence, his/her vascular behavior. Autogenic training (AT) involves the presentation of various statements by the trainer consisting of states of heaviness, warmth, and calmness in various parts of the body. After each statement, the trainee
repeats it to him/herself and attends to the described sensation.

Meditation and controlled breathing target the physical state. Meditation involves covertly repeating a word (mantra) to oneself while exhaling and observing one’s own verbal and breathing activity. With the technique of guided imagery, trainees are asked to construct scenes other than that of the training environment and to attend to feelings of relaxation including pulse and breathing. These scenes incorporate the senses of sight, sound, temperature, touch, and smell (Poppen, 1988). Techniques that target behavior center around attaining a healthier lifestyle (e.g., exercise, smoking cessation) and changing behaviors that precede or follow stress in order to lessen its impact. Finally, cognitive methods target the person’s stressful thoughts and alter the person’s appraisal of the stressful event.

One treatment program called Stress Inoculation Training, developed by Meichenbaum (1985), uses a variety of techniques. According to Fausel (1995), components of the treatment package include: (a) education about stress; (b) learning to self-monitor thoughts, images, feelings, and behaviors; (c) learning to problem solve using definition, consequence, anticipation, decision-making, and feedback; (d) rehearsal of direct action, emotion regulation, and self-control coping skills; (e) learning to use maladaptive responses as cues to implement coping strategies; and (f) practice imaginal and behavioral rehearsal of coping strategies both in vitro and in vivo.

Stress management techniques have been used successfully for a variety of problems and in a variety of settings. According to Lehrer et al. (1994), the methods typically used to reduce stress (those that have been described in this section) have been
found to be useful in treating various aspects of medical and behavioral disorders.

Somatic disorders treated with stress management techniques include hypertension, Raynaud's disease, dysmenorrhea, peptic ulcers, irritable bowel syndrome, and chronic pain. Stress management techniques have also been shown to decrease severity of atopic dermatitis (Habib, 1999), decrease symptoms of asthma (Hockemeyer & Smyth, 2002), reduce headache activity (Holroyd et al., 2001), decrease pain and depression in rheumatoid arthritis patients (Rhee et al., 2000) and improve hypertension (Garcia-Vera, Sanz, & Labrador, 1998). Stress management has also been shown to improve mood and decrease depressive symptoms (Cruess et al., 2002), decrease self-reported levels of anxiety, stress, and anger (Antoni et al., 2000), decrease psychological distress (Cruess, Antoni, Schneiderman et al., 2000) and reduce herpes simplex virus type 2 antibody titers in HIV-infected men (Cruess, Antoni, Cruess et al., 2000). Stress management has also been shown to increase serum testosterone levels (Cruess et al., 2001), reduce serum cortisol levels (Cruess, Antoni, McGregor et al., 2000), which are associated with better health outcomes. Research also shows that it can increase optimism and reduce prevalence of depression in women with breast cancer (Antoni et al., 2001).

Behavioral disorders treated with stress management techniques include insomnia, anxiety, anger and aggressive behavior, depression, substance abuse, and schizophrenia (Lehrer et al., 1994). Insomnia has been significantly improved through progressive relaxation, even into long-term follow-up (Lacks & Morin, 1992). Mild and moderately depressed individuals have experienced significant improvements in mood
following 10 weeks of regular aerobic exercise, which is widely considered a stress management technique (Fremont & Craighead, 1987). Panic and anxiety have also been greatly improved through the use of stress management, as in Barlow, Rapee, and Brown’s (1992) and Craske, Brown, and Barlow’s (1991) demonstrations of significant improvements in anxiety after progressive muscle relaxation both immediately after treatment and up to 2 years posttreatment. Similarly impressive long-term improvements have been demonstrated by Deffenbacher, Story, Stark, Hogg, and Brandon (1987) and Deffenbacher (1988) in their treatment of college students with anger problems using cognitive and relaxation coping skills. Techniques used included progressive relaxation training, relaxation without tension, breathing-cued relaxation, cue-controlled relaxation, and relaxation imagery. Again, long-term maintenance of improvements were maintained at 1-year follow-up. Individuals with schizophrenia have also been found to be capable of learning stress management techniques, reliably reducing muscle tension and general anxiety, and thus ameliorating secondary symptoms of the disorder (Lehrer et al., 1994; Nigel & Jackson, 1979; Pharr & Coursey, 1989; Van Hessel, Bloom, & Gonzalez, 1982). In fact, stress management has been found to reduce the number of hospital admissions in persons with schizophrenia for a year following stress management treatment (Norman et al., 2002).

In addition to being used for medical and psychological disorders, stress management has been used in business settings (Munz, Kohler, & Greenberg, 2001). By reducing their stress, employees in these settings experienced an improvement in their health and their productivity. Other occupational groups targeted successfully with
stress management training include the police force (Le Scanff & Taugis, 2002), high-risk maintenance workers (Peters & Carlson, 1999), and female physicians (Winefield, Farmer, & Denson, 1998).

Stress management has also been shown effective in improving feelings of depression and reducing anger and feelings of isolation in spousal caregivers of Alzheimer’s patients (Sala-Disesa, 2002). In another study using stress management in a family-type setting, Fausel (1995) used stress inoculation training with stepcouples. The researcher found that 62% of subjects who completed the Index of Clinical Stress (ICS) both at pretest and posttest had lower scores at posttest. Of those, 12% lowered their scores from above the clinically significant cutoff score to below it. However, the study did not use control groups and therefore no statistical significance testing was done.

The robust effects of stress management techniques are perhaps more fully demonstrated by a study by Timmerman, Emmelkamp, and Sanderman (1988). Rather than choosing a sample of individuals based on medical diagnoses, psychological diagnoses, or relative demand in occupation, these researchers chose participants randomly from a community. Subjects assigned to treatment attended eight weekly treatment sessions consisting of instruction on changing unhealthy life styles, relaxation skills including muscle relaxation, problem-solving techniques, and social skills. Although the treatment and control groups had similar risk profiles, the treatment group experienced significantly less distress, less trait anxiety, fewer daily hassles, and more assertiveness as compared to the control group at end of treatment.
In a review of the effectiveness of stress management, Lehrer et al. (1994) found that specific techniques produced corresponding outcome effects (i.e., cognitive methods had specific cognitive effects). The effectiveness of the intervention, therefore, depends on what effects are being measured for outcome. The superiority of one method over another is most clear when the method clearly matches the target area (i.e., using muscular techniques for tension headaches; Carlson & Hoyle, 1993), and is less clear when the method does not specifically target the problem area (i.e., using meditation for tension headaches; Lehrer et al.).

For muscular effects, PMR or EMG appear to be more effective than AT or thermal biofeedback (e.g., Gamble & Elder, 1983; Schneider, Rawson, & Bhatnager, 1987). For autonomic effects, AT or thermal biofeedback appears to be more effective than PMR or EMG biofeedback (e.g., Gamble & Elder; Lehrer, Atthowe, & Weber, 1980). Mantra meditation was found to be more effective than heart rate biofeedback or AT on the areas of autonomic arousal and generalization (e.g., Gallois, 1984; Pollard & Ashton, 1982). Poppen (1988) found similar conclusions regarding mantra meditation, but upon critical review found that meditation had no greater effects than asking subjects to rest quietly.

Overall, the various stress management techniques seem to produce specific positive effects, and these positive effects have been shown with a variety of techniques used for a variety of problems. Cognitive interventions appear to be most effective when the assessment of improvement involves self-report and interpretation of symptoms, as with the problems of pain, anxiety, insomnia, or anger. Some of these
same problem areas, however, have behavioral components that are best helped when the intervention has a behavioral focus. Because of overlap such as this, treatment programs that target multiple components of stress appear to be most appropriate.

Summary

Parents of children with behavior problems report a great deal of stress, a problem that has been improved using stress management training. A variety of behavior problems in children have been improved with behavioral parent training, and early interventions are recommended for more effective prevention of long-term behavior problems. Because individual and group parent behavioral training appear to be equally effective, the preferred approach may be group interventions due to their greater efficiency. Behavioral parent training has been shown in a very limited number of studies to reduce parental stress, but several parental factors such as high stress are indicative of low success in parent training. Therefore, a parent training procedure that also addresses parental factors such as stress may improve the efficacy of such an intervention.
CHAPTER III

METHODS

Participants

Parents receiving services through Bear River Head Start of Northern Utah were given the opportunity to volunteer for parenting groups in the spring of 2000 and the spring of 2001. Due to a lack of subjects in one treatment group, parents of preschoolers receiving services through a local state disabilities office were recruited for the final treatment group held in fall of 2001.

Parents participated in one of two treatment groups; one group received parent training followed by stress management training and the other received the treatments in the opposite order. The group that received parent training first had 12 parents, and the stress-management-first group had nine parents. Parents in the parent-training-first group consisted of seven mothers and five fathers. All parents in the stress-management-first group were mothers. Chi square analysis indicated that this difference is statistically significant ($p = .026, f = 5.82$). No other statistically significant demographic differences were found between the two groups. All parents were Caucasian, as were all but one child. Most parents in both groups were married. The mean household size for the parent-training-first group was 4.5; the mean household size for the stress-management-first group was five. Mean net monthly income was $1,395.00 for the parent-training-first group and $1,536.25 for the stress-management-first group. Most parents in both groups had completed some college. The majority of
parents overall had not attended parenting classes in the past. Approximately half of the parents in the parent-training-first group reported that they were more interested in the parent-training component, whereas most parents in the stress management training first group reported that they were more interested in the stress management-training component. See Table 1 for complete demographic information.

Table 1

*Demographic Information for Parents in Parent Training Groups*

<table>
<thead>
<tr>
<th>Variables</th>
<th>Parenting training n</th>
<th>Stress management n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number completed</td>
<td>12</td>
<td>9</td>
</tr>
<tr>
<td>Ethnicity: Caucasian</td>
<td>12</td>
<td>9</td>
</tr>
<tr>
<td>Relationship*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mothers</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>Fathers</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>Divorced/separated</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Mean household size</td>
<td>4.5</td>
<td>5</td>
</tr>
<tr>
<td>(SD = 1.38)</td>
<td>(SD = 1.69)</td>
<td></td>
</tr>
<tr>
<td>Mean net monthly income</td>
<td>$1,395.00</td>
<td>$1,536.25</td>
</tr>
<tr>
<td>(SD = $553.21)</td>
<td>(SD = $530.44)</td>
<td></td>
</tr>
<tr>
<td>Education attained</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Didn’t complete high school</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>High school diploma</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Some college</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Completed college</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Previous parenting class?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>No</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>Component most appealing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stress management</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Parenting training</td>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>

*Statistically significant difference between groups at \( p < .05 \).
All children who were the targets of the intervention were age 4 or 5. Child gender was evenly split between boys and girls in both groups. Because all five fathers who completed treatment were part of a mother-father dyad, five children were assessed twice at each observation period (once by mother and once by father). Therefore, although 12 child assessments are reported for the parent-training-first group, only 7 are for unique children. Only one child was reported to have a previous mental health diagnosis. See Table 2 for complete child demographic information.

Limited child demographic information was obtained from teacher assessments (see Table 3). Rating scales were completed on 14 males and 15 females. Data was obtained on seven children whose parents were in the parent-training-first group, five children whose parents were in the stress-management-first group, and 17

Table 2

<table>
<thead>
<tr>
<th>Demographic Information for Children as Reported by Parents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Variables</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>Child age</td>
</tr>
<tr>
<td>Age 4</td>
</tr>
<tr>
<td>Age 5</td>
</tr>
<tr>
<td>Child gender</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Child ethnicity</td>
</tr>
<tr>
<td>Caucasian</td>
</tr>
<tr>
<td>African American</td>
</tr>
<tr>
<td>Diagnoses of mental disorder</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>
Table 3

*Child Demographic Information from Teachers*

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent training first</td>
<td>7</td>
</tr>
<tr>
<td>Male</td>
<td>3</td>
</tr>
<tr>
<td>Female</td>
<td>4</td>
</tr>
<tr>
<td>Stress management first</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>3</td>
</tr>
<tr>
<td>Female</td>
<td>2</td>
</tr>
<tr>
<td>No treatment</td>
<td>17</td>
</tr>
<tr>
<td>Male</td>
<td>8</td>
</tr>
<tr>
<td>Female</td>
<td>9</td>
</tr>
</tbody>
</table>

children whose parents signed up for parent training groups but did not attend any of the meetings. No teacher assessments were obtained for children whose parents were recruited through the disabilities services agency.

Information was gathered on Head Start through their national website in order to determine if parents and children who participated in this study were representative of the population from which the sample was obtained. Head Start accepts preschool-aged children whose families have a yearly income below the poverty line, whose families receive public assistance, or who are in foster care. Families of slightly higher income can also participate if space is available at their local Head Start agency. The mean family income for both groups are within the poverty line for household sizes of four and five in the years during which groups were held. According to the U.S. Department of Health and Human Services, in the year 2000 the poverty line for a family size of four was $17,050 and for a family size of five was $19,950. In the year 2001 the poverty line for a family size of four was $17,650 and for family size of five
was $20,670. Therefore, even with non-Head Start participants included, participants in this study met criteria for being impoverished. Unfortunately, no other information regarding demographics for Head Start was located (e.g., mean income, child ethnicity).

Measures

Prior to the first group meeting, parents and teachers were asked to complete several assessments. Teachers completed the Disruptive Behavior Disorders Rating Scale (DBDRS)--Teacher Form and the Preschool and Kindergarten Behavior Scales (PKBS). Parents completed the Disruptive Behavior Disorders Rating Scale--Parent Form, the Child Behavior Checklist (CBCL), the Parenting Stress Index (PSI), the Perceived Stress Scale (PSS), the Parenting Sense of Competence Scale (PSOC), and the Marlowe-Crown Social Desirability Scale. The same scales were completed after the first of the two treatment components and then again after all of the training were complete (see ANOVA tables in Appendix A). The Therapy Attitude Inventory (TAI) was added to the final set of parent assessments. Copies of noncopyrighted measures can be found in Appendix B.

*Disruptive Behavior Disorders Rating Scale--Parent Form*

The parent form of the DBDRS contains 37 items. Items assessing symptoms of ADHD are from the ADHD Rating Scale--IV and are based on the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; 1994)* criteria for ADHD. These items contribute to a total ADHD score as
well as two subscale scores, Inattentive and Hyperactive/Impulsive. As reported by the authors of the ADHD Rating Scale--IV (DuPaul, Power, Anastopoulos, & Reid, 1998), these scores have adequate test-retest reliability (Pearson product-moment correlations of .78 and above over a 4-week period), internal consistency reliability (coefficient alphas of .86 and above), and adequate convergent and construct validity. Other items on the DBDRS parent form are based on DSM-IV criteria for ODD and CD. There is no normative information for these components. However, items are based directly on criteria for these disorders as listed in the DSM-IV and authors (e.g., Barkley, 1997) advocate their use as a screening measure.

*Child Behavior Checklist (CBCL)*

The CBCL contains 120 items and broadly assesses childhood emotional and behavior problems. Ratings of the items produce a total score, two composite scales (internalizing and externalizing), and eight subscale scores (withdrawn, anxious/depressed, somatic complaints, social problems, thought problems, attention problems, aggressive behavior, and delinquent behavior). The author (Achenbach, 1991) reports adequate test-retest reliability (greater than .80 for one week), high internal consistency reliability (.90s), and adequate construct and convergent validity. Intraclass correlations for interparent agreement and inter-interviewer reliability were in the .90s. High concurrent correlations with related instruments (e.g., Conners’ Parent Rating Scale) has been found, along with strong discriminant validity. The CBCL is the standard against which the validity of many other assessment tools are measured (Edelbrock & Costello, 1988).
**Parenting Stress Index (PSI)**

The PSI (Abidin, 1995) contains 120 items and measures parent stress and parent satisfaction. Items measuring parent stress primarily focus on the parent-child relationship. There are two domains of the PSI--the Child Domain and the Parent Domain. The author provides extensive reliability and validity data and reports adequate reliability and validity, with the internal consistency for domain scores .90 or higher. Test-retest reliability for the total score ranges from .65 for a 1-year interval to .96 for intervals from 1 to 3 months. Coefficient alpha was .90 and .93 for Child Domain and Parent Domain, respectively. Validity of the PSI has been demonstrated through correlations between the PSI and 92 other measures of parent and child functioning (e.g., CBCL, Beck Depression Inventory, and Child Abuse Potential Inventory), and scores have been shown to be sensitive to reductions in stress following parent training (Abidin).

**Perceived Stress Scale (PSS)**

The PSS contains 14 items that measure the extent to which life situations over the past month are perceived as stressful. The authors (Cohen, Kamarck, & Mermelstein, 1983) conducted reliability and validity studies on three samples of college students and report internal consistency reliability to be approximately .85; coefficient alpha reliability to be .84, .85, and .86 in each of the three groups; and test-retest reliability over a two-day period to be .85. Concurrent and predictive validity have also been confirmed (Fernandez-Ballesteros, 2003), with the PSS predicting success in a smoking cessation program (Glasgow, Mizes, Klesges, & Pechacek, 1985).
and being highly correlated with scores on the College Student Life-Event Scale (CSLES; Cohen et al., 1983).

Parenting Sense of Competence Scale (PSOC)

The PSOC contains 16 items that measure the degree to which parents agree with statements that reflect parenting efficacy and parenting satisfaction. These two areas comprise the two subscales. The authors (Johnston & Mash, 1989) report adequate internal consistency (.75 for satisfaction, .76 for efficacy, and .79 for the total score). The authors have found a negative relationship between scores on the CBCL and PSOC, with higher levels of child problem behavior being correlated with decreased parental efficacy and satisfaction.

Marlowe-Crowne Social Desirability Scale (MCSDS)

The MCSDS is a 33-item self-report questionnaire that measures the degree to which individuals attempt to present themselves in a socially desirable manner. The MCSDS was used in this study in order to help make conclusions regarding the accuracy of parent self-report. Items are presented in a forced-choice format (true-false). High scores suggest a tendency to give socially desirable answers to questions. Adequate reliability has been reported, with internal consistency (Kuder-Richardson reliability) at .88 and test-retest correlations of .89 (Crowne & Marlowe, 1960). Crowne and Marlowe found correlations with the Edwards Social Desirability Scale of .35, which they reported to be significant at the .05 level. The authors also computed
correlations between the MCSDS and various subscales of the Minnesota Multiphasic Personality Inventory (MMPI). They reported that the correlation of .40 with the MMPI's K scale (test-taking attitude) was significant at the .05 level, and the correlation of .54 with the L scale (lie) was significant at the .01 level. The authors concluded that the MCSDS-MMPI correlations “more accurately indicate the amount of MMPI scale variance which may be attributed to differences in the need to give socially desirable responses” (p. 353). The MCSDS is the most widely used measure of socially desirable response tendency (Reynolds, 1982).

*Therapy Attitude Inventory (TAI)*

The TAI consists of 10 items that measure consumer/parent satisfaction with a parent-training program. Parents rate the degree of satisfaction they feel with the program and with their child’s progress. The author (Eyberg, 1993) reports satisfactory internal consistency reliability (.88) and adequate discriminant validity for sensitivity to treatment effects. For the purposes of this treatment study, the TAI was revised to reflect both behavioral parent training and stress management training. Items on the original TAI include wording specific to parent training (e.g., “Regarding techniques for teaching my child new skills, I have learned...”). Revising the measure to include attitudes toward the stress management portion of training involved adding items identical to the original items but with pertinent wording changed (e.g., “Regarding stress management skills, I have learned...”).
Disruptive Behavior Disorders Rating
Scale--Teacher Form

The teacher form of the DBDRS consists of 26 items that are identical to the items that assess ADHD and ODD symptoms on the parent form. Items assessing CD are not included. As with the parent form of the DBDRS, items assessing symptoms of ADHD are from the ADHD Rating Scale--IV and are based on DSM-IV criteria for ADHD. These items contribute to a total ADHD score as well as two subscale scores, Inattentive and Hyperactive/Impulsive. As reported by the authors of the ADHD Rating Scale--IV (DuPaul et al., 1998), these scores have adequate test-retest reliability (.88 for hyperactivity-impulsivity, .89 for Inattention, and .90 for the Total score over a 4-week period), and adequate to excellent internal consistency reliability (coefficient alpha scores of .88 for hyperactivity-impulsivity, .96 for inattention, and .94 for the total score). Interrater agreement between parents and teachers was moderate (total score = .41, inattention = .45, and hyperactivity-impulsivity = .40). Other items on the DBDRS teacher form are based on DSM-IV criteria for ODD. There is no normative information for this component.

Preschool and Kindergarten Behavior Scales (PKBS)

The PKBS consists of 76 items that measure social adjustment and various problem behaviors. The Social Skills scale assesses peer-related and adult-related forms of social adjustment and is divided into three subscales: social cooperation, social interaction, and social independence. The Problem Behavior scale assesses internalizing and externalizing forms of problem behaviors and is divided into four subscales: self-
centered/explosive, attention problems/overactive, antisocial/ aggressive, social withdrawal, and anxiety/somatic problems. The author (Merrell, 1994) reports high internal consistency reliability ranging from .81 to .97, moderate to high test-retest reliability over a 3-week period (.58 to .87) and 3-month period (.36 to .78), adequate content validity, and moderately to very strong construct validity. Interrater reliability between teacher and parent was .16 for the Problem Behavior Total and .38 for the Social Skills Total, whereas between teacher and teacher aide it was .48 for Social Skills and .59 for Problem Behaviors. Convergent validity was demonstrated between the PKBS and the Social Skills Rating System, with correlations of .76 between the two Social Skills scores and .83 between the two Problem Behavior scores.

Session and Program Rating Scales

Session rating scales were developed to be filled out at the end of each session. Rating scales consisted of eight statements, four of which pertained to the current session (e.g., “The information presented today was helpful”) and the other four of which pertained to the previous session (e.g., “Last week’s in-class practice was worthwhile”) and what happened between the last session and the current session (e.g., “I tried last week’s skills outside of class”). Parents respond to these eight statements on a Likert-type scale ranging from 1 to 5, with 1 being “not at all” and 5 being “very much.” Items not referring to the current session had the additional option of “NA,” or “not applicable” since there may not have been a previous session (i.e., the form was completed after the very first session) or the parent may not have attended the previous session. The session rating scales also had four open-ended questions: What did you
learn in today’s class that was useful? What could have been improved in today’s class? Do you think you can use what you learned today at home? (Why or why not?) What else would have been helpful to cover in today’s class?

A program rating scale was also constructed in order to learn more about what parents thought of the stress management program developed for this project. This was done for the stress management program and not the parent training program because using stress management for parental stress is new, whereas parent training for parents is a well-established treatment. Based on the session rating scale previously described, this form had two statements on a Likert-type scale (1 = not at all, 5 = very much), four open-ended questions, and a list of the six main stress management topics beside which parents were to mark whether the topic was helpful (+) or unhelpful (-).

**Attendance Questionnaire**

Due to high dropout rates, an additional questionnaire was developed at the end of the first round of classes in order to gather more information about what factors contributed to attendance problems. The questionnaire consisted of a list of potential factors, with blanks for parents to fill in others not listed, and another column of blank spaces for parents to give suggestions for what the experimenter could have done to improve their attendance. Factors listed on the questionnaire included: lack of child care, day of class, time of class, too many classes, not enough incentives (e.g., prizes, gift certificates), lack of motivation, information not useful, class wasn’t what I expected, too much class-related work, too many commitments (not related to class), unexpected events, illness, transportation problems, and uncomfortable in this setting.
Procedures

Parents receiving services through Bear River Head Start of Northern Utah were given the opportunity to volunteer for parenting groups. A preschool population was used for this study because of the acknowledged need for early intervention (Campbell, 1990), the long-term efficacy of early intervention (Yoshikawa, 1994) and the link between low income (a prerequisite for enrollment in Head Start) and stress. The groups were announced in parent meetings and through newsletters that were sent home with each child’s school papers. Teachers and Head Start home visitors were also encouraged to refer parents whom they felt would be good candidates for the groups, and phone contact was attempted with all parents in the Head Start system. A minimum enrollment of 10 parents in each of the two treatment groups was desired. Any parent interested in attending the group meetings was welcome.

Even though more parents than were needed stated they would attend the meetings, several enrolled parents never attended the first meeting and many parents who attended the meetings dropped out at various stages of the training. More than 73 Head Start families were personally contacted and spoken to by the researcher, and fliers advertising the groups were sent home with every child enrolled in Head Start. Many personal contacts resulted in actual conversations, while some involved no reciprocal contact (i.e., left message on answering machine, received no answer, received busy signal, or phone disconnected). If an attempt at contact was unsuccessful, multiple attempts were made on subsequent days. Based on these phone conversations, 47 parents committed to attending sessions. At least 13 of these parents never attended
any sessions. Thirty-four parents attended the first session, half of whom dropped out. See Figure 1 for flowchart.

Because of the difficulties in retaining parents in the first round of parenting groups, one more group was started a few weeks after the first two began and the treatment order was decided by the researcher based on which group appeared to have the fewest members at the time. The new group meeting took place during the day because of the high number of parents who stated that they would attend if meetings were held during the day. Only a few of the parents who expressed interest actually attended the first meeting and only one parent came to the second meeting. Therefore, the third group was canceled.

![Figure 1](image_url)

*Figure 1.* Flowchart showing parent contact and commitment by location.
Approximately 6 months later the same procedure was followed to begin two new groups, and the same difficulties arose. After 11 weeks of running both groups, there still were not enough parents in one group to fulfill the goal of 10 completers. Approximately 1 year later it was tried again, but it was thought that Head Start was not a good prospect for recruiting and keeping enough parents to finish the project. Therefore, the researcher decided to recruit parents of preschoolers who were receiving services through a local state disabilities office. One group was run in order to fill the quota for the stress-management-first group and almost all of the parents who attended the first meeting stayed through the end.

Similar recruitment procedures occurred for parents connected to the disabilities services agency (fliers were distributed to families by case workers), with 16 parents being personally contacted by phone, nine parents enrolling, six attending the first session, and four completing the entire treatment (see Figure 1). One parent left in the middle of the first session, stating she was experiencing personal problems and would not be able to attend sessions after all. Another parent who completed all but the last session had an unexpected conflict in schedule, and she neither made up the session nor completed the final assessment packet. Therefore, the stress-management-first group still only had nine completers in all.

Demographic information for parents who dropped out after the first assessment versus parents who stayed in treatment for at least the first and second assessments are shown in Table 4. Chi-square analysis indicated that the two groups differed significantly different on which treatment component they found most appealing.
Table 4

Demographic Information for Those Who Dropped Versus Those Who Stayed

<table>
<thead>
<tr>
<th>Variables</th>
<th>Stayed $n^a$</th>
<th>Dropped $n^b$</th>
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<tr>
<td>Ethnicity:</td>
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<tr>
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<td>11</td>
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<tr>
<td>Native American</td>
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<td>1</td>
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<tr>
<td>Relationship</td>
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<td></td>
</tr>
<tr>
<td>Mothers</td>
<td>19</td>
<td>9</td>
</tr>
<tr>
<td>Fathers</td>
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<td>1</td>
</tr>
<tr>
<td>Other parent</td>
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<td>2</td>
</tr>
<tr>
<td>Marital status</td>
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<tr>
<td>Married</td>
<td>19</td>
<td>9</td>
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<tr>
<td>Divorced/separated</td>
<td>5</td>
<td>3</td>
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<tr>
<td>Mean household size</td>
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<td>5.11</td>
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<tr>
<td></td>
<td>$(SD = 1.49)$</td>
<td>$(SD = 1.75)$</td>
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<tr>
<td>Mean net monthly income</td>
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<td>$1,753.58$</td>
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<tr>
<td></td>
<td>$(SD = 534.68)$</td>
<td>$(SD = 1,087.24)$</td>
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<tr>
<td>Completed college</td>
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<td>1</td>
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<td>Previous parenting class?</td>
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<td></td>
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<tr>
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<td>3</td>
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<tr>
<td>No</td>
<td>12</td>
<td>9</td>
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<tr>
<td>Component most appealing*</td>
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<td></td>
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<td>Stress management</td>
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</tr>
<tr>
<td>Native American</td>
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</table>

$a =$ stayed for at least first and second assessments  
$b =$ dropped after first assessment  
* Statistically significant difference between groups at $p < .05$
(p = .025). The group that stayed for at least the first two assessments had 14 parents say they preferred SMT, whereas the group that dropped after the first assessment had two parents said they preferred SMT. Parents who reported they preferred parent training were evenly split between the two groups (n = 7). Therefore, preference for PT did not distinguish the two groups but preference for SMT did.

A comparison group, pretest-posttest, quasi-experimental design was used for this study. One group had four weeks of stress management training followed by seven weeks of parent training, while the other group received these treatments in reverse order, according to the timeline and treatment and testing schedule presented in Figure 2. Treatment involved both parent training and stress management training. Stress management training lasted 4 weeks, and parent training lasted 7 weeks. All parents received both treatments, with approximately half receiving parent training before stress management training and the other half receiving stress management training before parent training.

Teachers assessed three groups of children. These groups were (a) children whose parents were in the parent-training-first group, (b) children whose parents were in the stress-management-first group, and (c) children whose parents originally signed up for the parenting groups but did not attend any sessions. For the latter group’s second assessment (corresponding with the other groups’ posttreatment 1 assessment), children were randomly assigned to be evaluated by their teacher after either 4 weeks or 7 weeks.

The first two groups were held at separate Head Start locations in Logan, Utah
and Smithfield, Utah. In these two groups participating parents were assigned to groups primarily based on proximity to those sites. However, if a parent was not able to attend the closer class on the assigned night and was willing to drive to the farther site, they did so. Beginning each group during the same week, even though treatment phases lasted a different number of weeks, resulted in the observation for posttreatment 1 occurring at different times and the comparison of these measures for each group spanning a different amount of time (see Figure 2).

Stress management training involved teaching a variety of skills such as relaxation training, cognitive interventions (i.e., identifying irrational beliefs), and behavioral interventions (i.e., assertiveness training and time management). Parent training closely followed Barkley’s (1997) treatment protocol and involved teaching such skills as positive reinforcement, time out, and the use of privileges. Groups were held once per week and lasted approximately 1.5 to 2 hours each. Throughout treatment, all parents received a phone call once a week from the researcher. The purpose of the

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<th>Week</th>
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<th>1</th>
<th>2</th>
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<tr>
<td>SMT First</td>
<td>Opre</td>
<td>Xa</td>
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<tr>
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<td>Opost2a</td>
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</tbody>
</table>

O = Observation (assessment)
Xa = Stress Management Training begins
Xb = Parent Training begins
" = Current treatment continues

Figure 2. Research design and time of assessments.
phone calls was to assess the parents’ progress, remind them to use the skills taught thus far, and field questions. At the end of each session, parents were asked to complete session rating scales in order to provide the researcher with information about the usefulness of each session and skills learned, as well as the leader’s effectiveness. Homework assignments were given each week.

Stress management sessions included lecture, discussion, and practice of that day’s skills. Handouts were provided for each topic. Outlines of each session can be found in Appendix C; parent handouts and homework can be found in Appendix D. Details of each session were as follows:

**Week 1: Introduction and Overview**

1. Definition of Stress
2. Components of Stress (worksheet to be handed in next week)
3. Three Phase Model
   - Phase I: Occurrence of stressor
   - Phase II: Response to Stressor—Physical, Emotional, and Cognitive Reaction
   - Phase III: Personal Interpretation of Stressor
4. Homework: Components of Stress worksheet

**Week 2: Relaxation Training**

1. Progressive Muscle Relaxation (PMR)
2. Deep Breathing
3. Imagery
4. Homework: practice PMR, deep breathing, and imagery

**Week 3: Cognitive Interventions**

1. Albert Ellis’ A-B-C’s: activating event, belief, consequence, different belief, and emotional consequence
2. Categories of Irrational Beliefs
3. Stress Inoculation
a. Prepare self for stressor by developing self-statements
b. Confront and handle the stressor
c. Cope with feeling overwhelmed
d. Reinforce self for use of self-statements to cope

4. Homework: Irrational Beliefs worksheet

Week 4: Behavioral Interventions

1. Assertive Interpersonal Interactions: assertiveness training
2. Time Management
   a. Make lists of things one has to do and wants to do. Choose what to do by
      alternating items on list.
   b. Make “to do” lists and prioritize items
   c. Schedule “down time”
   d. Avoid activities that waste time

3. Aerobic Exercise
4. Healthy Lifestyle
5. Tips to Improve Sleep
6. Homework: complete daily schedule

Parent training sessions involved lecture, demonstration, discussion, video, and
role play. Handouts were provided for each topic. Details of each session were as
follows.

Week 1:

1. Introduction
2. Using Positive Reinforcement to Increase Appropriate Behavior
3. Homework: child behavior logs, increase positives for good behavior

Week 2:

1. Child’s Game: 5 minutes of child-directed play (parent follows child’s lead)
   using positive interaction style (providing praise, reflecting appropriate
   statements, describing what child is doing, imitating appropriate play, and
   avoiding commands, reprimands, and negative statements)
2. Homework: child behavior logs, practice Child’s Game and complete logs
Week 3:

1. How to Manage Behavior with Positive Reinforcement and Differential Attending
2. Homework: child behavior logs, practice Child’s Game and complete logs

Week 4:

1. Ignoring Negative Behavior
2. Setting Limits
3. Giving Effective Commands

Homework: child behavior logs, practice Child’s Game and complete logs, use effective commands

Week 5:

1. Effectively Using Time Out
2. Homework: child behavior logs, practice Child’s Game and complete logs

Week 6:

1. Other Discipline Techniques
   a. Using Privileges
   b. Token Economies
   c. Extending Principles Outside the Home
2. Homework: child behavior logs, complete privilege worksheet

Week 7:

1. Assessments
2. Wrap-up
3. Open Discussion
4. Drawing for Door Prizes
5. Homework: child behavior logs

Treatment integrity checks were completed for 33 of the 47 sessions. Twenty-two sessions were audio taped and listened to later by a research assistant, and a research assistant who recorded integrity as each class progressed attended 11 sessions. Information from these 33 sessions was checked against the researcher’s session
checklists. It was determined that 100% treatment integrity was obtained for all 33 sessions.

Incentives were given at each session to those parents who attended. Parents who missed a class were required to attend make-up sessions. Incentives for parents in the Head Start groups included childcare reimbursement, mileage reimbursement, and free food and drinks on site, all of which were provided by the Head Start organization. Parents at the disabilities agency were able to utilize on-site daycare services provided by consumers and their job coaches. At each of the meetings both the Head Start groups and the group at the disabilities agency were able to participate in drawings for coupons and gift certificates donated by local organizations. At the first treatment session, parents were told they would have a chance of winning an extra incentive for having perfect attendance throughout the entire 11 weeks of treatment. Research grant money was used to purchase $20 gift certificates from local stores, which were provided to five parents who, as of the last session, had perfect attendance (did not need to attend any make-up sessions). Out of the six total groups that were run, 10 of the parents who completed treatment had perfect attendance. However, two of these groups had four parents with perfect attendance on the last day and at the time grant money was not available to purchase the gift certificates. On these occasions, the groups that had participants with perfect attendance put their names in a hat and one name was drawn. The two parents whose names were drawn on these two occasions were provided with a gift certificate purchased by the researcher.
CHAPTER IV

RESULTS

Parent Measures

Group means were calculated for the Marlowe-Crowne Social Desirability Scale (MCSDS), on which higher scores indicate the tendency to answer questions in a socially desirable manner. Out of a total possible score of 33, the group that received parent training first reported means of 17.1 \((SD = 7.22)\) at the time of the first assessment, 14.2 \((SD = 7.84)\) at the second assessment, and 13.7 \((SD = 7.27)\) at the third assessment. The group that received stress management first reported means of 15.7 \((SD = 5.1)\) at the first assessment, 17.1 \((SD = 4.04)\) at the second assessment, and 16.1 \((SD = 5.73)\) at the third assessment. The standardization group in the original study on the MCSDS had a mean score of 13.72 and a standard deviation of 5.78. The means obtained in this study were all within one standard deviation of the mean of the original standardization sample, suggesting the parents in this sample did not respond in an overly positive manner. Therefore, it was concluded that the scores that follow do not represent false reports of parental attitudes.

Repeated measures ANOVAs were performed in order to determine if there were differences in parent stress, severity of problematic child behaviors, and feelings of parental efficacy at different stages of treatment (pretreatment, after the first treatment component, and after the second treatment component). More importantly, time by group interactions were analyzed in order to look more closely at group
differences over time and changes at different points in treatment. This was done because of primary interest in this study was whether the treatment groups improve differentially over time. The repeated measures ANOVA suits the data in this exploratory study better than the MANOVA, although it is acknowledged that the possibility of Type I error (finding significant differences when there actually is none) is heightened by using this statistic. However, given the small sample size, power is low and there is likely to be a greater chance of a Type II error. Group membership and time of assessment (between subjects variables) were the independent variables (IV) and data from the assessment measures comprised the dependent variables (DV). Standard mean effect sizes were also calculated in order to provide information on meaningful change beyond that of statistical significance, which is difficult to achieve with a small sample size. Effect sizes of .2 to .49 are considered small, .5 to .79 medium, and .8 and up large (Cohen, 1977). Means for the groups on all measures are shown in Tables 5 and 6. Figures 3 through 13 show graphic representations of group means at all three times of assessment (before treatment, after the first treatment component was complete, and after the second treatment component was complete). Effect sizes for all measures are shown in Table 7.

Parent Outcomes

Five 2 x 3 repeated measures ANOVAs were used to analyze whether there were significant changes in parent functioning as measured by the Parenting Stress Scale (PSS) total score; the Parenting Efficacy (PE) and Parenting Satisfaction (PS) subscales of the Parenting Sense of Competence Scale (PSOC); and the Child Domain
Table 5

Means and Standard Deviations for Parents Who Received Parent Training (PT) Before Stress Management Training (SMT)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Pretreatment</th>
<th></th>
<th>Post-PT</th>
<th></th>
<th>Post-SMT</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Perceived Stress Scale (PSS)</td>
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<td>7.55</td>
<td>29.67</td>
<td>6.14</td>
<td>26.50</td>
<td>7.95</td>
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<tr>
<td>PSI(^d) (Child Domain)</td>
<td>124.08</td>
<td>25.35</td>
<td>112.31</td>
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<td>101.54</td>
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<td>PSOC(^c) (Parenting efficacy)</td>
<td>24.58</td>
<td>4.50</td>
<td>25.75</td>
<td>3.72</td>
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<td>PSOC (Parenting Satisfaction)</td>
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<td>32.58</td>
<td>5.95</td>
<td>36.83</td>
<td>6.79</td>
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<td>13.17</td>
<td>7.15</td>
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<td>10.42</td>
<td>6.56</td>
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<td>2.42</td>
<td>6.42</td>
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<td>DBDRS (CD)</td>
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<td>CBCL(^b) Total</td>
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<td>9.17</td>
<td>4.39</td>
<td>9.50</td>
<td>7.22</td>
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\(^a\) = Disruptive Behavior Disorders Rating Scale  
\(^b\) = Achenbach Child Behavior Checklist  
\(^c\) = Parenting Sense of Competence Scale  
\(^d\) = Parenting Stress Index

Table 6

Means and Standard Deviations for Parents Who Received Stress Management Training (SMT) Before Parent Training (PT)

<table>
<thead>
<tr>
<th>Measure</th>
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<tr>
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<tr>
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<td>5.11</td>
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<td>5.78</td>
<td>3.73</td>
<td>5.22</td>
<td>3.49</td>
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\(^a\) = Disruptive Behavior Disorders Rating Scale  
\(^b\) = Achenbach Child Behavior Checklist  
\(^c\) = Parenting Sense of Competence Scale  
\(^d\) = Parenting Stress Index
Figure 3. Perceived Stress Scale (PSS).

Figure 4. Parenting Stress Index (Child Domain).
Figure 5. Parenting Stress Index (Parent Domain).

Figure 6. Parenting sense of competence: Parenting efficacy.
Figure 7. Parenting sense of competence: Parenting satisfaction.

Figure 8. Disruptive Behavior Rating Scale: ADHD subscale.
\[ \begin{array}{ccc}
1 & 2 & 3 \\
PT 1st & 8.42 & 5.25 & 6.42 \\
SMT 1st & 4 & 5.11 & 3.44 \\
\end{array} \]

**Figure 9.** Disruptive Behavior Disorders Rating Scale: ODD subscale.

\[ \begin{array}{ccc}
1 & 2 & 3 \\
PT 1st & 1.83 & 1.42 & 1.58 \\
SMT 1st & 0.44 & 0.67 & 0.56 \\
\end{array} \]

**Figure 10.** Disruptive Behavior Disorders Rating Scale: CD subscale.
Figure 11. Achenbach Child Behavior Checklist: Total Scale.

Figure 12. Achenbach Child Behavior Checklist: Externalizing Scale.
Figure 13. Achenbach Child Behavior Checklist: Internalizing scale.

Table 7  

Effect Sizes for Parent Data

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<td>.03</td>
</tr>
<tr>
<td>CBCL Internalizing</td>
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<td>.06</td>
</tr>
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</table>

\( a = \text{Disruptive Behavior Disorders Rating Scale}\)  
\( b = \text{Achenbach Child Behavior Checklist}\)  
\( c = \text{Parenting Sense of Competence Scale}\)  
\( d = \text{Parenting Stress Index}\)
(CD) and Parent Domain (PD) subscales of the Parenting Stress Index (PSI). Again, independent variables were group (parent training first or stress management training first) and time of assessment (pretreatment, posttreatment 1, or posttreatment 2). Standard mean effect sizes were also calculated.

There was a significant main effect for time on the total score of the PSS ($F_{2,18} = 6.05, p = .01$). Post-hoc pairwise comparisons indicate that parental stress from pretreatment to after the first treatment significantly decreased ($p = .027$), as did stress from before treatment to after both treatments ($p = .002$). There was no significant main effect for group, nor was there a significant group by time interaction. Effect sizes on the PSS for both groups supports the significant main effect for time. Parents who received parent training first reported a medium reduction in their stress levels ($ES = -0.65$) from pretreatment to post-parent training, small improvement ($ES = -0.45$) from post-parent training to post-stress management training, and large ($ES = -0.99$) overall improvement (pretreatment to after both treatment components). The group that received stress management first reported a small decrease ($ES = -0.32$) in stress from pretreatment to post-stress management training, a small improvement ($ES = -0.22$) from post-stress management training to post-parent training, and medium ($ES = -0.51$) overall improvement. With respect to clinical interpretation, means for both groups were more than one standard deviation above the mean as compared to the combined male and female student norm samples published in the original manuscript (Cohen et al., 1983) at Time 1, and in the average range at Time 2 and Time 3. Overall, results show that all parents experienced some reduction in stress.
There was a significant main effect for group on the Child Domain subscale of the PSI \((F_{2,22} = 4.656, p = .042)\), with the group that received parent training first reporting more stress associated with their children than did the group that received stress management first. There was also a significant main effect for time, \((F_{2,22} = 8.135, p = .002)\). Post-hoc pairwise comparisons indicate that parents reported a significant decrease in stress associated with their children from pretreatment to after the first treatment component \((p = .032)\), from after the first treatment to after the second treatment component \((p = .023)\), and from pretreatment to after the second treatment component \((p = .003)\). Parents in the group that received parent training first reported moderate improvements in child-related stress from pretreatment to after parent training \((ES = -.53)\), nonmeaningful improvement from post-parent training to post-stress management, and moderate improvement from pretreatment to after stress management training \((ES = -.69)\). Parents in the group that received stress management training first reported nonmeaningful improvement from pretreatment to post-stress management, large decreases in child-related stress from after stress management training to after parent training \((ES = -.99)\) and from pretreatment to post-parent training \((ES = -.95)\). Therefore, although the group by time interaction was not significant, effect sizes show that parent training contributed most to overall change. In the PSI manual, Abidin (1995) indicates that scores above the 90th percentile are considered clinically elevated. Compared to both the 4- and 5-year-old norms in the PSI manual, means for the parent training first group were above the 90th percentile at Time 1, but below this at times 2 and 3. Compared to both the 4- and 5-year-old norms, means for the stress
management-first group were below the clinical cutoff of 90% at all time periods.

Statistical analyses of the Parent Domain of the PSI revealed no significant main
effects for group or time, nor a significant group by time interaction. Reports of parents
in the group that received parent training first indicated there was nonmeaningful
improvement in parent-related stress from pretreatment to post-parent training, a small
\( ES = -0.36 \) improvement from post-parent training to post-stress management training, and small improvement \( ES = -0.44 \) from pretreatment to post-stress management training. Parents in the group that received stress management first reported
nonmeaningful improvement in stress from pretreatment to post-stress management
training and from post-stress management to post-parent training, and small
improvements \( ES = -0.20 \) from pretreatment to after both treatment components.
Overall, very little change occurred in parent-related stress. A small change occurred in
the group that received parent training first and that change is most attributed to the
stress management component. As with the Child Domain scores, scores on the Parent
Domain of the PSI are considered to be clinically significant if they are at or above the
90\(^{th}\) percentile. Compared to 4-year-old norms, means for the parent-training-first group
were not clinically significant at any of the assessment periods. However, compared to
5-year-old norms, means for the parent-training-first group were above the 95\(^{th}\)
percentile at Time 1, above the 95\(^{th}\) percentile at Time 2, and above the 90\(^{th}\) percentile
at Time 3. Compared to 4-year-old norms, means for the stress-management-first group
were below the 90\(^{th}\) percentile at all assessment times. However, compared to 5-year-
old norms, means for the stress-management-first group were above the 95\(^{th}\) percentile
at Time 1, above the 70th percentile at Time 2, and above the 90th percentile at Time 3. Therefore, both groups remained in the clinical range across time in reference to 5-year-old norms, and means remained below the clinical range in reference to 4-year-old norms.

There were no significant main effects for group or time, nor were there any group by time interactions for the Parenting Efficacy or Parenting Satisfaction subscales of the PSOC. The group that received parent training first reported a small improvement (ES = 0.28) in Parenting Efficacy from pretreatment to post-parent training and a medium (ES = 0.57) improvement from post-parent training to post-stress management. Overall, they reported a medium improvement (ES = 0.79) in their parenting efficacy. The group that received stress management first had a small improvement (ES = 0.43) in Parenting Efficacy from pretreatment to post-stress management, a small improvement (ES = 0.31) for post-stress management to post-parent training, and a medium (ES = 0.67) improvement overall. Effect sizes on the Parenting Satisfaction subscale of the PSOC for the group that received parent training first revealed a nonmeaningful decrease in Parenting Satisfaction from pretreatment to post-parent training, a medium (ES = .67) improvement in satisfaction from post-parent training to post-stress management training, and a medium (ES = 0.67) overall improvement (from pretreatment to post-stress management). Parents in the group that received stress management first reported a small decrease (ES = -0.38) in Parenting Satisfaction from pretreatment to post-stress management, nonmeaningful decrease in Parenting Satisfaction from post-stress management to post-parent training, and medium decrease
Overall, parents in both groups reported feeling somewhat more effective after the treatment program but only parents in the parent-training-first group felt more satisfied in their role as parents after treatment. As compared to the original norm sample (Johnston & Mash, 1989), parenting efficacy means in the parent-training-first group remained in the average range over time, whereas parenting efficacy means in the stress-management-first group were average at Time 1 and Time 2 and were above average (more than one standard deviation above the mean; indicating greater parenting efficacy) at Time 3. Parenting satisfaction means for the parent-training-first group were below average (indicating less satisfaction) for mother reporters but average for father reporters at Time 1, average for mother reporters with boys but below average for all others (mothers with girls, fathers with boys, and fathers with girls) at Time 2, and average at Time 3. Parenting satisfaction means for the stress-management-first group remained in the average range at all observation periods.

**Child Outcomes**

Six 2 X 3 repeated measures ANOVAs were used to analyze parental report on the six child behavior outcome measures of ADHD, ODD, and CD subscales of the DBDRS and on the CBCL Total, Externalizing, and Internalizing scales. Independent variables were group membership (Parent Training first or Stress Management training first) and time of assessment (before treatment, after the first treatment component, or after the second treatment component).

On the DBDRS subscales, there were no significant main effects for time or
group, and there were no significant group by time interactions. Examination of effect sizes and group means, however, provides additional information about changes with treatment. There was a medium effect size ($ES = -.50$) for the change in ADHD symptoms for the group that received parent training before stress management training from pretreatment to post-parent training, and a nonmeaningful increase in ADHD symptoms following stress management training. There was a small ($ES = -.40$) improvement in children’s ADHD symptoms from pretreatment to post-stress management training. In the group that received stress management training first, however, parents reported a slight increase in ADHD symptoms from pretreatment to post-stress management training ($ES = .28$). A small improvement ($ES = -.45$) in ADHD behaviors from post-stress management to post-parent training was noted, and a small improvement ($ES = -.22$) overall (from pretreatment to after both treatment components) in child ADHD symptoms was found. Therefore, parent training appears to have been the only contributor to improvements in child ADHD symptoms and stress management training may make ADHD symptoms worse, at least in the short term.

Using norms (DuPaul et al., 1998), for children ages 5-7 (there are none for age 4), all means for both groups are within the average range and fall between the 25th to 75th percentiles for boys and the 50th to 75th percentiles for girls.

Parents who received parent training first reported medium improvements ($ES = -.66$) in their children’s ODD symptoms from pretreatment to post-parent training, whereas they reported small elevations ($ES = .49$) in their child’s ODD behaviors from post-parent training to post-stress management and small improvement
overall \( (ES = -.37) \), from pretreatment to after both treatment packages. The group that received stress management training first reported a small increase \( (ES = .33) \), or a worsening, of their child’s ODD behaviors from pretreatment to post-stress management. They reported moderate improvements \( (ES = -.56) \) in child ODD behaviors from post-stress management to post-parent training. These changes resulted in small improvements \( (ES = -.22) \) overall (from pretreatment to after both treatments).

As with the ADHD subscale, reported improvement in ODD symptoms appears to be attributed solely to parent training, and stress management training may make ODD symptoms worse. There are no norms for the ODD scale based on mean scores. However, the mean for the parent-training-first group at Time 1 \((m = 8.42)\) could be interpreted as clinically significant if the score were obtained by rating 4 ODD symptoms as a 2 or higher. Means for the parent-training-first group at Time 2 and Time 3 appear to be within the average range, as do means for the stress-management-first group at all observation times.

Examination of effect sizes for the CD subscale of the DBDRS reveals that parents who received parent training first reported small decreases \( (ES = -.23) \) in behaviors associated with CD from pretreatment to post-parent training. Nonmeaningful effect sizes were found for this group’s reported slight increase in their children’s CD symptoms from post-parent training to post-stress management training and for the slight decrease in their children’s CD symptoms overall, from pretreatment to post-stress management training. Parents who received stress management first reported a small increase \( (ES = .21) \) in their children’s CD behaviors from pretreatment to post-
stress management, with nonmeaningful improvement from post-stress management to post-parent training and nonmeaningful increases in CD behaviors overall. Therefore, although only small improvements occurred in both groups, parent training was the only component associated with this improvement. However, very few CD behaviors (under 2 on average) were reported overall. Therefore, significant decreases in symptoms would be difficult to find. Clinically, none of the group means are elevated.

There were no significant main effects for group, nor was there a significant group by time interaction for the CBCL total raw score. There was a significant main effect for time on the CBCL total score ($F_{2,18} = 3.686, p = .046$). Post-hoc pairwise comparisons indicate that parental report of problematic child behaviors on this measure decreased in severity ($p = .017$) from pretreatment to after the completion of both treatments. Medium improvements in CBCL total scores ($ES = -0.61$) were reported by parents who received parent training first for the time period from pretreatment to post-parent training. A nonmeaningful effect size was obtained for the small increase in, or worsening of, the CBCL total score from post-parent training to post-stress management training. Parents who received parent training first also reported a small improvement ($ES = -0.46$) in scores on the CBCL total score from pretreatment to after both treatments. Parents who received stress management training first reported a nonmeaningful increase (worsening) from pretreatment to post-stress management training, medium improvements ($ES = -0.56$) from post-stress management to post-parent training, and small improvements ($ES = -0.46$) in problematic child behaviors from pretreatment to after the completion of both treatment packages. Again, only
parent training was associated with positive change in problematic child behavior, and stress management training may make problematic child behavior worse. Clinically, the parent-training-first group’s mean at Time 1 was greater than 1½ standard deviations above the mean (Achenbach, 1991), whereas means at Time 2 and Time 3 were in the average range. Means for the stress-management-first group were in the average range at all observation times.

There was a significant main effect for group on the Externalizing subscale of the CBCL ($F_{2,18} = 4.383, p = .05$), showing that the two groups differed significantly in their reports of their children’s externalizing symptoms. The group that received parent training first reported more problem behaviors for their children than those parents in the stress-management-first group. There was no main effect for time and there was no significant group by time interaction for the CBCL Externalizing subscale. Effect sizes for change in child behavior according to the report of parents who received parent training first were medium ($ES = -0.59$) for decreases in behavior from pretreatment to post-parent training, nonmeaningful for worsening of externalizing symptoms from post-parent training to post-stress management, and small ($ES = -0.42$) for pretreatment to after both treatment packages. Effect sizes for change in child behavior according to the report of parents who received stress management first were nonmeaningful for worsening of symptoms from pretreatment to post-stress management training, small ($ES = -0.39$) for improvements from post-stress management to post-parent training, and were small ($ES = -0.25$) for improvement from pretreatment to post-parent training. As with the total score on the CBCL, improvements in externalizing scores occurred
only after parent training. Again, stress management training appears to have made externalizing symptoms slightly worse. Regarding clinical interpretation, means at Time 1 for the parent-training-first group were more than 1 standard deviation above the mean compared to boy norms and more than 1½ standard deviation above the mean compared to girl norms (Achenbach, 1991). The mean at Time 2 was in the average range, whereas for Time 3 this group’s mean was in the average range for boys and more than 1 standard deviation above the mean for girls. Means for the stress-management-first group remained in the average range at all observation times.

There were no significant main effects for group or time on the Internalizing subscale of the CBCL, nor was there a significant group by time interaction. For the group that received parent training first, there was a medium ($ES = -.53$) improvement from pretreatment to post-parent training, nonmeaningful worsening of symptoms from post-parent training to post-stress management training, and small improvement ($ES = -0.40$) from pretreatment to post-stress management training. The group that received stress management first reported small improvements in their children’s Internalizing behavior ($ES = -0.20$) from pretreatment to post-stress management training, nonmeaningful improvement from post-stress management training to post-parent training, and small improvement overall ($ES = - 0.31$) from pretreatment to after both treatment components. Overall, the group that received stress management first reported small improvements in child internalizing symptoms after each treatment component. However, the parent-training-first group reported more improvement, all of which occurred with the parent-training component. Clinically, the Time 1 mean for the
parent-training-first group was more than one standard deviation above the mean for both boys and girls (Achenbach, 1991). However, means at Time 2 and Time 3 were in the average range. Means for the stress-management-first group remained in the average range at all observation times.

Teacher Data

Repeated measures ANOVAs were used to analyze the results from the measures completed by Head Start teachers. Teachers completed the Preschool and Kindergarten Behavior Scales (PKBS), which yields two subscales: Social Skills and Problem Behavior. High scores on the Social Skills subscale indicate better peer-related and adult-related social adjustment, and high scores on the Problem Behavior subscale indicate more severe problem behaviors in both the internalizing and externalizing realms. Head Start teachers also completed the DBDRS--Teacher Form, which consists of ADHD and ODD subscales. High scores on both of these subscales indicate greater severity of problem behaviors. Group membership (Parent Training first, Stress Management first, and no treatment) and time (before treatment, after the first treatment component, after the second treatment component) were the independent variables and subscale total scores were the dependent variables. The no-treatment group was comprised of children whose parents signed up to participate in the parent training classes but never attended. Because treatment components lasted a different number of weeks (7 weeks for Parent Training and 4 weeks for Stress Management Training), the time of assessment for children in the no-treatment group was determined according to
what group the parents originally signed up for. The second time of assessment (post-treatment 1) occurred after 4 weeks for approximately half of the children in the no-treatment group and at approximately 7 weeks for the rest of the children. Means for the groups are shown in Tables 8 through 10. Figures 14 through 17 show graphic representations of group means at all three times of assessment. Effect sizes are shown in Table 11.

Table 8

*Teacher Means and Standard Deviations for Children Whose Parents Completed Parent Training (PT) Before Stress Management Training (SMT) Group*

<table>
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<th>Post-SMT</th>
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<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
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<td>PKBS^a (Social Skills)</td>
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<td>PKBS (Behavior Problems)</td>
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<td>DBDRS (ODD)</td>
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^a = Preschool and Kindergarten Behavior Scale  
^b = Disruptive Behavior Disorders Rating Scale

Table 9

*Teacher Means and Standard Deviations for Children Whose Parents Completed Stress Management Training (SMT) Before Parent Training (PT) Group*

<table>
<thead>
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<td>DBDRS (ODD)</td>
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^a = Preschool and Kindergarten Behavior Scale  
^b = Disruptive Behavior Disorders Rating Scale
Table 10

*Teacher Means and Standard Deviations for Children Whose Parents Received No Treatment*

<table>
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<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
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<td>DBDRSb (ADHD)</td>
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a = Preschool and Kindergarten Behavior Scale
b = Disruptive Behavior Disorders Rating Scale

*Figure 14*. Preschool and Kindergarten Behavior Scale (Social Skills).
Figure 15. Preschool and Kindergarten Behavior Scale (Behavior Problems).

Figure 16. Disruptive Behavior Disorders Rating Scale (ADHD Subscale).
Figure 17. Disruptive Behavior Disorders Rating Scale (ODD Subscale).

Table 11

Effect Sizes for Teacher Data

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<th>Time 1 to Time 3</th>
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</tr>
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</tr>
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</tr>
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<td>.08</td>
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<tr>
<td>No treatment</td>
<td>-.40</td>
<td>.08</td>
<td>-.30</td>
</tr>
</tbody>
</table>

PKBS: = Preschool and Kindergarten Behavior Scale
DBDRS: = Disruptive Behavior Disorders Rating Scale
There were no significant main effects for time or group on the Social Skills subscale of the PKBS, nor was there a significant group by time interaction. Examination of effect sizes for children in the parent-training-first group shows nonmeaningful improvement in social skills from pretreatment to post-parent training, small improvements ($ES = 0.44$) in social skills from post-Parent Training to post-Stress Management Training, and medium improvements ($ES = .56$) from pretreatment to post-Stress Management Training. For the group of children whose parents received stress management training first, teachers reported nonmeaningful improvement ($ES = 0.19$) in social skills from pretreatment to post-stress management, a small decline ($ES = -0.28$) in social skills from post-Stress Management Training to post-Parent Training, and nonmeaningful decline from pretreatment to post-parent training ($ES = -0.02$). Teachers of children whose parents signed up for classes but did not attend reported small improvements in social skills ($ES = 0.24$) from pretreatment (Time 1) to Time 2, nonmeaningful improvement ($ES = 0.02$) from Time 2 to Time 3, and small overall improvement, from Time 1 to Time 3 ($ES = 0.24$). Overall, children whose parents received parent training first showed the most improvement, and most of this improvement occurred after stress management training. Clinically, all means for the three groups were in the average range compared to the norms presented in the PKBS manual (Merrell, 1994).

Analysis of the Problem Behavior subscale revealed no significant main effects for group or time and no significant group by time interaction. Examination of effect sizes show that teachers of children whose parents received parent training first reported
nonmeaningful improvement in behavior from pretreatment to post-parent training, medium improvements ($ES = -0.65$) in children’s behavior from post-parent training to post-stress management training and medium improvement ($ES = -0.58$) from pretreatment to post-stress management training. Teachers of children whose parents received stress management first reported nonmeaningful improvement in behavior problems from pretreatment to post-stress management and from post-stress management to post-parent training were nonmeaningful, and only small changes ($ES = -0.20$) from pretreatment to post-Parent Training. Teachers of children whose parents did not receive treatment reported decreases from the first observation period to the second, but the effect size for this change was nonmeaningful. Again, children in the parent-training-first group showed the most improvement, and the majority of the improvement occurred after stress management training. Clinically, all means for the three groups were in the average range according to the PKBS norms (Merrell, 1994).

Two 2 x 3 repeated measures ANOVAs were used to analyze results from the ADHD and ODD subscales of the DBDRS. There was no significant main effect for group, nor was there significant group by time interaction on the ADHD subscale. There was a significant main effect for time ($F_{2,25} = 3.425, p = 0.048$). Post-hoc pairwise comparisons indicate that behaviors associated with ADHD were significantly higher at pretreatment than at post-treatment 2 ($p = .026$). Effect size analysis indicated that teachers of children whose parents received parent training first reported large improvements in ADHD behaviors ($ES = -0.93$) from pretreatment to post-parent training, medium improvement ($ES = -0.57$) from post-parent training to post-stress
management, with large overall improvement ($ES = -1.34$). Teachers of children whose parents received stress management training first reported nonmeaningful improvement in ADHD behaviors for all three time comparisons. Teachers of children whose parents did not receive treatment reported small improvement in ADHD behaviors ($ES = -0.40$) from Time 1 to Time 2, nonmeaningful worsening of children's ADHD symptoms from Time 2 to Time 3, and small improvement ($ES = -0.36$) in ADHD behavior from Time 1 to Time 3. Again, children in the parent-training-first group showed the most improvement in ADHD symptoms, although this time the majority of the improvement occurred with parent training. Compared to normative data for children ages 5-7 (DuPaul et al., 1998), all means were within the average range falling between the 25th and 75th percentiles.

On the ODD subscale of the DBDRS, there were no significant main effects for group or time, nor significant group by time interaction. Examination of effect sizes indicates that teachers of children whose parents received parent training first reported medium improvements ($ES = -0.57$) in ODD behaviors from pretreatment to post-parent training, small improvement ($ES = -0.23$) from post-parent training to post-stress management training, and medium overall improvement ($ES = -.71$). Teachers of children whose parents received stress management first reported nonmeaningful improvement of ODD behaviors from pretreatment to post-stress management, a small increase ($ES = 0.34$) in ODD behaviors in the children from post-stress management to post-parent training, and a nonmeaningful increase in ODD symptoms overall. Teachers of children whose parents did not receive treatment reported small decreases
(ES = -0.40) in ODD behaviors from Time 1 to Time 2, nonmeaningful increases in ODD behaviors from Time 2 to Time 3, and small decreases in ODD behavior from Time 1 to Time 3 (ES = -0.30). As with ADHD symptoms, children in the parent-training-first group showed the most improvement in ODD symptoms, and the majority of the improvement occurred with parent training. Clinically, all means for the three groups were in the average range.

Treatment Satisfaction

In order to compare how acceptable each group (Parent Training first vs. Stress Management first) found their treatment, a one-way ANOVA was computed using the total score of the Therapy Attitude Inventory (TAI) as the dependent variable. See Table 12 for means and standard deviations. By using the total score, the acceptability of the total treatment package rather than each separate component (parent training or stress management training) was evaluated. Both groups rated treatment acceptability highly, with mean ratings (out of a total possible of 75) of 63.17 (SD = 6.56) for the group that received parent training first and a mean of 62.44 (SD = 4.45) for the group that received stress management first. The difference in treatment satisfaction between groups was not statistically significant, and computation of effect size reveals no meaningful difference between the groups (see Table 13). The average item mean for all participants was 4.19 (SD = 0.38) on a scale of 1 through 5, indicating a high level of satisfaction.
Table 12

Means and Standard Deviations for Treatment Acceptability

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>PT(^1) before SMT(^2)</td>
<td>63.17</td>
<td>6.56</td>
</tr>
<tr>
<td>SMT before PT</td>
<td>62.44</td>
<td>4.45</td>
</tr>
<tr>
<td>Preferred treatment first</td>
<td>63.70</td>
<td>5.95</td>
</tr>
<tr>
<td>Nonpreferred treatment first</td>
<td>62.00</td>
<td>6.14</td>
</tr>
</tbody>
</table>

\(^1\) = Parent Training  
\(^2\) = Stress Management Training

Table 13

Effect Sizes for Treatment Acceptability

<table>
<thead>
<tr>
<th>Group</th>
<th>ES</th>
</tr>
</thead>
<tbody>
<tr>
<td>PT(^1) First vs. SMT(^2) First</td>
<td>.13</td>
</tr>
<tr>
<td>Preferred Treatment First vs.</td>
<td>.28</td>
</tr>
<tr>
<td>Nonpreferred treatment First</td>
<td></td>
</tr>
</tbody>
</table>

\(^1\) = Parent Training  
\(^2\) = Stress Management Training

The demographic questionnaire that was filled out by all parents included a question regarding which treatment component (parent training or stress management training) parents were most interested in. Of the 21 parents who completed the treatment and all assessments, four left that question blank. Of the nine who received parent training first, four had indicated they were most interested in parent training. Of the eight parents who received stress management training first, six indicated they were most interested in stress management training. Therefore, 10 parents received their most preferred treatment component first and seven did not. Another one-way ANOVA was computed, with groups being those who received preferred treatment first and those
who did not, and effect size was also computed. It was found that although there was again no statistically significant difference in treatment satisfaction between groups, the effect size was consistent with the finding that parents who received their preferred treatment first were slightly more satisfied with the overall treatment package than parents who received their preferred treatment second ($ES = .28$). See Table 12 for group means.

Session rating scales were also completed at the end of each session. Mean responses to the first 8 questions are summarized in Table 14. Mean parent responses for each item were favorable, with the lowest item mean being 3.0 and the highest being 5.0 on a scale of 1 to 5. The majority of individual item means were 4.0 and above, indicating most parents regarded each aspect favorably.

Answers to the open-ended questions were also generally positive and reflected knowledge of specific session content and an appreciation for the information. For the question, “What did you learn in today’s class that was useful?” there were no negative answers or answers of “nothing” during stress management. Examples of answers during stress management included, “that stress can affect physical health,” “I’m not so different, my reactions are similar to those of others,” “to visualize so you can relax,” “how to relax,” “I am not going to die over stressful situations,” “how to effectively use cognitive interventions,” “new sleep techniques” and “changing patterns of thinking.” All answers (53 out of 53) were specific (similar to the examples given), and were quite varied due to the different topics covered in each session. During parent training, only two of 53 answers were “nothing” and one was “not much.” The vast majority (50 of
### Table 14

**Mean Responses for Session Rating Scale Items on Scale of 1 to 5**

<table>
<thead>
<tr>
<th>Item</th>
<th>ST1</th>
<th>ST2</th>
<th>ST3</th>
<th>ST4</th>
<th>PT1</th>
<th>PT2</th>
<th>PT3</th>
<th>PT4</th>
<th>PT5</th>
<th>PT6</th>
<th>PT7</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>m</td>
<td>SD</td>
<td>m</td>
<td>SD</td>
<td>m</td>
<td>SD</td>
<td>m</td>
<td>SD</td>
<td>m</td>
<td>SD</td>
<td>m</td>
</tr>
<tr>
<td>1. The leader encouraged group participation</td>
<td>4.5</td>
<td>.88</td>
<td>4.8</td>
<td>.56</td>
<td>4.9</td>
<td>.30</td>
<td>5.0</td>
<td>na</td>
<td>4.8</td>
<td>.43</td>
<td>4.7</td>
</tr>
<tr>
<td>2. I actively participated in today’s session</td>
<td>4.1</td>
<td>.95</td>
<td>4.4</td>
<td>.71</td>
<td>4.4</td>
<td>.67</td>
<td>5.0</td>
<td>na</td>
<td>3.8</td>
<td>1.3</td>
<td>4.5</td>
</tr>
<tr>
<td>3. I paid careful attention to information presented today</td>
<td>4.2</td>
<td>1.2</td>
<td>4.7</td>
<td>.59</td>
<td>4.7</td>
<td>.47</td>
<td>5.0</td>
<td>na</td>
<td>4.4</td>
<td>.51</td>
<td>4.5</td>
</tr>
<tr>
<td>4. The information presented today was helpful</td>
<td>4.2</td>
<td>1.2</td>
<td>4.7</td>
<td>.47</td>
<td>4.6</td>
<td>.51</td>
<td>4.8</td>
<td>.41</td>
<td>5.0</td>
<td>na</td>
<td>4.6</td>
</tr>
<tr>
<td>5. Last week’s in-class practice was worthwhile</td>
<td>4.2</td>
<td>.98</td>
<td>4.1</td>
<td>.73</td>
<td>4.6</td>
<td>.70</td>
<td>5.0</td>
<td>na</td>
<td>4.3</td>
<td>1.3</td>
<td>4.6</td>
</tr>
<tr>
<td>6. I tried last week’s skills outside of class</td>
<td>3.7</td>
<td>1.4</td>
<td>3.9</td>
<td>1.1</td>
<td>4.0</td>
<td>1.4</td>
<td>4.5</td>
<td>.58</td>
<td>5.0</td>
<td>na</td>
<td>3.9</td>
</tr>
<tr>
<td>7. My child responded well to last week’s assignment(s)</td>
<td>3.5</td>
<td>1.4</td>
<td>3.7</td>
<td>1.0</td>
<td>4.2</td>
<td>.75</td>
<td>5.0</td>
<td>na</td>
<td>3.7</td>
<td>1.1</td>
<td>4.4</td>
</tr>
<tr>
<td>8. Last week’s homework assignment(s) was/were helpful</td>
<td>3.8</td>
<td>1.2</td>
<td>3.6</td>
<td>.51</td>
<td>4.4</td>
<td>.70</td>
<td>4.5</td>
<td>.58</td>
<td>4.0</td>
<td>na</td>
<td>4.0</td>
</tr>
</tbody>
</table>

ST = Stress Management Training  
PT = Parent Training  
Scale: 1 = not at all; 5 = very much
53) were specific, such as “how to communicate in a positive way,” “how to deal with kids without yelling,” “how to play with my child,” proper ways of time out,” “reward techniques,” and “how to keep my kids from interrupting.”

For the question, “What could have been improved in today’s class?” 28 of 46 responses from stress management sessions were “nothing,” “not a thing,” or the like. The remainder of the responses consisted of three general positive comments (e.g., “Perfect class! I loved the info,” “I enjoyed it”) and 16 specific suggestions. Examples of specific suggestions include “a little more guided discussion,” “more relaxing environment” and “a few more examples of [Ellis’] ABC,” and “increase meditation practice.” Thirty of 53 answers to the question about improvement during parent training were “nothing” or “NA” or the like. The remainder consisted of 6 general positive comments (e.g., “everything was fine,” “I thought it was really good”) and 17 specific suggestions (e.g., “information on older children,” “more examples of specific scenarios,” and “role play with child in class”).

For the question, “Do you think you can use what you learned today at home? Why or why not?” three of 46 responses were “NA” and 43 of 46 responses during stress management training either included “yes” or another affirmative answer (e.g., “of course,” “absolutely”) to the first part of the question. Parents who answered the second part of the question gave various detailed answers. Examples include, “I have tons of stress and need to cope,” “it gives another avenue of relief,” “it might help with overall attitude,” “my thoughts need to be changed,” and “I need to manage time better.” Of the 52 responses during parent training 49 were “yes” to the first part of the
question, with one parent stating, "Maybe" and 2 stating "I already use what we learned today." Answers to the latter part of the question were varied and detailed (e.g., "I definitely need to praise my children more," "because I know it will work," and "we have a lot of behaviors that can probably be turned around").

For the question, "What else would have been helpful to cover in today's class?" 39 of 48 answers during stress management training were "nothing," "not a thing," "I don’t know," "not sure," or "NA." There was one general positive comment ("the topics were covered well"). The eight remaining comments consisted of specific suggestions such as "have a sheet that covers the exercises step by step," "more life examples," and "where you can buy [relaxation] tapes." Twenty-seven of 43 answers during parent training were "nothing" or "NA." The remaining 16 consisted of specific suggestions, examples of which include "list of comments to use for praising children," "I think if we spread out more we wouldn't have been so nervous [during the Child’s Game]," "what to do with teenagers," "playing with different toys," "more handouts," and "more movie presentations, more different play scenes."

Results of the program rating scale for the stress management program are summarized in Tables 15 and 16. The majority of parents found all topics helpful, with percentages ranging from 77% (Cognitive Interventions) to 94% (Assertiveness Training and Time Management).

Attendance questionnaires were also completed in order to gather more information about what factors contributed to attendance problems. Unfortunately, all questionnaires returned to the experimenter were completed by parents who had missed
Table 15

*Mean Responses for Overall Evaluation of Stress*

*Management Training on Scale of 1 to 5*

<table>
<thead>
<tr>
<th>Item</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The information presented was helpful</td>
<td>4.6</td>
<td>.62</td>
</tr>
<tr>
<td>2. The homework assignments were helpful</td>
<td>4.1</td>
<td>.43</td>
</tr>
</tbody>
</table>

Scale: 1 = not at all; 5 = very much

Table 16

*Percentage of Parents Indicating Stress*

*Management Topics Were Useful*

<table>
<thead>
<tr>
<th>Topic</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Components of stress</td>
<td>88</td>
</tr>
<tr>
<td>Relaxation training</td>
<td>93</td>
</tr>
<tr>
<td>Cognitive interventions</td>
<td>77</td>
</tr>
<tr>
<td>Assertiveness training</td>
<td>94</td>
</tr>
<tr>
<td>Time management</td>
<td>94</td>
</tr>
<tr>
<td>Improving your sleep</td>
<td>82</td>
</tr>
</tbody>
</table>

at least one class but finished the entire treatment program. No parents who dropped out returned the questionnaire. The questionnaire consisted of a list of potential factors, with blanks for parents to fill in others not listed, and another column of blank spaces for parents to give suggestions for what the experimenter could have done to improve their attendance. Factors checked included lack of childcare, too many commitments (not related to class), unexpected events, illness, day of class, and too many classes.
Presumably, lack of childcare was marked because the parent had difficulty obtaining a babysitter (even though Head Start provided the funds with which to pay the sitter). The only suggestion given for what could have been changed was to change the day on which that particular person’s class was held.
Preschool children exhibit a variety of problematic "acting out" behaviors that can be associated with parent stress. Although a great deal of literature documents the effectiveness of parent training in reducing problematic child behavior (e.g., Eisenstadt et al., 1993), less is known about what effect such treatment has on parents' emotional state. Some parents have reported lower stress levels after completing parent-training programs (e.g., Eyberg et al., 2001). However, research in this area is limited and it is not clear if parent training alone lowers stress or if other factors contribute to this finding. Because stress management programs are widely documented as having robust positive effects on adult stress (e.g., Antoni et al., 2000; Fausel, 1995), it was thought that combining adult stress management with parent training might enhance the standard parent-training package.

The purpose of this study was to investigate whether adding stress management training to parent training positively affects parental stress levels, problematic child behaviors, and parenting efficacy. In this study, parents of preschool-age children received seven sessions of parent training and four sessions of stress management training. Approximately half of the parents received parent training first and stress management second, whereas the other half received stress management first and parent training second. Because all parents in the study received both behavioral parent training and stress management training, a secondary purpose was to determine if there are any differences in outcome based on the order the treatments were received.
In this study, both stress management training and parent training improved parent stress levels. This may be because both groups were receiving treatment for significant stressors in their lives (child-related stress from child behavior problems was being treated with parent training and parent-related stressors, such as work or marital difficulties, were being treated with stress management). Because stress and factors closely tied to stress (e.g., low socioeconomic status, negativity, depression, low education level, low marital satisfaction, and low social support) are related to poor outcome in parent training (Graziano & Diament, 1992; Webster-Stratton, 1985b; Webster-Stratton & Hammond, 1990), it had been hypothesized that giving parents specific stress-reduction skills prior to tackling child behavior problems may enhance the stress reduction that comes with more effectively managing problematic child behavior. However, parent training resulted in greater stress reduction than did stress management training, thus contradicting the hypothesis that SMT would contribute more to stress reduction than PT.

The order of treatment did not consistently affect degree of overall stress reduction, as the PT first group improved more on two stress measures (in one case improved only slightly more), and the SMT first group improved more on the third stress measure. In fact, previous studies have found both reductions in parent stress after parent training (e.g., Anastopoulus et al., 1993; Schuhmann et al., 1998) and reduction in adults' stress after stress management training (e.g., Antoni et al., 2000). Therefore, it is not all that surprising that equal decreases in stress occurred by learning better stress management techniques and learning better child management techniques.
Although parent training appears to have contributed more to parent-reported reduction in stress, parents were better off after receiving both PT and SMT. Stress continued to decrease slightly, over time throughout both treatments, leading to the observation that parents were somewhat better off after receiving both treatments than they would have been if they had received only one of the treatments. Therefore, it appears that in the area of stress, parents of preschoolers, a population widely acknowledged as experiencing a great deal of stress, may benefit more from receiving both parent training and stress management training rather than one or the other. However, we do not know if simply receiving more treatment (e.g., 11 weeks of parent training) would yield similar cumulative improvements.

One explanation for this almost universal cumulative improvement over time is that parents feel better about themselves when taking measures to improve problematic areas in their lives. In these times of managed care and preference for brief therapy, one wonders what extending this program beyond 11 sessions would do. Improvements would have to stop at some point, but it would be interesting to find out at what time more treatment does not result in more improvement. Another explanation for the improvement in parent constructs, such as stress, may be that parents felt a great deal of general support in the group setting. Along this vein, parents may have felt less isolated after treatment and their experiences and feelings may have become more normalized through hearing of other parents’ experiences and frustrations.

Parents in both groups reported equal improvements in parenting efficacy. Equal credit can be given to each treatment component in the group that received stress
management first, while in the group that received parent training first, more of the effect was attributed to stress management. On the Parenting Satisfaction subscale of the PSOC, there were no statistically significant differences between groups. However, the parents who received stress management first reported an overall decrease in parenting satisfaction, with the most contributory component being stress management. The group that received parent training first reported an overall increase in parenting satisfaction, with stress management contributing overwhelmingly to the improvement. It is interesting to note that both group means for parenting competence were in the average range before treatment, which is intuitively backwards given the fact that they were voluntarily seeking help for parenting and stress. However, there is some literature to suggest that parents of young children with behavior problems do not necessarily have decreased efficacy due to a limited history of unsuccessful behavior modification (Mash & Johnston, 1990).

It appears that SMT contributed much more to the change, both positive and negative, in parenting satisfaction for both groups. It is unclear as to why parenting satisfaction improved for one group but slightly declined over the course of treatment for the other. One possibility is that the order of treatment contributed to these differences. Perhaps, for those parents in the stress-management-first group, drawing attention to their stress before giving them tools to manage their children’s behavior contributed to the decline in parenting satisfaction. However, because scores for parents in the stress-management-first group remained in the average range, perhaps the decrease has no meaningful impact.
There were no consistent differences between groups in the degree of overall improvement in problematic child behavior. Parent training contributed almost exclusively to improvement in child behavior, which is presumably the case because parents learned effective child management skills during parent training and did not during stress management training. The finding that parent training contributed more to improved child behavior should not be a surprise given the robust effects of parent training alone on child behavior found in the literature over the years (e.g., Anastopoulus et al., 1993; Dubey & Kaufman, 1978; Hood & Eyberg, 2003; Pisterman et al., 1989). A surprising finding is that child behavior consistently became more problematic during SMT, contrary to the hypothesis that SMT might enhance the positive effects of PT. With only one exception, all measures of child behavior as completed by parents were worse for both groups after finishing stress management training. However, most of these changes were very small (small to nonmeaningful effect sizes) and thus may not be reliable findings.

This worsening of behavior may be a result of parents being less consistent in their parenting when focusing on their own stress reduction, or perhaps focusing on stress made parents focus even more on areas in their life that cause stress (i.e., problematic child behavior). These results have implications for treatment in that some worsening of child behavior should be expected when focusing on parent issues and thus therapist and parent expectations should be adjusted accordingly. If expectations for child functioning is not lowered somewhat, frustration can occur in both therapist and parent, thus jeopardizing the therapeutic relationship and possibly even treatment
outcomes. In fact, results from this study indicate that perhaps it is wiser to use parent training alone to reduce parental stress, as the increase in severity of problematic child behavior during stress management training may outweigh the benefit to parental stress levels. Results may also support the presence of an order effect in that in most cases, there was greater overall improvement in the groups that received PT before SMT. When different, effect sizes are still in the same category (e.g., small), but the pattern is consistent enough to be worthy of consideration. This suggests that if one is going to provide both parent training and stress management for parents, overall outcome in child behavior may be slightly better if parent training is done first. Unfortunately, because no other studies were found that combined stress management with parent training (or add a separate treatment component which addresses other parent factors, such as stress), one does not have the benefit of previous literature to help interpret these findings.

Teacher data did not consistently support the results from parent ratings. In fact, children in the no treatment group did not differ significantly from those in the treatment groups. Children in all groups, even those whose parents did not receive treatment, improved in almost all areas assessed. One explanation for these findings is that the general trend toward improved social skills had more to do with instruction and experience within the Head Start classroom than with improved parenting and stress management skills learned by the children’s parents. In fact, treatment gains in one setting (e.g., home) are often not found to generalize to other settings (e.g., school; Forehand et al., 1979). An additional explanation is that improvements are often seen
with general passage of time. Regression toward the mean is a common phenomenon wherein extreme scores (high or low) tend to become closer to the mean upon repeated measurement (Gravetter & Wallnau, 1992).

Both treatment groups reported high satisfaction with the treatment program. When parents were grouped by whether they received their preferred treatment first or second, it was found that parents who received their preferred treatment first were slightly more satisfied with the overall treatment package. This finding suggests that, when providing multiple treatment components, clinicians should consider individuals' preferences, if possible, when designing treatment packages. However, given the fact that parents were still highly satisfied with treatment regardless of their preference, this is a minor issue.

Parents were also highly satisfied with specific aspects of treatment sessions throughout the 11 weeks of treatment (e.g., found the information helpful, used skills learned at home, etc.). Their answers to open-ended questions were specific, informative and generally positive, echoing their positive ratings on Likert-scale items and indicating that they paid attention in class and were providing valid information. On the program rating scale for stress management training, parents generally found all topics helpful, with relaxation training, assertiveness training, and time management receiving the most endorsements and components of stress, cognitive interventions, and improving sleep receiving less endorsements. While one could interpret the discrepancy in reported usefulness as a need to remove certain components of the intervention, it is this researcher's opinion that all components should remain because all topics were
considered useful to at least three fourths of the parents.

Related to treatment satisfaction was the issue of attendance and parent report of factors, which contributed to missing classes. Parents who missed at least one class indicated on a checklist which factors contributed to their absence(s). Items checked included: lack of childcare (presumably due to difficulty in finding a babysitter, because Head Start reimbursed parents for child care), too many commitments (not related to class), unexpected events, illness, day of class, and too many classes. While some factors cannot be helped by the researcher (e.g., illness), others can be catered to under better circumstances. For instance, more time and resources could facilitate the ability to offer on-site childcare (so parents do not have to find their own child care provider) and offering more classes across more days of the week. Also, reducing the number of sessions (e.g., by condensing the introductory information in both PT and SMT and beginning interventions in the first session) may be possible without compromising the benefits of treatment.

Limitations

Because the parents were volunteers, certain complications arise because their voluntary participation may be related to what was measured (Rosnow & Rosenthal, 1976). For example, volunteers tended to be better educated, more intelligent, more sociable, more unconventional than nonvolunteers, and higher in need for social approval (although the latter was not supported by results from the Marlowe-Crowne Social Desirability Scale). In addition, women were more likely to volunteer than were
men, and volunteers, especially if female, tended to be younger than nonvolunteers. As seen in clinical settings and other settings in general, women and mothers tended to seek help and be involved in parenting-related activities more so than men and fathers. One can only speculate what effect the volunteer nature of this study’s subjects might have on these results. If they were more educated than the other parents in the population, they may have made more progress with their newly learned skills than the other parents would have. They also may have known more about parenting skills and stress management skills in the first place and thus their children may have been better behaved and they may have been experiencing less stress than other parents may have.

Another limitation is that parents were not randomly assigned to treatment groups. Although they were not told in advance what the treatment order would be for each group, parents signed up for one night or the other based on personal preference, whether they had prior commitments on the other night, and where the group was held (some groups were held in different towns). This may have led to differences in the parents, which contributed, to differences in outcome measures, rather than the treatment itself. Although the only demographic variable that was significantly different between groups was the number of fathers participating (all fathers who completed treatment were in the parent-training-first group), there may have been something else unmeasured and thus unknown about parents who ended up in a particular treatment group that influenced outcomes. For instance, parents in a particular group may have had more in common or lived closer to one another and thus had more contact outside of group instructional time. In fact, two women in one group told the examiner that they
began going out for coffee together after each session in order to prolong the break from their families that the sessions provided. Such additional benefits from being in one group over another may contribute to group differences.

The fact that all fathers who completed treatment were in the parent-training-first group is also an important limitation. It is unknown what effect this may have had on overall outcomes, but one would be more comfortable making group comparisons if the groups were equal on major demographic variables. Also, most outcome studies on parent training are done with mothers and therefore the effect fathers may have on outcomes is largely unknown.

The treatment design was another important limitation. Because the two treatment components (parent training and stress management training) lasted different amounts of time, the time of assessment after the first treatment component was different for the two groups by three weeks. There may have been differences in outcome measures merely due to the amount of time parents had been receiving treatment. After all, results indicate that parents (although not children) appear to improve more after greater passage of time.

The lack of direct observation of child behavior is another factor that limited this study. All outcome measures were subjective reports by parents and teachers, and thus prone to bias and distortion. Due to the lack of corroborating evidence, it is unknown if parents’ reports of child behavior were accurate. One possible bias already mentioned was in the case of child outcomes after stress management training. Both groups reported worse child behavior after the stress management component, and one wonders
if this was due to parents focusing on stress and thus being hypersensitive to the areas in their life which cause stress (e.g., problematic child behavior). Hypersensitivity could mean being more accurate than at other times of assessment, or it could mean overestimating the severity of the factors in question (e.g., problematic child behavior). Having direct observation of child behaviors would help to clarify that issue.

The small number of subjects lowers the statistical power and generalizability of findings, and thus limits the conclusions that can be drawn from them. Because dropout is expected in treatment studies and eleven weeks is a long time commitment for parents, significant efforts were made to recruit large numbers of parents. However, each time a class was offered not enough parents signed up to allow for dropouts. This problem occurred both in the late winter/early Spring (March) and in the Fall (September). One can only speculate as to whether better numbers could have been attained by starting the classes at different times of the year. However, it is the researcher’s opinion that convincing a program like Head Start to make such classes part of a standard parent education package (rather than one more voluntary opportunity) would greatly improve attendance in research projects which contribute to the literature in areas considered to be of importance to that organization.

Finally, the fact that parents in the stress-management-first group consistently reported fewer problems for themselves and their children than those parents in the parent-training-first group makes it difficult to truly compare change and/or improvement. This is particularly the case given that the stress-management-first group was in the normal range at the beginning of treatment (and therefore had little room for
improvement) and remained in that range throughout treatment. It may be that this group would have changed more if they had been more distressed initially or had children with more severe behavior problems.

In order to clarify and expand on the findings in this study, it is hoped that similar studies are conducted in the future. Future researchers would do well to recruit larger numbers of parents to improve the statistical power of the analyses and generalizability of the findings. With larger numbers of subjects, one might be able to disperse fathers evenly between groups and possibly even compare father outcomes to mother outcomes. This would be very valuable in clarifying the unknown effect fathers had in this study, not to mention the fact that more single fathers are raising their children than before and are possibly a growing consumer group for parent training. Using a better research design would also be valuable, perhaps using random assignment to groups and adding a wait list control. Adding direct observation, although time consuming, would also add a great deal to this type of study. Finally, making small alterations based on parent feedback would be useful for future studies. Specifically, having a more comfortable setting for relaxation, more handouts, and giving more examples and showing more videotape scenarios during parent training appear to be popular suggestions.

Persuading a large agency like Head Start to make such a treatment package mandatory as part of their standard parent education would help in recruiting larger numbers of parents. Head Start requires parents to attend a certain number of educational meetings covering such topics as nutrition, child safety, and child
development. Making child behavior management one of the available classes in a large number of Head Start agencies would benefit research, and making child behavior management classes mandatory, even in only a few Head Starts, would greatly benefit research in this area. Having more parents enroll in child behavior management classes would necessitate the need to offer more classes throughout the week, thus providing parents with more class options that would interfere less with other commitments. However, with more participants and more classes, one needs the resources to support such an endeavor. One would need monetary support through larger research grants, as well as the use of multiple group facilitators to disperse the time commitment.

Final Summary

Despite the limitations, valuable information was gained. Parent training improves problematic behavior in preschool children and stress management improves stress in parents. While stress management was not shown to enhance the benefits from parent training (improve child behavior even more), in most cases parents were better off after receiving both treatments than they were after receiving only one treatment component (both parent training first and stress management first). However, when undergoing a treatment more focused on parent factors (such as stress), this study suggests one can expect some worsening of child behavior during that time. It has been suggested that a lowering of expectations for child behavior may aid in treatment for parent factors, but in some cases (such as when child behavior is particularly problematic or dangerous in the absence of diligent treatment) parent-focused treatment
may have to be abandoned, at least temporarily, until such a time when child behavior management practices can realistically be relaxed. Parents in both groups also reported equally high satisfaction with treatment, and both felt much more effective as parents after both treatments (and more so after both treatments than after just one treatment). However, parents who received their preferred treatment first were slightly more satisfied with the overall treatment package than were parents who received their preferred treatment second. Finally, teachers reported general improvement in children whose parents received treatment and those whose parents did not receive treatment, leading one to question whether teacher-reported improvements were related to the treatment provided in this study, or to experience with the Head Start curriculum or simply to the passage of time.

Overall, it appears that parents of young children can benefit from parent training and from stress management training (although more so with the former than the latter). Moreover, clinicians should be sensitive to the presence of multiple problems and screen parents for high levels of stress (and possibly other potential problems, such as depression or marital discord) when parents present to clinics for child behavior problems. Doing so may lead to better global outcomes and higher satisfaction with treatment, in that more areas of difficulty can be improved and thus parents feel as if they received better treatment. Finally, results from treatment preference and treatment satisfaction data point to the benefits of placing more value on parent-reported need when developing treatment plans, when clinicians may instead tend to prioritize treatment goals according to their own needs assessment, preferences, or biases.
REFERENCES


Jensen, P. S. (Summer 2003). Setting the record straight: Fact vs. fiction about ADHD. *NAMI Beginnings*, 3-7.


APPENDIX A

ANOVA Tables
Parent Measures

Table A-1

*Perceived Stress Scale*

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**p ≤ .01

Table A-2

*Parenting Stress Index: Child Domain*

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Table A-3

*Parenting Stress Index: Parent Domain*

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Table A-5

*Parenting Sense of Competence: Parenting Satisfaction*

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Table A-6

*Disruptive Behavior Disorders Rating Scale: ADHD Subscale*

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### Table A-9

**Achenbach Child Behavior Checklist: Total Scale**

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* p ≤ .05
Table A-10

*Achenbach Child Behavior Checklist: Externalizing Scale*

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*p ≤ .05

Table A-11

*Achenbach Child Behavior Checklist: Internalizing Scale*

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Table A-12

*Therapy Attitude Inventory*

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### Teacher Measures

#### Table A-13

*Preschool and Kindergarten Behavior Scale: Social Skills*

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#### Table A-14

*Preschool and Kindergarten Behavior Scale: Behavior Problems*

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<td>74.697</td>
<td>.106</td>
<td>.956</td>
</tr>
</tbody>
</table>

#### Table A-15

*Disruptive Behavior Disorders Rating Scale: ADHD*

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>SS</th>
<th>MS</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Within-subjects</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>2</td>
<td>273.043</td>
<td>136.521</td>
<td>3.881</td>
<td>.026*</td>
</tr>
<tr>
<td>Time* Group</td>
<td>6</td>
<td>1001.686</td>
<td>16.948</td>
<td>.482</td>
<td>.819</td>
</tr>
<tr>
<td>Error</td>
<td>60</td>
<td>2110.412</td>
<td>35.174</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Between-subjects group</strong></td>
<td>3</td>
<td>106.513</td>
<td>35.504</td>
<td>.374</td>
<td>.773</td>
</tr>
</tbody>
</table>

* p ≤ .05
### Table A-16

**Disruptive Behavior Disorders Rating Scale: ODD**

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>SS</th>
<th>MS</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within-subjects</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>2</td>
<td>59.007</td>
<td>29.503</td>
<td>2.672</td>
<td>.077</td>
</tr>
<tr>
<td>Time* Group</td>
<td>6</td>
<td>40.678</td>
<td>6.78</td>
<td>.614</td>
<td>.718</td>
</tr>
<tr>
<td>Error</td>
<td>60</td>
<td>662.596</td>
<td>11.043</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between-subjects group</td>
<td>3</td>
<td>7.697</td>
<td>2.566</td>
<td>.086</td>
<td>.967</td>
</tr>
</tbody>
</table>
APPENDIX B

Informed Consent to Treatment
Informed Consent

Treatment for Improving Parenting Skills and Reducing Parental Stress

Introduction

Theresa Gunderson, a graduate student at Utah State University, and Gretchen Gimpel, a faculty member in Psychology, are conducting this research study to investigate the effectiveness of parent training (both with and without stress management training) on parenting skills, parental stress levels, problematic child behaviors, and parenting efficacy. You have been asked to take part because you are a parent of a Head Start child. Approximately 20 other parents will also take part.

Procedures

You will be asked to complete four weeks of stress management training and seven weeks of parent training. Some parents will receive stress management first and some will receive parent training first. Stress management training will involve teaching such skills as relaxation training, cognitive interventions, and behavioral interventions. Parent training will involve teaching such skills as positive reinforcement, time out techniques, and the use of token economies. Groups will be held once per week and will last approximately 1.5 hours each. Throughout treatment, all parents will receive a phone once a week from the researcher or an assistant. The purpose of the phone calls is to assess your progress and to remind you to use the skills taught thus far.

You and your child’s teachers will complete several assessments. Teachers will fill out the Disruptive Behavior Disorders Rating Scale - Teacher Form, the Preschool and Kindergarten Behavior Scales (PKBS), and the Penn Interactive Peer Play Scale (PIPPS). You will fill out the Disruptive Behavior Disorders Rating Scale - Parent Form, the Child Behavior Checklist (CBCL), the Parenting Stress Index (PSI), the Perceived Stress Scale (PSS), the Parenting Sense of Competency Scale (PSOC), and the Personal Reaction Inventory. These scales will be completed prior to treatment and after the first of the two treatment components (stress management or parent training) and then again after all of the training is complete. A treatment acceptability questionnaire will also be added to the final set of assessments. Observations of your child in the classroom setting will also be done.

New Findings

You will be told of any significant new findings developed during the course of this study.
Informed Consent

Treatment for Improving Parenting Skills and Reducing Parental Stress

Risks

There are no known risks associated with participating in this study.

Benefits

Direct benefits to you include free parent training and stress management training. In addition, the information obtained from this study may aid clinicians in their future work with parents.

Explanation & offer to answer questions

Theresa Gunderson has explained this study to you and answered your questions. If you have other questions or research-related problems, you may reach Professor Gimpel at 797-0721.

Voluntary nature of participation and right to withdraw without consequence

Participation in research is entirely voluntary. You may refuse to participate or withdraw at any time without consequence.

Confidentiality

Information about you and your child will be kept confidential and will be available only to people directly involved in the project. Measures completed by you and your child’s teachers will be kept in a locked file cabinet. A code number will be assigned to each parent, and that number will be used to keep track of all data. Names will not be associated with results and will remain in the sole possession of the researchers. Public presentations of the results of this study will in no way identify your child.

IRB Approval Statement

The Institutional Review Board (IRB) for the protection of human subjects at Utah State University has reviewed and approved this research project.
Informed Consent
Treatment for Improving Parenting Skills and Reducing Parental Stress

Copy of Consent

You have been given two copies of this Informed Consent. Please sign both copies and retain one copy for your files.

Investigator Statement

"I certify that the research study has been explained to the above individual, by me or my research staff, and that the individual understands the nature and purpose, the possible risks and benefits associated with taking part in this research study. Any questions that have been raised, have been answered."

Signature of PI & student or CoPI

Gretchen A. Gimpel
Principal Investigator
(435) 797-0721

Theresa Gunderson
Student Researcher
(435) 753-0951

Signature of Subject

You agree to participate.

Subject’s signature

Date
Appendix C

Assessments
INFORMATION SHEET

**Parent Information**

Name: ____________________  Parent’s Gender (circle):  Male  Female

Parent’s ethnicity (circle one):

<table>
<thead>
<tr>
<th>Latino/a</th>
<th>Black/African American</th>
<th>White/Caucasian</th>
<th>Asian/Pacific Islander</th>
<th>Native American</th>
<th>Other (specify): ________________</th>
</tr>
</thead>
</table>

Relationship to Head Start Child (circle one):

- Mother
- Father
- Other (specify): ________________

Marital Status (circle one):

- Never married
- Married
- Divorced/Separated
- Widowed

Number of people living in household: ______  Net (take home) monthly income (approx.): ______

Highest level of education (circle one):

- Didn’t complete high school
- High school diploma
- Some college/vocational ed.
- Completed college
- Completed graduate/post-grad. ed.

Have you participated in any parenting classes or received counseling for parenting issues (circle one)?

- Yes
- No
- If Yes, please describe: ____________________________

Which aspect of the upcoming parenting class did you find most appealing? (circle one)

- Stress Management
- Parent Training

**Child Information**

Child’s Name: ____________________  Age: ______  Birth Date (MM/DD/YY): ________________

Child’s Gender (circle one):  Male  Female

Head Start Class (i.e., Logan A, Sunrise, etc.): ____________________  Class time (circle): am / pm

Child’s ethnicity (circle one):

<table>
<thead>
<tr>
<th>Latino/a</th>
<th>Black/African American</th>
<th>White/Caucasian</th>
<th>Asian/Pacific Islander</th>
<th>Native American</th>
<th>Other (specify): ________________</th>
</tr>
</thead>
</table>

Has your child been diagnosed with any psychological or behavioral disorders (circle)?

- Yes
- No
- If Yes, please specify: ____________________________

What do you see as the most problematic behaviors in your Head Start child? ____________________________
Perceived Stress Scale

The questions in this scale ask you about your feelings and thoughts during the last month. In each case, you will be asked to indicate how often you felt or thought a certain way. Although some of the questions are similar, there are differences between them and you should treat each one as a separate question. The best approach is to answer each question fairly quickly. That is, don’t try to count up the number of times you felt a particular way, but rather indicate the alternative that seems like a reasonable estimate.

1) In the last month, how often have you been upset because of something that happened unexpectedly?
   - Never
   - Almost Never
   - Sometimes
   - Fairly Often
   - Very Often

2) In the last month, how often have you felt that you were unable to control the important things in your life?
   - Never
   - Almost Never
   - Sometimes
   - Fairly Often
   - Very Often

3) In the last month, how often have you felt nervous and "stressed"?
   - Never
   - Almost Never
   - Sometimes
   - Fairly Often
   - Very Often

4) In the last month, how often have you dealt successfully with irritating life hassles?
   - Never
   - Almost Never
   - Sometimes
   - Fairly Often
   - Very Often

5) In the last month, how often have you felt that you were effectively coping with important changes that were occurring in your life?
   - Never
   - Almost Never
   - Sometimes
   - Fairly Often
   - Very Often

6) In the last month, how often have you felt confident about your ability to handle your personal problems?
   - Never
   - Almost Never
   - Sometimes
   - Fairly Often
   - Very Often

7) In the last month, how often have you felt that things were going your way?
   - Never
   - Almost Never
   - Sometimes
   - Fairly Often
   - Very Often

8) In the last month, how often have you found that you could not cope with all the things that you had to do?
   - Never
   - Almost Never
   - Sometimes
   - Fairly Often
   - Very Often

9) In the last month, how often have you been able to control irritations in your life?
   - Never
   - Almost Never
   - Sometimes
   - Fairly Often
   - Very Often

10) In the last month, how often have you felt that you were on top of things?
    - Never
    - Almost Never
    - Sometimes
    - Fairly Often
    - Very Often

11) In the last month, how often have you been angered because of things that happened that were outside your control?
    - Never
    - Almost Never
    - Sometimes
    - Fairly Often
    - Very Often

12) In the last month, how often have you found yourself thinking about things that you have to accomplish?
    - Never
    - Almost Never
    - Sometimes
    - Fairly Often
    - Very Often

13) In the last month, how often have you been able to control the way you spend your time?
    - Never
    - Almost Never
    - Sometimes
    - Fairly Often
    - Very Often

14) In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?
    - Never
    - Almost Never
    - Sometimes
    - Fairly Often
    - Very Often
**DISRUPTIVE BEHAVIOR DISORDERS RATING SCALE—PARENT FORM (FORM 4)**

<table>
<thead>
<tr>
<th>Child’s name</th>
<th>Age</th>
<th>Date</th>
</tr>
</thead>
</table>

Form completed by: __________________________

Relationship to child: (Circle one)
- Mother
- Father
- Stepparent
- Other: __________ (explain)

**Instructions:** Circle the number that *best describes* your child’s behavior at home over the past 6 months.

<table>
<thead>
<tr>
<th></th>
<th>Never or rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Fails to give close attention to details or makes careless mistakes in school</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Has difficulty sustaining attention in tasks or play activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Does not seem to listen when spoke to directly</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Does not follow through on instructions and fails to finish work</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Has difficulty organizing tasks and activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Avoids tasks (e.g., schoolwork, homework) that require mental effort</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Loses things necessary for tasks or activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Is easily distracted</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Is forgetful in daily activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10. Fidgets with hands or feet or squirms in seat</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11. Leaves seat in classroom or in other situations in which remaining seated is expected</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12. Runs about or climbs excessively in situations in which it is inappropriate</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13. Has difficulty laying or engaging in leisure activities quietly</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14. Is “on the go” or acts as if “driven by a motor”</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15. Talks excessively</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16. Blurs out answers before questions have been completed</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17. Has difficulty awaiting turn</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

(Cont.)
Form 4 (p. 2 of 2)

<table>
<thead>
<tr>
<th></th>
<th>Never or rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>18.</td>
<td>Interrupts or introduces on others</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>19.</td>
<td>Loses temper</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>20.</td>
<td>Argues with adults</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>21.</td>
<td>Actively defies or refuses to comply with adults' requests or rules</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>22.</td>
<td>Deliberately annoys people</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>23.</td>
<td>Blames others for his/her mistakes or misbehavior</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>24.</td>
<td>Is touchy or easily annoyed by others</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>25.</td>
<td>Is angry and resentful</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>26.</td>
<td>Is spiteful or vindictive</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

**Instructions:** Please indicate whether your child has done any of these activities in the past 12 months.

1. Often bullied, threatened, or intimidated others
2. Often initiated physical fights
3. Used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, or gun)
4. Has been physically cruel to people
5. Has been physically cruel to animals
6. Has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)
7. Has forced someone into sexual activity
8. Has deliberately engaged in fire setting with the intention of causing serious damage
9. Has deliberately destroyed others' property (other than by fire setting)
10. Has broken into someone else's house, building, or car
11. Often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)
12. Has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)
13. Often stays out at night despite parental prohibitions
   If so, at what age did this begin? _______
14. Has run away from home overnight at least twice while living in parent's home, foster care, or group home.
   If so, how many times? _______
15. Is often truant from school
   If so, at what age did he/she begin doing this? _______
Rater ____________________________ Child’s Name ____________________________
Relationship to child ____________________________ Date _____________ Child’s Age ______

PSOC

(Please circle the response for each statement which best expresses how you honestly feel.)

Strongly Agree=SA  Agree=A  Mildly Agree=MA
Strongly Disagree=SD  Disagree=D  Mildly Disagree=MD

1. The problems of taking care of a child are easy to solve once you know how your actions affect your child, an understanding I have acquired.

SA  A  MA  MD  D  SD

2. Even though being a parent could be rewarding, I am frustrated now while my child is at his/her present age.

SA  A  MA  MD  D  SD

3. I go to bed the same way I wake up in the morning – feeling I have not accomplished a whole lot.

SA  A  MA  MD  D  SD

4. I do not know what it is, but sometimes when I’m supposed to be in control, I feel more like the one being manipulated.

SA  A  MA  MD  D  SD

5. My parents were better prepared to be good parents than I am.

SA  A  MA  MD  D  SD

6. I would make a fine model for new parents to follow in order to learn what they would need to know in order to be good parents.

SA  A  MA  MD  D  SD

7. Being a parent is manageable and any problems are easily solved.

SA  A  MA  MD  D  SD

8. A difficult problem in being a parent is not knowing whether you’re doing a good job or a bad one.

SA  A  MA  MD  D  SD

9. Sometimes I feel like I’m not getting anything done.

SA  A  MA  MD  D  SD
10. I meet my own personal expectations for expertise in caring for my child.
   SA  A  MA  MD  D  SD

11. If anyone can find the answer to what is troubling my child, I am the one.
   SA  A  MA  MD  D  SD

12. My talents and interests are in other areas, not being a parent.
   SA  A  MA  MD  D  SD

13. Considering how long I’ve been a parent, I feel thoroughly familiar with this role.
   SA  A  MA  MD  D  SD

14. If being a parent of a child were only more interesting, I would be motivated to do a better job as a parent.
   SA  A  MA  MD  D  SD

15. I honestly believe I have all the skills necessary to be a good parent to my child.
   SA  A  MA  MD  D  SD

16. Being a parent makes me tense and anxious.
   SA  A  MA  MD  D  SD
Personal Reaction Inventory

Listed below are a number of statements concerning personal attitudes and traits. Read each item and decide whether the statement is true or false as it pertains to you personally.

Circle One

1. Before voting I thoroughly investigate the qualifications of all the candidates. T  F
2. I never hesitate to go out of my way to help someone in trouble. T  F
3. It is sometimes hard for me to go on with my work if I am not encouraged. T  F
4. I have never intensely disliked anyone. T  F
5. On occasion I have had doubts about my ability to succeed in life. T  F
6. I sometimes feel resentful when I don’t get my way. T  F
7. I am always careful about my manner of dress. T  F
8. My table manners at home are as good as when I eat out in a restaurant. T  F
9. If I could get into a movie without paying and be sure I was not seen, I would probably do it. T  F
10. On a few occasions, I have given up doing something because I thought too little of my ability. T  F
11. I like to gossip at times. T  F
12. There have been times when I felt like rebelling against people in authority even though I knew they were right. T  F
13. No matter who I’m talking to, I’m always a good listener. T  F
14. I can remember “playing sick” to get out of something. T  F
15. There have been occasions when I took advantage of someone. T  F
16. I’m always willing to admit it when I make a mistake. T  F
17. I always try to practice what I preach. T  F
18. I don’t find it particularly difficult to get along with loud mouthed, obnoxious people. T  F
19. I sometimes try to get even rather than forgive and forget. T  F
20. When I don’t know something I don’t at all mind admitting it. T  F
21. I am always courteous, even to people who are disagreeable.

22. At times I have really insisted on having things my own way.

23. There have been occasions when I felt like smashing things.

24. I would never think of letting someone else be punished for my wrongdoings.

25. I never resent being asked to return a favor.

26. I have never been irked when people expressed ideas very different from my own.

27. I never make a long trip without checking the safety of my car.

28. There have been times when I was quite jealous of the good fortune of others.

29. I have almost never felt the urge to tell someone off.

30. I am sometimes irritated by people who ask favors of me.

31. I have never felt that I was punished without cause.

32. I sometimes think when people have a misfortune they only got what they deserved.

33. I have never deliberately said something that hurt someone’s feelings.
<table>
<thead>
<tr>
<th>Rater</th>
<th>Child’s Name</th>
<th>Relationship to child</th>
<th>Date</th>
<th>Child’s Age</th>
</tr>
</thead>
</table>

**PARENT SURVEY**

*(Please circle the response for each statement which best expresses how you honestly feel.)*

1. Regarding techniques for disciplining, I feel I have learned.

<table>
<thead>
<tr>
<th>nothing</th>
<th>very little</th>
<th>a few new techniques</th>
<th>several useful techniques</th>
<th>very many useful techniques</th>
</tr>
</thead>
</table>

2. Regarding techniques for teaching my child new skills, I feel I have learned.

<table>
<thead>
<tr>
<th>nothing</th>
<th>very little</th>
<th>a few new techniques</th>
<th>several useful techniques</th>
<th>very many useful techniques</th>
</tr>
</thead>
</table>

3. Regarding the relationship between myself and my child, I feel we get along.

<table>
<thead>
<tr>
<th>much worse than before</th>
<th>somewhat worse than before</th>
<th>the same as before</th>
<th>somewhat better than before</th>
<th>very much better than before</th>
</tr>
</thead>
</table>

4. Regarding my confidence in my ability to discipline my child, I feel

<table>
<thead>
<tr>
<th>much less confident</th>
<th>somewhat less confident</th>
<th>the same</th>
<th>somewhat more confident</th>
<th>much more confident</th>
</tr>
</thead>
</table>

5. The major behavior problems my child presented at home before the program started are now

<table>
<thead>
<tr>
<th>considerably worse</th>
<th>somewhat worse</th>
<th>the same</th>
<th>somewhat improved</th>
<th>greatly improved</th>
</tr>
</thead>
</table>

6. I feel that my child’s compliance to my commands or requests is at this time

<table>
<thead>
<tr>
<th>considerably worse</th>
<th>somewhat worse</th>
<th>the same</th>
<th>somewhat improved</th>
<th>greatly improved</th>
</tr>
</thead>
</table>

7. Regarding the progress my child has made in his/her general behavior, I am

<table>
<thead>
<tr>
<th>very dissatisfied</th>
<th>somewhat dissatisfied</th>
<th>neutral</th>
<th>somewhat satisfied</th>
<th>greatly satisfied</th>
</tr>
</thead>
</table>

8. To what degree has the parenting portion of the treatment program helped with other general personal or family problems?

<table>
<thead>
<tr>
<th>hindered much more than helped</th>
<th>hindered slightly than helped</th>
<th>neither helped nor helped somewhat</th>
<th>helped very much</th>
</tr>
</thead>
</table>

9. I feel the type of program that was used to help me improve the behaviors of my child was

<table>
<thead>
<tr>
<th>very poor</th>
<th>poor</th>
<th>adequate</th>
<th>good</th>
<th>very good</th>
</tr>
</thead>
</table>
10. Regarding techniques of relaxation and stress reduction, I feel I have learned

<table>
<thead>
<tr>
<th></th>
<th>nothing</th>
<th>very little</th>
<th>a few new techniques</th>
<th>several useful techniques</th>
<th>very many useful techniques</th>
</tr>
</thead>
</table>

11. Regarding my confidence in my ability to relieve my stress, I feel

<table>
<thead>
<tr>
<th></th>
<th>much less confident</th>
<th>somewhat less confident</th>
<th>the same</th>
<th>somewhat more confident</th>
<th>much more confident</th>
</tr>
</thead>
</table>

12. Compared to before the program started, my stress level is currently

<table>
<thead>
<tr>
<th></th>
<th>considerably worse</th>
<th>somewhat worse</th>
<th>the same</th>
<th>somewhat improved</th>
<th>greatly improved</th>
</tr>
</thead>
</table>

13. To what degree has the stress management portion of the treatment program helped with other general personal or family problems?

<table>
<thead>
<tr>
<th></th>
<th>hindered</th>
<th>hindered slightly</th>
<th>neither helped nor hindered</th>
<th>helped somewhat</th>
<th>helped very much</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>much more than helped</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

14. I feel the type of program that was used to help me improve my stress level was

<table>
<thead>
<tr>
<th></th>
<th>very poor</th>
<th>poor</th>
<th>adequate</th>
<th>good</th>
<th>very good</th>
</tr>
</thead>
</table>

15. My general feeling about the program I participated in is

<table>
<thead>
<tr>
<th></th>
<th>I disliked it very much</th>
<th>I disliked it somewhat</th>
<th>I feel neutral</th>
<th>I liked it somewhat</th>
<th>I liked it very much</th>
</tr>
</thead>
</table>

16. What part of the program was most helpful to you?

17. What part of the program was least helpful to you?

18. How could the program have been improved to help you more?
# DISRUPTIVE BEHAVIOR DISORDERS RATING SCALE – SCHOOL VERSION
(Original Version – For Intake Only)

Child’s Name_________________________ Age____ Grade____ Sex____

Name of Rater_________________________ Date Completed____________________

Circle the number that best describes this student’s school behavior over the past 6 months (or since the beginning of the school year).

<table>
<thead>
<tr>
<th></th>
<th>Never or Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4.</td>
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<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5.</td>
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<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7.</td>
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<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8.</td>
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<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9.</td>
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<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10.</td>
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<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11.</td>
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<td>3</td>
</tr>
<tr>
<td>12.</td>
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<td>3</td>
</tr>
<tr>
<td>13.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
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<td>1</td>
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<td>3</td>
</tr>
<tr>
<td>15.</td>
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<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>18.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>19.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
20. Argues with adults.  
21. Actively defies or refuses to comply with adults' requests or rules.  
22. Deliberately annoys people.  
23. Blames others for his/her mistakes or misbehavior.  
24. Is touchy or easily annoyed by others.  
25. Is angry and resentful.  
26. Is spiteful or vindictive.  

Please indicate whether the student has done any of these activities in the past 12 months

1. Often bullied, threatened, or intimidated by others
   - No
   - Yes
   - Don’t Know
2. Often initiated physical fights.
   - No
   - Yes
   - Don’t Know
3. Used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, or gun).
   - No
   - Yes
   - Don’t Know
4. Has been physically cruel to people.
   - No
   - Yes
   - Don’t Know
5. Has been physically cruel to animals.
   - No
   - Yes
   - Don’t Know
6. Has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, or armed robbery).
   - No
   - Yes
   - Don’t Know
7. Has forced someone into sexual activity.
   - No
   - Yes
   - Don’t Know
8. Has deliberately engaged in fire setting with the intention of causing serious damage.
   - No
   - Yes
   - Don’t Know
9. Has deliberately destroyed others' property (other than by fire setting).
   - No
   - Yes
   - Don’t Know
10. Has broken into someone else’s house, building, or care.
    - No
    - Yes
    - Don’t Know
11. Often lies to obtain goods or favors or to avoid obligations (i.e., cons others).
    - No
    - Yes
    - Don’t Know
12. Has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery).
    - No
    - Yes
    - Don’t Know
13. Often stays out at night despite parental prohibitions
    If so, at what age did this begin? _____
    - No
    - Yes
    - Don’t Know
14. Has run away from home overnight at least twice while living in parent’s home, foster care, or group home. If so, how many times? _____
    - No
    - Yes
    - Don’t Know
15. Is often truant from school If so, at what age did he/she begin doing this? _____
    - No
    - Yes
    - Don’t Know
Session Rating Scale

Today’s Date ________________________

For each item, indicate how much you agree with the statement (1 = not at all, 5 = very much, or “NA” if the statement is not applicable for this week).

1) The leader encouraged group participation. 1-----2-----3-----4-----5
2) I actively participated in today’s session. 1-----2-----3-----4-----5
3) I paid careful attention to information presented today. 1-----2-----3-----4-----5
4) The information presented today was helpful. 1-----2-----3-----4-----5
5) Last week’s in-class practice was worthwhile. 1-----2-----3-----4-----5----NA
6) I tried last week’s skills outside of class. 1-----2-----3-----4-----5----NA
7) My child responded well to last week’s assignment(s). 1-----2-----3-----4-----5----NA
8) Last week’s homework assignment(s) was/were helpful. 1-----2-----3-----4-----5----NA

What did you learn in today’s class that was useful?

What could have been improved in today’s class?

Do you think you can use what you learned today at home? Why or why not?

What else would have been helpful to cover in today’s class?
Program Rating Scale

Today’s Date ____________________

For each item, indicate how much you agree with the statement (1 = not at all, 5 = very much). These items pertain to all 4 stress management classes as a whole.

1) The information presented was helpful. 1------2------3------4------5

2) The homework assignments were helpful. 1------2------3------4------5

What did you learn that was useful?

What could have been improved?

Do you think you can use what you learned at home?

What other topics would you have liked covered?

Indicate topics you found helpful with a (+) and topics you found unhelpful with a (-).

___ Components of stress

___ Assertiveness Training

___ Relaxation Training

___ Time Management

___ Cognitive Interventions

___ Improving Your Sleep
Dropout Questionnaire

Please answer the following questions to help me improve dropout rates the next time I offer my parent training/stress management classes.

Please check all factors that contributed to your need to drop out of the classes. At the bottom add any that are not listed for you. If possible, please give me suggestions for what I could have done differently to keep you in the group.

Factor: What Theresa or Head Start could have done differently:

- lack of child care
- day of class
- time of class
- too many classes
- not enough incentives (e.g., prizes, gift certificates)
- lack of motivation
- information not useful
- class wasn’t what I expected
- too much class-related work
- too many commitments (not related to class)
- unexpected events
- illness
- transportation problems
- uncomfortable in this setting

---
Appendix D

Session Outlines
SMT WEEK 1

---

Prizes for assessments brought filled out

---

General information for first class:
• importance of participation, homework, attendance

---

SMT

---

Definition of stress

---

(Give handout)

---

Components of stress: mnemonic device

---

Three phase model

---

HOMEWORK

---

Fill in own examples using STRESS mnemonic (@ least 1)

---

Child behavior logs

---

First Meeting

---

Allow time at end for filling out assessments, parent discussion re: child care, etc.
SMT WEEK 2

General

- attendance sheet, child care reimbursement & mileage reimbursement
- attendance prizes

SMT

- Collect and discuss last week’s homework (STRESS mnemonic & Bx. Logs)
- Overview of Relaxation Training (*Relaxation Training Handout*)
- Practice Relaxation
  - Stress level (0-10)
  - Practice breathing first (continue throughout)
  - PMR
  - Imagery
  - Stress level (0-10)
- Discuss logistics of Relaxation (i.e., setting - alone or not?, time, etc.)

HOMEWORK

- Practice the full relaxation exercise at least once during the week
- Child behavior logs
SMT WEEK 3

General
- attendance sheet, child care reimbursement & mileage reimbursement
- attendance prizes

SMT
- Collect and discuss last week’s homework (Bx. Logs & relaxation practice)
- Overview of Cognitive Interventions (*Week 3 Handout*)
  - Ellis’ ABC’s
  - Categories of irrational beliefs; checklist of cognitive distortions
  - Examples of irrational beliefs (have them come up with some as well)
    - examples of how to make them different beliefs (replacement thoughts)
  - Stress inoculation
- Provide Handout: *10 Ways to Untwist Your Thinking*

HOMEWORK
- Monitoring homework
- Child behavior logs
SMT WEEK 4

General

— attendance sheet, child care reimbursement & mileage reimbursement
— attendance prizes

SMT

— Collect and discuss last week’s homework (Bx. Logs & monitoring homework)

— Provide Handout: Assertiveness and Time Management

— Assertiveness Training
  • Traditional Assumptions
  • Definitions - stress that assertiveness is not aggression

— Time Management
  • Stress balance

— Improving Your Sleep (Provide Handout)

— Other
  • Aerobic Exercise
  • Healthy Lifestyle (no smoking, proper diet, moderate alcohol and caffeine)

HOMEWORK (if going on to PT)

— Finish Time Management schedules
— Child behavior logs

If Last Class

— Hand out post- Assessments and arrange way to get them back
  • Will draw for prize when all handed in

— Prize for perfect/best attendance

— SMT rating form
PT WEEK 1

First Meeting
   ______  Prizes for assessments brought filled out
   ______  General information for first class:
   _____  • Preston’s child care idea
   _____  • importance of participation, homework, attendance

General
   ______  attendance sheet, child care reimbursement & mileage reimbursement
   ______  attendance prizes

PT
   ______  Introduction to behavior terms (handout: Terminology and Guidelines)
   _____  • **highlight:** what we think of as reinforcement and punishment
don’t necessarily work for every child—each is unique
   _____  • interaction between parent and child behavior
   _____  • examples of appropriate and inappropriate behaviors, parental reactions, and reinforcement (stress attention!)
   _____  • and punishment
   ______  Using positive reinforcement to increase appropriate behavior
   _____  • behavior game
   _____  • illustrate on board
      - briefly discuss extinction
      - mention that reinforcement will be the main focus at first
   _____  • punishment and reinforcement best if immediate!

HOMEWORK
   ______  **Increase positives for good behavior**
   ______  **Child behavior logs**

First Meeting
   ______  Allow time at end for filling out assessments, parent discussion re: child care, etc.
PT WEEK 2

General
—— attendance sheet, child care reimbursement & mileage reimbursement
—— attendance prizes

PT
—— Collect and discuss last week’s homework
  • Child behavior logs
  • Increase positives for good behavior

—— Introduce Child’s Game
  • Positives can change child’s behavior
    • tie in homework of increasing positives for good behavior
  • Ignoring annoying behaviors to make them decrease
  • Increasing positives now will make discipline strategies more effective, and
    discipline may not have to be used as often

—— Handout provided (Paying Attention to Your Child’s Good Play Behavior)
  • Rationale: over learn positive reinforcement skills, increase child’s self-esteem
  • This is not permissive parenting—key is to learn to give attn. to positive bx.
  • Go over handout and dos and don’ts and examples of these
  • Rationale for “don’ts”: completely focus on child and focus on attending to their
    positive behaviors—even questions can take focus away from child
  • Will feel unnatural at first

—— Handout provided (Top 10 Questions about the Child’s Game)

—— Video clips of Child’s Game shown—have parents pick out good and bad aspects

—— Child’s Game practiced by parents
  • mingle and give feedback
  • have each person comment on partner’s performance

HOMEWORK
—— Child behavior logs

—— Practice Child’s Game for 5 minutes a day—at least 3 days out of the week
PT WEEK 3

General
- attendance sheet, child care reimbursement & mileage reimbursement
- attendance prizes

PT
- Collect and discuss last week’s homework
  - Child behavior logs
  - Increase positives for good behavior
- Model Child’s Game
  - talk about frequency (25 descrip./reflec.-5/minute; 15 praise – 3 minute)
- Parents practice Child’s Game again for 1 minute each (with “criteria” in mind)
- Handout: Rewards Children Like (social, activity, material)
- Managing behavior with positive reinforcement
  - are you making good behavior worthwhile and bad behavior unworthy?
  - Video clips (discussion questions from video leader’s guide)
    - 30:25 Ignoring report card (scene #1; good bx. unworthy.)
    - 33:01 Cookies at grocery store (scene #3; bad bx. worth.)
    - 33:42 Cleaning the sink (scene #4; good bx. worthwhile)
    - 35:56 Get me milk! (scene #7; bad bx. worthwhile)
- Managing behavior with differential/selective attention
  - Replacement behavior for problem behavior
  - add & subtract: add a lot of attention for positive (replacement) behavior and subtract attention for misbehavior
  - be consistent!

HOMEWORK
- Child behavior logs
- Practice Child’s Game for 5 minutes a day—at least 3 days out of the week
PT WEEK 4

General

- attendance sheet, child care reimbursement & mileage reimbursement
- attendance prizes

---

PT

- Collect and discuss last week’s homework
  - Child behavior logs
  - Child’s Game—ask about frequency of descrip./reflec./praise

- Problems with spanking/hitting—list pros and cons

- Ignoring Negative Behavior (Handout)

- Setting Limits
  - Children will test parents’ rules. If these rules have been inconsistent (haven’t been enforced or have been enforced inconsistently), the child’s protests and noncompliance will escalate.

- Giving Effective Commands (Handout)
  - Rationale: - make commands as clear as possible for increased compliance
    - children can clearly tell that they are expected to obey
  - Provide examples and have parents provide some

- Video clips on commands (parents point out good and bad aspects of commands)
  - USU video
  - SOS video: 25:32 Jumping on bed (Bad command)  
    26:05 Jumping on bed (Good command)

HOMEWORK

- Child behavior logs

- Child’s Game

- Attend to how you state commands and try to reword according to handout
PT WEEK 5

General
- attendance sheet, child care reimbursement & mileage reimbursement
- attendance prizes

PT
- Collect and discuss last week’s homework
  - Child behavior logs
  - Child’s Game
  - Attending to how commands are stated (tie in to next activity)
- Review how to give effective commands
  - Have parents come up with the rule and discuss
  - Have each parent give me a command (give feedback)
- Effectively Using Time Out (Handout)
  - Discuss spanking as a short-term “quick fix” with long-term disadvantages
  - Discuss their past use of Time Out
  - Go over handout
    -- Discuss rationale for waiting 10 sec.
- View video clip of Time Out
  - Review the different steps
  - Discuss ignoring child jumping on chair
  - Point out giving command again after time out and reinforcing compliance
- Pair up on role play using time out (give feedback)
- Discuss time out for breaking rules (no warning provided)
- Discuss technicalities of using at home (i.e., location, other people/kids around)
  - Tell parents to explain new T.O. to child before they start to use it at home
    -- When break rule or don’t follow directions, will need to go to time out and stay there until quiet and parent says he/she can leave
    -- Show child where they will be sitting
    -- Model/practice sitting in chair appropriately

HOMEWORK
- Child behavior logs
- Child’s Game
PT WEEK 6

General

- attendance sheet, child care reimbursement & mileage reimbursement
- attendance prizes

PT

- Collect and discuss last week's homework
  - Child behavior logs
  - Child's Game
  - Time Out

- Discuss handout: Using Privileges to Manage Behavior (privilege wksht on back)
  - Rationale: may need more motivation, when T.O. no feasible, portable
  - Discuss ideas for everyday, special, and automatic privileges

- Discuss fun ways to use privileges (handout: Dot-to-Dot & Grab Bag)
  - dot-to-dot and grab bag reward systems
  - token economies/sticker charts
  - mystery motivator (Spinner: “Utah’s Best Project 1993” 1-801-538-7571)
  - “beat the clock”

* Drawing for toys (if available)

HOMEWORK

- Child behavior logs
- Privilege worksheet
PT WEEK 7

General
- attendance sheet, child care reimbursement & mileage reimbursement
- attendance prizes

PT
- Collect and discuss last week’s homework
  - Child behavior logs
  - Privilege Worksheet
  - Ask how Time Out and Child’s Game going
- Discuss handout: *Attending to Independent Play*
- Discuss handout: *Managing Behavior in Public Places*
- PT wrap-up and open discussion

HOMEWORK (if going on to SMT)
- *Child behavior logs*

If Last Class
- Fill out post-PT Assessments
  - Draw for prize when all handed in
- Prize for perfect/best attendance
Appendix E

Parent Handouts and Homework
## Child's Game Homework Sheet

**Child's Name:** ______________________

<table>
<thead>
<tr>
<th>Date</th>
<th>Did you practice? (yes or no)</th>
<th>Any comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>
Behavior Log

Child’s Name: _____________________

Behaviors should be recorded for at least 3 days during the time between dinner-time and bed-time.

If no problem behaviors occurred on a certain day, make sure to indicate so with either a “0” or by writing in “no behaviors” in the appropriate column.

In Hours column, please record the number of hours between dinner-time and bed-time (i.e., the time period in which you recorded behaviors).

<table>
<thead>
<tr>
<th>Date</th>
<th>Hours</th>
<th>Non-Compliance</th>
<th>Physical Aggression</th>
<th>Temper Tantrums</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: 1-199</td>
<td>Example: 3</td>
<td>Example</td>
<td>Example: 0</td>
<td>Example:</td>
</tr>
</tbody>
</table>

---

This is a behavior log where Child’s Name is requested along with instructions on the recording of behaviors. It emphasizes the importance of recording behaviors for at least 3 days between dinner-time and bed-time, ensuring that if no problem behaviors occurred, they are indicated as such using a “0” or “no behaviors” in the appropriate column. The log also instructs on recording the number of hours between dinner-time and bed-time in the Hours column, essential for accurately tracking behavior patterns.
**Components of Stress**

Think of a stressor in your life and write it down beside "stressor." Then fill in examples of the other components as they relate to that stressor.

<table>
<thead>
<tr>
<th></th>
<th>Example 1</th>
<th>Example 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stressor</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Transaction</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Resistance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Energy spent</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Strain</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Solution or slide</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Monitoring Homework

A. Give a brief description of an event or situation you were involved in just prior to experiencing a negative emotion.

B. What did you say to yourself about “A” (use exact phrases when possible)?

C. Give a brief description of the feeling or negative emotion (guilt, anger, depression, anxiety, etc.) that you experienced after event “A.”

D. Describe a different belief that you could have about “A” which would still be true yet lead to a better emotional outcome.

E. Briefly describe the new emotional outcome.
Definition of Stress

The condition that results when interactions with the environment lead the individual to perceive a discrepancy (real or not) between the demands of the situation and the resources of the person’s biological, psychological, or social systems.

Components of Stress

S  Stressor  A stimulus that triggers internal tension.

T  Transaction  Negotiations between the person and the environment.

R  Resistance  The private struggle that goes on while trying to cope with the stressor.

E  Energy spent  Mental and physical energy that are part of the cost of coping.

S  Strain  The wear and tear that results from coping efforts.

S  Solution or Slide  Coping efforts may yield a solution, but continued stress may lead to gradual decline in energy, health, and motivation.

Three Phase Model

Phase I:  Occurrence of Stressor

Phase II:  Response to Stressor – Physical, emotional, and cognitive reaction

Phase III:  Personal Interpretation of Stressor
What is Relaxation Training?
Relaxation training is a term that covers a variety of techniques that are designed to help people relax their various muscle groups and increase their sense of well-being. These are learned skills that must be practiced in order to be mastered. It is not a substitute for other treatments that you may be receiving but rather is an additional way to help you with your particular problem. Relaxation training has been successfully used to treat a variety of problems including:

- excessive anxiety
- pain
- headache
- gastrointestinal disturbance
- muscle tightness

In addition to the obvious effects of relaxing muscles, relaxation also brings about other bodily changes. The following are a natural part of relaxation:

- heaviness of the eyelids
- limpness or heaviness of the limbs
- slower and/or deeper breathing
- hands and feet becoming warm and toes and fingers becoming tingly
- more awareness of your heartbeat

You will never relax too deeply or too quickly. You may, however, fall asleep. If this is a problem, you may consider setting an alarm prior to beginning your relaxation session.

Why Can’t I Relax?

Your muscles and nervous system adapt readily to varying levels of tension. For example, your body retains muscular control without you being aware of it. If this were not so, you would spend all your time thinking about the changing state of your muscles as you walk, sit, etc.

Over a long period of stress or pain, or during shorter periods of severe stress or pain, your body will adapt to the high levels of tension. You continue to function, often unaware that you are in an abnormally high state of tension. Thus, the feedback signals that normally inform your nervous system to take it easy go unnoticed.

The reason for our inability to relax during such extreme tension is based on a well-known principle of perception. For example, lighting a match in a brightly lit room does not appear to change the overall illumination of the room, whereas when you light a match in a dimly lit room the illumination seems to change dramatically. The same is true with stress. The greater the tension in our muscles, the less we can sense any easing of that tension. Because our muscles relax in gradual steps, we sometimes cannot notice the change at all if we are very tense. As a result, we are often least able to relax precisely at the times when we most need to.

What Am I Learning?

You will be learning three techniques combined into one exercise. You will probably find that one is more effective than the other techniques, or that a combination is more effective than any one used alone.
A. **Progressive Muscle Relaxation (PMR):** You will tense and relax various muscle groups in sequence. PMR forms the basis for your relaxation experience and is probably the easiest of the techniques to learn and achieve an effect from.

B. **Deep Breathing:** You will take several deep breaths to enhance the effect of PMR. Remember to breathe from your diaphragm instead of your chest.

C. **Imagery:** You will imagine that you are in a pleasant location. This technique works best if you incorporate all of your senses (see, hear, feel, and smell).

**Tips for Practicing Relaxation and Trouble Shooting**

1. **Start Fresh**
   While it is acceptable to use relaxation to assist with sleep, you should also practice when you are alert and your mind is active.

2. **Preparation**
   Relaxation works best if consistently practiced on a daily basis rather than waiting until you are feeling severely distressed. However, you may want to help the relaxation process along by engaging in certain activities prior to practicing. Examples include sitting in a warm bath, sitting in a quiet place, and listening to soothing music. These activities should be used in addition to your relaxation, not instead of it.

3. **Interruptions**
   Initially it is best if you can practice without interruption. This may mean taking the phone off the hook or telling others that you are not to be disturbed. If you wear glasses or contact lenses it is a good idea to remove them prior to practicing.

4. **Intrusive Thoughts**
   It is expected that you will have intrusive thoughts while using relaxation. The best approach is to adopt a passive attitude and let the thoughts drift away, and then return to where you were in the exercise. Some people plan a pleasant image that they will return to following intrusive thoughts and from there will return to their relaxation.

5. **Do Not Rush**
   You may experience a tendency to rush. Take it slow and easy.

6. **Pain**
   If you experience muscle twitches, do not worry as these are common. If, however, you experience muscle cramps it is best to generate less tension and hold it for a shorter time. It is also good to move the cramped muscle while keeping other muscles relaxed. If your pain increases, adjust your relaxation to avoid tensing the areas that are causing the pain.
Albert Ellis’ A-B-C’s

A = Activating event
B = Belief (Irrational)
D = Consequence (Emotional, Physical)

D = Different belief
E = Emotional consequence (moderated)

Categories of Irrational Beliefs

1. “Awfulizing” statements
   a. See events as catastrophic

2. “Should,” “Must,” “Ought to” Statements
   a. Changes preferences (“I want”) into demands (“I should”)

3. Self-Evaluations
   a. Take one negative behavior and use it as a basis for general, negative self-adjustment

4. Need Statements
   a. Need = survival
   b. If you set up something as a “condition for living,” you have an excuse to experience constant anxiety about it
Examples of Irrational Beliefs

1. I must always do well and win the approval of others.
2. Others should treat me well and in precisely the manner I would like to be treated.
3. This is the end of __________________ (my career, my life, etc.).
4. This is ridiculous, having to spend the entire day waiting to see the doctor.
5. I'll never be a good __________________ (mother, father, wife, husband, employee, etc.).
6. I'm worthless because I didn't get my work done by the end of the day.

Stress Inoculation

1. Preparation
   • develop self-statements to assist you in getting ready for a stressful event
   • i.e., “Just think about what I can do about it”

2. Confronting and handling the stressor
   • prepare self-statements to manage negative emotions when they begin in the stressful situation
   • i.e., “Relax. I’m in control,” “Don’t assume the worst.”

3. Coping with feeling overwhelmed
   • prepare self-statements that will help you cope with the particular aspects of the situation that may make you feel overwhelmed
   • i.e., “I can’t eliminate stress completely; just keep it manageable.”

4. Reinforce self-statement coping
   • reinforce yourself for having coped with the stressful circumstance
   • i.e., “I did it.” or “Don’t give up. I’ll do better next time.”
10 Ways to Untwist Your Thinking

1. Identify the Distortions
   After you have the negative thought, identify the distortion or type of irrational belief.

2. The Straightforward Approach
   Substitute a more positive and realistic thought.

3. The Cost-Benefit Analysis
   List the advantages and disadvantages of a negative feeling, thought, or belief.

4. The Double-Standard Technique
   Instead of putting yourself down, talk to yourself in the same compassionate way you might talk to a friend who was upset.

5. Examine the Evidence
   Instead of assuming that your negative thought is true, examine the actual evidence for it.

6. The Survey Method
   Do a survey to find out if your thoughts and attitudes are realistic.

7. The Experimental Technique
   Do an experiment to test the validity of your negative thought.

8. Thinking in Shades of Gray
   Instead of thinking about your problems in black-or-white categories, evaluate things in shades of grade.

9. The Semantic Method
   Substitute language that is less colorful and emotionally loaded.

10. Re-Attribution
    Instead of blaming yourself entirely for a problem, think about the many factors that may have contributed to it. Focus on solving the problem instead of using all your energy blaming yourself and feeling guilty.
Assertiveness

Some Mistaken Traditional Assumptions about Life and Your True Legitimate Rights

**Mistaken Traditional Assumptions**

1. It is selfish to put your needs before others' needs.
2. It is shameful to make mistakes.
3. You should respect the views of others and keep your differences of opinion to yourself.
4. You should be flexible and adjust. It's not polite to question others' actions.
5. You should never interrupt people.
6. Things could get worse; don't rock the boat.
7. You should always try to accommodate others.
8. You should help people when they're in trouble.
9. You shouldn't take up others' valuable time with your problems.
10. Keep it to yourself if you feel bad.

**Your Legitimate Rights**

1. You have a right to put yourself first, sometimes.
2. You have a right to make mistakes.
3. You have a right to your own opinions and convictions.
4. You have the right to protest unfair treatment or criticism.
5. You have a right to interrupt in order to ask for clarification.
6. You have a right to negotiate for change.
7. You have a right to say no.
8. You have a right not to take responsibility for someone else's problem.
9. You have a right to ask for help or emotional support.
10. You have the right to feel and express pain.

**Definitions**

1. **Assertiveness**: the disposition to bold or confident assertion without need for proof.
2. **Assertion**: confident declaration or affirmation of a statement.
3. **Assert oneself**: to compel recognition of one's rights or position.

**An assertive person can:**

1. Talk about feelings
2. Talk about yourself
3. Accept compliments
4. Disagree mildly
5. Ask for clarification; ask why
6. Express active disagreement
7. Speak up for your rights
8. Be persistent
9. Avoid justifying every opinion
10. **Negotiate mutually satisfying solutions to a variety of interpersonal problems**
LADDER

Look at the situation. What are your rights, needs, and feelings about the situation?
Arrange a time to discuss your problem. (Omit this step in spontaneous situations.)
Define the problem. Be specific and objective!
Describe your feelings. Use “I messages” (i.e., “I feel hurt” rather than “You hurt me”)
Express your request in one or two easy-to-understand sentences.
Reinforce. Let the listener know the positive consequences for them if they cooperate.

Application

1. You’re giving a friend a lift to a meeting. The friend keeps puttering around for half an hour so that you will arrive late.

Describe how you should handle the situation.

TIME MANAGEMENT

A. Alternating Strategy
   1. Schedule things we have to do at certain times
   2. Make list of other things you have to do
   3. Make list of things you want to do
   4. Schedule by choosing from #2 and #3 in alternating fashion

B. Make “To Do” lists and prioritize
   1. High = most essential
   2. Medium = desirable
   3. Low = could wait or be done by someone else

C. Schedule Down Time
   • Large and small activities/chunks of time

D. Time Wasters
   • e.g., indecisiveness, phone calls, visitors, unnecessary meetings and paperwork, etc.
   • Solutions:
     1. Assertiveness
     2. Saying “no”
     3. Consider commitments before making them
     4. Delegate
Behavior Tips to Improve Sleep

Sleep disturbance can be caused from many factors including pain, illness, stress, depression, changing work shifts, environmental factors (e.g., barking dogs, airplanes, too much light, temperature extremes), hot flashes, heartburn, job problems, etc. When people experience loss of sleep they may find themselves becoming irritable, fatigued, depressed, and even ill. On the other hand, it is sometimes amazing how much better people feel if they start sleeping well. The treatments for sleep disturbance include both medication and behavioral intervention. In many ways sleep is a habit and, therefore, like any habit it can be trained for better or worse. In what follows I have listed several simple behavioral techniques that can help you to improve your sleep.

1. Always get up at the same time every morning. This is the one aspect of the sleep cycle that you can easily control and will help to begin developing the habit.

2. Take no naps. While it is very tempting to nap the day following a restless night, resist the urge. You want to establish a habit of sleeping at night when your body can move through all phases of the sleep cycle and, therefore, be rejuvenated. Naps will rob you of nighttime sleep.

3. Use your bed only for sleep. Do not read books, watch television, eat, etc., in bed. You want your body to get the signal when it sees the bed that it is time for sleep.

4. Similar to number 3, go to bed only when you are sleepy. If you are not sleepy, continue doing something else, perhaps something that will be sleep inducing.

5. If you are not sleeping after about 15 minutes, get up and go do something relaxing. Then when you feel sleepy return to bed and try again. Keep doing this until you fall asleep.

6. Utilize relaxation strategies prior to getting in bed. Perhaps you know of some good ways to calm yourself and prepare for sleep (such as a warm bath or reading). Additionally, you may benefit from relaxation training. There are specific relaxation skills that you can learn that will help you calm down and get sleepy. Ask you psychologist about these.

7. Exercise, but do so early in the day. Exercise is good in that it helps relieve stress and brings about fatigue and relaxation; however, you should not exercise late in the day. Although it is relaxing in the long run, the immediate effect of exercise for many people is to make them more alert and aroused. Thus, I recommend exercise be completed before dinner.

8. Do not ingest caffeine after noon. Remember caffeine is found in coffee, tea, many soft drinks, and chocolate among other sources. It is a stimulant and, therefore, can affect your sleep.

9. Do not ingest alcohol or tobacco within one to two hours of going to bed.

10. Do ingest a bagel or glass of milk. These contain naturally sleep-enhancing substances.
11. Try to retain a passive-relaxed attitude. Trying to “force” sleep will only result in more arousal and less sleep.

12. If you are a “bedtime worrier,” that is you try to solve your problems while in bed, set aside another specific time of the day for worrying and problem solving. This will not only allow you to be more productive in your waking hours, but will also free your mind to not have to attempt to solve problems at night.

13. Utilize relaxing imagery (i.e., pictures in your mind) as a way of calming down your thoughts. You may picture yourself in a pleasant place or engaging in some type of relaxing and enjoyable activity. While using your imagination, incorporate all of your senses so that the picture in your mind is as real and, therefore, as relaxing as possible.

These strategies need to be practiced “religiously” over a period of a couple of weeks. Your body needs, and in fact will crave, sleep. The trick is to channel it in the proper ways. Obviously if you physician has prescribed any medication for sleep, you should use it as directed in addition to performing the steps outlined here. If your sleep has not improved after a couple of weeks, you should again consult your physician and/or psychologist.

These tips are intended only for those having sleep problems. If your sleep is fine you do not need to be concerned with performing the behaviors listed above.
Terminology and Guidelines

People act according to what we will call “laws of behavior.” Understanding these laws and the ways they work can help you understand why your child behaves the way he/she does. Applying skills and principles based on these laws will help you increase your child’s good behaviors and decrease his/her unwanted behaviors. Many of these principles will sound like common sense, while others may not. Just remember that all of them have been studied extensively and have been shown to be effective.

ABCs

A - This stands for antecedent stimuli, which is a fancy word meaning “before.” These are “cues” or “events” that happen before a behavior that signal a behavior to occur.

B - This is the behavior that happens.

C - This stands for consequence. A consequence is something that happens after a behavior. Consequences can affect children’s behaviors. If the consequence is good, it is likely that the behavior will happen again, but if the consequence is negative, it is unlikely that the behavior will happen again.

Let’s look at the ABCs using an example. A child in the store with his mother sees the candy rack at the checkout counter and begins pestering his mother for candy. The antecedent, or “A,” would be candy in the checkout isle. The behavior, or “B,” would be asking or pestering for candy. If the consequence, or “C,” is that the mother buys some candy, the child will be more likely to behave this way in the future in the same situation. But, if the consequence is that the mother does not buy candy and ignores the pestering, the child will be less likely to try this again in the future.

Reinforcement

Positive Reinforcement - This type of reinforcement involves giving a pleasant consequence to increase behavior. Consequences that increase behaviors are called reinforcers. To determine if a consequence is a reinforcer, observe your child’s behavior after the consequence is given. If your child’s behavior increases that consequence is a reinforcer. Reinforcers can be anything: attention, food, toys, money, praise, and even things we may consider unpleasant. For example, children are often reinforced by parental attention and even negative parental attention (yelling, etc.) may increase behaviors.

For reinforcers (and all consequences) to be most effective they must occur immediately after a behavior.

Negative Reinforcement - This is also called Escape. Escape involves taking away unpleasant consequences to increase a behavior.

A good example of this principle occurs when children whine. Whining is unpleasant and to get children to stop, parents often give in to children’s demands. If you give into your child’s whining, this makes it more likely that the next time your child whines, you will do the same thing because you have been negatively reinforced (the unpleasant whining stops). This is only half of the interaction though. Your child is also being positively reinforced for whining. Your child learns that every time he/she whines, you will give in to his/her demands.

Extinction

Extinction is one way to decrease behavior. It involves making the behavior occur less and less until it
no longer occurs at all. The best way to do this is to take away whatever is reinforcing the behavior. Here’s a simple example of how this principle decreases behavior. Let’s say that you had a friend who paid you $10.00 to do his dishes every day. One day your friend says, "I’m sorry, but I cannot pay you anymore for doing my dishes." Most likely, you will stop doing his dishes because there is no longer reinforcement for this task.

**Extinction Burst**

When using extinction, something interesting happens. The behavior gets worse before it gets better. This is called an Extinction Burst. A good example of this is with a soda machine that is broken. You put your money in the machine, and it takes your money without giving you a soda. You might push the coin return, hit the machine, and put more money in, until you finally realize that the reinforcement of having the soda is not going to happen, so you stop.

If you use extinction to decrease a child’s behavior, you can expect the same thing. If your child whines every night before bed and you decide not to reinforce the behavior (by giving it attention) but instead put it on extinction (by ignoring it), you can expect louder whining and maybe even some kicking and screaming in the short term. However if you are persistent, the whining will stop. This persistence is important. If you initially ignore a behavior but give in when it gets too bothersome, you will have taught your child that if he/she stays at it long enough he/she will be reinforced. In reality you will have made matters worse! This is why you must be committed to using extinction before you begin.

**Differential Reinforcement**

When children misbehave, we can often change their behavior by reinforcing them for something we approve of. This is called “differentially reinforcing other behavior (DRO)” meaning other behavior that is appropriate. This is an effective way of changing behaviors, especially when paired with extinction. For example, when your child is throwing toys (in an effort to get your attention), ignore the throwing behavior and once he/she does any other appropriate behavior, reinforce him/her for it quickly. For example, if he/she picks up a truck and rolls it on the floor, reinforce him/her for this appropriate activity. Keep reinforcing good behaviors and ignoring the inappropriate behaviors. This will stop the throwing and increase the behaviors you reinforce.

**Punishment**

Punishment is another way to decrease behavior, but it is often not the best way. Just like Reinforcement, there are 2 types of punishment.

**Type 1** - This is when something negative happens right after a behavior. For example, a child refuses to eat his vegetables and is sent to his room or is spanked. A Type 1 punishment is something that happens after the behavior that is not pleasant, and reduces the behavior.

**Type 2 (Response Cost)** - This is removal of a positive reinforcer after a behavior occurs. For example, a child refuses to eat her vegetables and has her dinner taken away. Or a teenager comes home late and has car privileges taken away. These are examples of Type 2 punishment, which is also known as Response Cost. Because something is being taken away, the misbehavior “costs” the child something that is reinforcing to him/her.

Type 1 punishment may work immediately and quickly when you want a child to stop a behavior but there are drawbacks to this method. Often when the punisher / punishment is absent, the behavior still occurs. Punishment may also make the person who does the punishing feared. For example, when a mother says "Just wait until your father gets home!" the children may pair punishment with their father. And finally, when using physical punishment in the home, it creates an environment for aggression and increases the chances that children will react in aggressive ways. For example, when someone pushes you, your first response is to push back.
Paying Attention to Your Child’s Good Play Behavior

This portion of the program involves learning how to pay attention to and increase your child’s good behavior. To learn this, it is first necessary to practice the skills of “paying attention.” Later, you will learn how to use these skills to increase your child’s compliance with commands and requests as well as other positive behaviors. These skills are practiced most easily in the context of a special playtime between you and your child as outlined below:

1) Select a 5 minute time each day for your “special time” with your child. This can be after other children are at school if you have a preschool child, or after school or dinner if your child is of school age.

2) No other children are to be involved in this special playtime! If you have other children in your family, either have your spouse look after them or choose a time when the other children are not likely to disturb your special time. You may choose to do this activity with all the children in your family, but always do this individually.

3) Set up this standard playtime before engaging in playtime for the first time. When that time comes around simply say to your child, “It’s now our special time to play together.” Then allow the child to choose from several toys/activities you have selected which you know your child enjoys. It is important that the child is the one to select the activity. The parent is not to take control or direct the play.

Suggested activities include: crayons and paper, legos, building blocks, tinker toys, etc. Try to choose constructive and non-violent toys.

4) Relax!! Casually watch what your child is doing for a few minutes, and then join in when it seems appropriate. Do not try to do this special playtime when you are upset, very busy, or planning to leave the house immediately for an errand or trip, as your mind will be preoccupied by these matters.

5) After watching your child’s play, begin to describe out loud what your child is doing. This is done to show your child that you find his/her play interesting. It is done something like the way a sportscaster might describe a baseball or football game over the radio. It should be exciting and action oriented.

6) Ask no questions and give no commands. This is critical! Asking questions and giving directions is unnecessary and disruptive to your child’s play. This is your child’s special time to relax and enjoy your company, not a time to teach or take over the child’s play.

7) Frequently provide your child with positive statements of praise, approval, and positive feedback about what you like about his/her play. Be accurate and honest. For instance, “I like it when we play quietly like this,” “I really enjoy our special time together,” or “Look at how nicely you have made that...” are all positive, appropriate comments. If you need help thinking of these comments, see the second page of this handout for a list of ways to show approval to your child.

8) If your child begins to misbehave, simply turn away and look elsewhere for a few moments. If the misbehavior continues, then tell your child that the special playtime is over and leave the room.

9) Each parent is to spend 5 minutes with the child in this special playtime. During the first week, try to do this every day or at least 5 times in a week. After the first week, try to have this special time at least 3 to 4 times per week. You should continue this special playtime indefinitely.

This program is easy to read; it is not easy to do!! Initially many parents give commands or ask questions of their child. Don’t worry too much about making such mistakes at first. Just try harder the next time to improve your “attending” skills.
## Paying Attention to Your Child’s Good Play Behavior
(Rules and Examples)

<table>
<thead>
<tr>
<th>Rule</th>
<th>Reasons</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do Describe appropriate behavior</td>
<td>- Allows child to lead</td>
<td>- That’s a red block.</td>
</tr>
<tr>
<td></td>
<td>- Shows child you’re interested</td>
<td>- You’re making a tower!</td>
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<tr>
<td></td>
<td>- Teaches concepts</td>
<td>- You drew a smiling face.</td>
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<tr>
<td></td>
<td>- Models speech</td>
<td>- The cowboy looks happy.</td>
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<tr>
<td></td>
<td>- Holds child’s attention</td>
<td></td>
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<tr>
<td></td>
<td>- Organizes child’s thoughts about play</td>
<td></td>
</tr>
<tr>
<td>Do Reflect appropriate talk</td>
<td>- Doesn’t control the conversation</td>
<td>- Child: &quot;I made a star.&quot;</td>
</tr>
<tr>
<td></td>
<td>- Shows the child you’re really listening</td>
<td>- Parent: &quot;Yes, you made a star.&quot;</td>
</tr>
<tr>
<td></td>
<td>- Demonstrates acceptance and understanding</td>
<td>- Child: &quot;The camel has got bumps on top.&quot;</td>
</tr>
<tr>
<td></td>
<td>- Improves child’s speech</td>
<td>- Parent: &quot;It has two bumps on top.&quot;</td>
</tr>
<tr>
<td></td>
<td>- Increases verbal communication</td>
<td></td>
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<tr>
<td></td>
<td>- Shows child you are involved</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Shows the child how to play with others (forms basis of taking turns)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Tends to increase child’s imitation of what you do</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Makes both parent and child feel good</td>
<td></td>
</tr>
<tr>
<td>Do Imitate appropriate play</td>
<td>- Lets the child lead</td>
<td>- Child: &quot;I’m putting baby to bed.&quot;</td>
</tr>
<tr>
<td></td>
<td>- Approves child’s choice of play</td>
<td>- Parent: &quot;I’ll put sister to bed too.&quot;</td>
</tr>
<tr>
<td></td>
<td>- Shows child you are involved</td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>- Makes both parent and child feel good</td>
<td></td>
</tr>
<tr>
<td>Do Praise appropriate behavior</td>
<td>- Causes the behavior to increase</td>
<td>- Terrific counting!</td>
</tr>
<tr>
<td></td>
<td>- Lets child know what you like</td>
<td>- I like the way you’re playing so quietly.</td>
</tr>
<tr>
<td></td>
<td>- Increases self-esteem</td>
<td>- You have wonderful ideas for this game.</td>
</tr>
<tr>
<td></td>
<td>- Adds to warmth of the relationship</td>
<td>- I’m proud of you for being polite.</td>
</tr>
<tr>
<td></td>
<td>- Makes both parent and child feel good</td>
<td>- You did a nice job on that building.</td>
</tr>
<tr>
<td></td>
<td>- Thank you for showing the colors to me</td>
<td></td>
</tr>
</tbody>
</table>
TOP TEN QUESTIONS ABOUT THE CHILD'S GAME

1. Why aren’t we talking about discipline?
   - Time-in vs. time-out
   - Contrast!

2. Why should we use descriptive comments?
   - Shows interest; lets child lead

3. Why no questions?
   - No questions allow children to lead

4. Why no commands?
   - Avoid discipline situations

5. Should I let my child play with anything he/she wants?
   - Suggestion: Let your child choose from “appropriate toys” to play with

6. What if there are behavior problems during our special playtime?
   - Ignore insignificant behaviors!
   - Reinforce only behaviors you want to see more of!

7. What if my child wants me to structure the play?
   - Support and encourage children to take the lead

8. How should I end the play session?
   - Ignore protests/pleading
   - Tell your child you enjoyed your special playtime with him/her

9. What if I have no time to do this?
   - Remember—five minute time periods!
   - Decide upon a time that works best for you

10. Isn’t this unfair to my other children?
    - If possible, establish special playtimes with all of your children
Rewards Children Like

"That’s great! You’re learning to tie your own shoes!"

It’s important to reward your child’s good behavior. Rewarding good behavior is the easiest and best way to improve behavior. What rewards should parents use? Rewards that motivate children are social rewards, activity rewards, and material rewards.

Rewards Children Like

<table>
<thead>
<tr>
<th>Social Rewards</th>
<th>Activity Rewards Including Privileges</th>
<th>Material Rewards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smiles</td>
<td>Play cards with mother</td>
<td>Ice cream</td>
</tr>
<tr>
<td>Hugs</td>
<td>Go to park</td>
<td>Ball</td>
</tr>
<tr>
<td>Pats</td>
<td>Look at book with father</td>
<td>Money</td>
</tr>
<tr>
<td>Attention</td>
<td>Help bake cookies</td>
<td>Book</td>
</tr>
<tr>
<td>Touching</td>
<td>Watch a late TV movie</td>
<td>Jump rope</td>
</tr>
<tr>
<td>Clap hands</td>
<td>Have a friend over</td>
<td>Balloons</td>
</tr>
<tr>
<td>Winks</td>
<td>Play ball with father</td>
<td>Yo-yo</td>
</tr>
<tr>
<td>Praise</td>
<td>Play a game together</td>
<td>Flashlight</td>
</tr>
<tr>
<td>“Good job”</td>
<td>Go out for pizza together</td>
<td>Doll</td>
</tr>
</tbody>
</table>
IGNORING

While irritating behaviors (i.e., whining, teasing, arguing, swearing, and tantrums) are not dangerous, they do lead to peer rejection and isolation which in turn lead to decreased self esteem. Ignoring these types of behaviors is effective because the behaviors are maintained by the attention they receive, even negative attention such as yelling and scolding. If ignoring is consistently maintained, the behavior will eventually stop. If children are then given approval and attention for appropriate behaviors, they will learn that it is more beneficial to behave appropriately.

Rules of ignoring:
1. Avoid eye contact and discussion while ignoring.
2. Physically move away from the child but stay in the room if possible.
3. Be subtle.
4. Be consistent.
5. Combine distractions for the child with ignoring.
6. Return attention to the child as soon as misbehavior stops.
7. Limit the number of behaviors to ignore.
8. Give attention to the child's positive behaviors.

Questions about ignoring:

1. *What if you can't ignore the misbehavior?*
   Sometimes ignoring the child’s misbehavior causes anger to mount in the parent, resulting in explosive behavior on the part of the parent. In this case set a limit on the frequency or duration of the behavior. After this limit is reached provide a mild punishment (i.e., after three swear words a valuable toy is taken away for the week, after 30 seconds of whining the same consequence is given).

2. *What if I am ignoring my child but others are not?*
   If others in the room are giving the child attention, remove the child to another place where he/she can be ignored effectively. Consider informing relatives, teachers, child care providers, neighbors, etc. ahead of time of the ignoring strategy and the target behaviors to ignore.

Remember: At first the child’s misbehavior becomes worse before it gets better. Be consistent!
Giving Effective Commands

Parents can often achieve significant improvements in their children's compliance simply by changing the way they give commands to their children. When you are about to give a command or instruction to your child, be sure that you do the following:

1) **Make sure you mean it!** That is, never give a command that you do not intend to see followed up to its completion. When you make a request, plan on backing it up with appropriate consequences, either positive or negative, to show that you mean what you say.

2) **Do not present the command as a question or favor.** State the command simply, directly, and in a businesslike tone of voice.

3) **Do not give too many commands at once.** Most children are able to follow only one or two instructions at a time. For now, try giving only one specific instruction at a time. If a task you want your child to do is complicated, then break it down into smaller steps and give only one step at a time.

4) **Make sure the child is paying attention to you.** Be sure that you have eye contact with the child.

5) **Make sure your child is capable of completing the command.** It is unfair to punish a child for disobeying if he/she is physically or cognitively unable to complete the task.

6) **Reduce all distractions before giving the command.** Often, parents try to give instructions while a television, stereo, or video game is on. Children often have a hard time attending when something more entertaining is going on in the room. Turn off or remove any distractions.

7) **Use explanations sparingly.** Children who ask for explanations are often more interested in stalling than knowing the answer. If you feel like you need to provide an explanation, give it before the command (e.g., "Our playtime is over and we need to get ready to go to the store. Please put your crayons away.") or after the child has complied (e.g., "Thank you for putting your crayons away. We're going to go to the store.")

Remember not to give too many direct commands. No one likes constantly being told what to do! In addition, it can become difficult for you to follow through with consequences if you give too many commands. Use commands only when necessary and use choice commands if possible (i.e., please put on your white or red coat.)
## Giving Effective Commands
(Rules and Examples)

<table>
<thead>
<tr>
<th>Rule</th>
<th>Rationale</th>
<th>Examples</th>
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| Make commands **direct**, not indirect | • Eliminates any ambiguity about whether parent expects child to obey.  
• Makes it clear the child, not parent, is to do the task. | • Sit down right here (Instead of: Would you like to sit down?)  
• Pick up your toys (Instead of: Let's pick up your toys, OK?) |
| Make commands **single and small**, not compound. | • Easier for child to obey smaller commands that are not overwhelming  
• Some children can’t remember multiple-part commands  
• The child gets more opportunities for praise | • Put your shoes in the closet (Instead of: Clean your room)  
• Put on your pajamas. Thank you, now brush your teeth. Good! (Instead of: Get ready for bed.) |
| State commands **positively**. (Tell child what to do, instead of what not to do.) | • Oppositional children rebel against “stop” and “don’t” commands.  
• Tells child what (s)he can do instead. | • Please sit in the chair (Instead of: Don’t climb on the counter!)  
• Please get a book to read (Instead of: Stop bouncing that ball!) |
| Make commands **specific** not vague. | • Lets child know exactly what is expected.  
• Eliminates confusion.  
• Makes it easier to decide whether the child has obeyed. | • Use your indoor voice (Instead of: Act nice!)  
• Please walk (Instead of: Behave yourself!)  
• Wait for your turn (Instead of: Play nicely!) |
| Use a **neutral tone** of voice instead of pleading your case. | • Children need to learn to respond to commands given in a normal conversational voice.  
• Makes interactions more pleasant for both child and parent. | • Come sit next to me (Instead of: Sit here now!!! or It would really make mommy happy if you would sit here, please?) |
| Be **polite and respectful**, while still being direct. | • Makes interactions more pleasant  
• Models good social skills  
• Less likely to cause an oppositional child to disobey | • Please hand me the crayon  
• Sit next to me please |
| **Always provide a consequence** for obedience and disobedience. | • Fastest way to teach young children to mind better.  
• Compliance should not be taken for granted  
• Consistency in providing consequences is the most powerful tool for improving child behavior. | • Parent: Hand me your paper.  
• Child: (hands paper to parent)  
Parent: Thanks for doing what I asked! You’re a good helper!  
• Child: (fails to hand paper to parent)  
Parent: Hand me the paper or you will go to time-out. |
Effectively Using Time Out

Time out can be very effective in reducing your child's non-compliance and other inappropriate behaviors. However, it must be used in combination with other techniques you have already learned. Never give a command that you do not intend to back up and always provide praise and approval to your child for obeying you. To effectively use time out with your child follow the guidelines below:

1. Always give commands in a firm but pleasant voice. Do not yell at the child, but also do not ask commands as favors. Follow the suggestions given in the handout for giving effective commands. You may want to review that handout at this time. Make each command a simple, direct statement in a businesslike tone of voice.

2. After you have given the command, count backwards to yourself from 10 to 1. Do not count out loud. This is so your child will not learn to wait until a certain number is said before complying.

3. If the child has not made a move to comply within these 10 seconds, you should say firmly, "If you don't [do what I asked], then you are going to time out." (pointing to time out area)

4. Once you give this warning, count down from 10 to 1 again (to yourself, not out loud).

5. If your child has not started to comply within these 10 seconds then say, "You did not do as I asked, so you must go to time out." This should be said calmly but firmly. The child is to go to the chair immediately, regardless of any promises he/she may make. The child is not to go to the bathroom, get a drink, or stand and argue with you. If the child resists going to time out, use slight physical guidance, but as little as necessary. If physical guidance is absolutely necessary, pick up the child from behind and carry him/her to the time out chair.

6. Place the child in the chair and say firmly, "Stay there until I tell you to get out."

7. Do not talk to the child at all while he/she is in time out. Go back to doing your previous work, but be sure to keep an eye on what the child is doing in the chair (without staring at him/her). When the child has remained in the chair quietly for the appropriate amount of time (see below), return to the child and say, "You may get out of time out now."

8. At this point you should repeat your original command. If the child complies praise him/her. If the child does not comply, he/she should be sent to time out again.

9. Watch for your child's next appropriate behavior and praise the child for it. This ensures that the child always receives praise and shows that you are not angry at the child but at what he/she did.

10. When using time out for something other than non-compliance (e.g. breaking a set rule) send the child to time out immediately (i.e., do not use a warning statement).
Commonly Asked Questions About Time Out

**How Long Should the Child Stay in Time Out?**

Your child should stay in time out until two conditions are met:

1. The child should always remain in time out for at least a minimum amount of time predetermined by you. This should be about 1 minute for each year of his/her age up to a maximum of 5 minutes.

2. Once the minimum amount of time has expired, wait until the child is quiet. The first time your child is sent to time out, this may take several minutes or longer. You are not to go to the child until he/she has been quiet for a few moments (about 30 seconds or so), even if it means the child remains in time out for a long period of time because he/she is arguing, throwing tantrums, screaming, or crying loudly.

**What if the Child Leaves the Chair Without Permission?**

Many children will test their parents' authority when time out is first used. They will try to escape from the chair before time is up. The procedure for correcting this behavior is to simply put the child back in the chair each time he/she gets up. This is to be done as often as is needed, no matter how often the child gets up from the chair. When placing the child back in the chair do not threaten or yell. Simply direct the child back to the chair and say in a businesslike voice, "You need to stay in time out until you are quiet."

**What Should I Consider as Leaving the Chair?**

Generally, a child is considered to have left the chair if both buttocks leave the flat seat of the chair. Thus, the child can swivel about in the chair on his/her buttocks and does not have to face the wall, but if his/her buttocks leave the seat of the chair, then the procedure described above is to be followed.

**What Type of Chair Should be Used and Where Should it be Placed?**

The chair should be a straight-backed, adult sized, dinette-style chair. It should be placed far enough away from the wall that the child cannot kick or hit the wall while in the chair. There should be no play objects nearby and the child should not be able to watch television from the chair. Most parents use a corner of a kitchen, first-floor laundry room, the foyer or entry area of a home, the middle or end of a long hallway, or a corner of a living room (not occupied by others). The location should be such that parents can observe the child while continuing about their business. Do not use bathrooms, closets, or the child's bedroom.

**What Should I do if My Child Says He/She Needs to Get Out of the Chair?**

The child is not to leave the time out chair to use the bathroom or get a drink until his/her time is up and he/she has completed the task that was asked of him/her. If children are permitted to do so, they will come to use this demand as a means of escaping from time out on each occasion they are placed in the chair.
Using Privileges to Manage Behavior

When disciplining children with behavior problems, it is common to find that praise alone is not enough to motivate them to do chores, follow rules, or obey commands. Especially with older children it may be necessary to use additional methods to motivate them. Using privileges is one possibility.

PART 1

1) Sit down and explain to your child that you feel he/she has not been rewarded enough for doing nice things at home. Explain that you want to set up a new reward program so your child can earn privileges for behaving properly. This sets a positive tone to the program.

2) With your child, make up a list of privileges he/she can earn. These can include occasional special privileges (going to the movies, getting a new toy) as well as more everyday privileges (15 minute later bedtime, getting extra dessert). Try to have at least 10-15 privileges on your list.

3) Make a list of behaviors, chores, etc. which your child can do to earn privileges. Make sure that you don't place unreasonable expectations on your child but also don't choose tasks that are overly easy. Good examples of chores/tasks are: setting the table, picking up toys, feeding the dog, etc.

4) When your child completes a chore or does a behavior on your list, provide the child with one of the privileges he/she can earn. Be sure to always pair the awarding of privileges with praise. By doing so you ensure that praising your child maintains reinforcing value for your child. Also make sure that you tell your child what he/she has done to earn a privilege. For example, when your child earns the privilege of playing video games you might say, "Thanks for cleaning your room Johnny. Because you cleaned your room and did such a good job you may play video games for 1 hour."

5) Don’t Be Stingy!!! One of the most common mistakes parents make is to expect too much at once. For the first week go out of your way to award privileges for any small appropriate behavior. Remember that you can reward a child for good behaviors that are not on the list you have made.

PART 2

1) Make a list of privileges you feel should be "automatic." Automatic privileges are those your child does not need to do anything special to obtain but are the everyday privileges you allow your child (television, video games, phone calls, etc.).

2) Make a list of behaviors, chores, etc., which must be done in order for your child to maintain his/her "automatic" privileges. This list should relatively short and should include chores that your child is expected to complete on a daily basis.

3) Make a list of inappropriate behaviors that you will not tolerate from your child.

4) As long as your child completes the chores listed in #2, he/she is allowed to keep his/her automatic privileges. If chores are not completed or your child exhibits one of the inappropriate behaviors listed in #3, then take away certain "automatic" privileges. It may be easiest to pair each negative behavior with a specific privilege that will be lost. By making a list of specific things your child can do to lose privileges, you will not be faced with the difficult situation of deciding what to take away from your child. Share this list with your child so that he/she knows what is expected of him/her.

It is important to understand that you are not bribing your child. Many parents feel that their children should obey house rules simply because it is their responsibility. Remember though, that you get paid for working at a job. In the same sense, obeying house rules is your child’s job and he/she should be able to earn privileges in the same way you earn a paycheck.
PART 1:

<table>
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<tr>
<th>LIST OF CHORES</th>
<th>EVERYDAY PRIVILEGES</th>
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SPECIAL PRIVILEGES

| 1. ___________ _ | 2. ___________ _ | 3. ___________ _ |
| 4. ___________ _ | 5. ___________ _ |

PART 2:

<table>
<thead>
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<th>EVERYDAY EXPECTATIONS</th>
<th>AUTOMATIC PRIVILEGES</th>
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Use of the dot-to-dot reward program either by itself or in conjunction with the grab bag reward program, is a fun and practical way to reward your child’s appropriate behaviors. The following steps outline how to use this system.

1. Identify an item or an activity to be used as a reward. This could be a toy, an article of clothing, a trip to an amusement park, etc. It should be something your child will enjoy and will want to have. It is important to include your child in the selection process but you have final say regarding the reward.

2. After selecting the reward, draw a picture of the item on a piece of paper using dots. If you are not artistically inclined, you may use dots to spell out a word describing the reward (for example, if the reward is a new doll, spell out the word “doll” with dots). The number of dots you use should depend on the size (cost, time involved) of the reward item. For example, if the reward is a new baseball, you might want to have 10-15 dots but if the reward is an expensive new pair of sneakers, you might want to have 40-50 dots.

3. Post the drawing in a place where it can be easily seen and reached by your child. Each time your child exhibits the behavior you are working on, have him/her connect to the next dot. When your child has connected all the dots, he/she receives the pictured reward.

4. You may want to use this program in conjunction with the grab bag reward program (see additional handout). To do this, make every second or third dot in your drawing larger than the rest. When your child connects to a large dot, he/she is able to draw from the grab bag and receive a reward.
Grab Bag Reward Program

Consistent use of a Grab Bag incentive system is a practical way to reward your child’s appropriate or desired behaviors. The Grab Bag system uses three types of rewards including: special “goodies,” privileges, and special parental time/activities. This system should be used immediately following appropriate behaviors, whether that is a good school note, dry bed in the morning, taking medication correctly, etc. To construct a Grab Bag system, you will need the following items: several sheets of paper, a container (jar, bag, hat, etc.), a pen, and scissors.

The following steps are necessary to construct the Grab Bag system:

1. Rewards should be selected based on what your child finds interesting or fun. Have your child assist you in generating reward ideas. You may “veto” specific rewards, such as a red Ferrari or weekend trip to Disney World, but keep in mind that rewards your child selects may be among the most effective and motivating.

2. Create a range of rewards of different values. Some parents in the past have used a 15 or 30 minute later bedtime; special time with a parent; a nickel, dime, or quarter; having a friend over; a special TV program; a special snack; a no chore day; or a movie rental. Emphasizing privilege and parent time activities. Be sure to include a few (one or two) larger rewards.

3. Cut 50 small slips of paper (e.g., 1” x 3”) and write one reward on each slip of paper. You should duplicate rewards (e.g., 8 slips with special parent time).

4. Place the completed slips in a container. Be sure to keep this container out of the child’s reach, or larger rewards may mysteriously “float” to the top of the pile.

5. When your child earns access to the Grab Bag, he or she should select a slip randomly. There should be no negotiation after the reward has been identified. If the reward cannot be provided immediately (i.e., trip to McDonalds), the child should receive a redeemable coupon to be used as a more convenient time. However, these coupons should be redeemed as soon as possible or you risk reducing the effectiveness of the Grab Bag.

6. Place the drawn slip back into the Grab Bag and remember to mix up the slips prior to the next drawing.
Attending to Independent Play

Many parents of children with behavior problems complain that they are unable to do things, such as talk on the phone, cook dinner, visit with a neighbor, etc., without being interrupted. The following steps were designed to help you teach your child to play independently when you are busy with another activity. Many parents provide a lot of attention to a child who is interrupting them but almost no attention to the child when he/she stays away, plays independently, and does not interrupt. No wonder kids interrupt parents so much!

1) When you are about to become occupied with some activity, such as a phone call, reading, fixing dinner, etc., give your child a direct command. This command should contain two instructions. One part of it tells the child what he/she is to be doing while you are busy, and the second part specifically tells him/her not to interrupt you while you are busy. For instance, you can say, "Mom has to talk on the telephone, so I want you to stay in this room and watch television and please don’t interrupt me."

   Remember, give the child something to do that he/she enjoys and tell him/her you do not what to be interrupted.

2) As you begin your activity, stop what you are doing after a moment, go to the child, and praise the child for remaining occupied and not interrupting you. Remind the child to stay with his/her assigned task and to not interrupt you. Return to what you were doing.

3) Wait a few moments, then return to the child and again praise him/her for not interrupting you. Return to your activity, wait a little longer, and again praise the child.

4) Over time, what you are trying to do is gradually reduce how often you praise your child for not interrupting while you increase the length of time you stay at your own task. Initially, you will have to interrupt what you are doing and praise your child very frequently, say every 30 seconds to 2 minutes, but you should gradually increase the length of time you wait.

5) If it sounds like your child is about to leave what he/she is doing and interrupt you, immediately go to your child, praise him/her for not interrupting you, and redirect him/her to stay with the task you gave him/her.

6) As soon as you finish what you are doing, provide special praise to your child for letting you complete your task. You may even periodically give your child a small privilege or reward for having allowed you to complete your task.

You may want to practice this before using it in "real" situations. For example, you could have a friend call you on the phone simply to have an opportunity to practice these steps.
Managing Behavior Problems in Public Places

After your child has learned to comply with rules and commands at home, it will be easier to teach your child to behave in public places, such as stores, restaurants, etc. As at home, when out in public it is important to praise appropriate behaviors and provide consequences for inappropriate behaviors. Below are some guidelines to help you do this.

1) Take practice trips

Take several short trips as trial runs before making a longer trip. Limit these trips to 15-20 minutes and make their sole purpose to practice these guidelines.

2) Set up rules beforehand

Before entering the store or other public place, always review with your child the rules you expect him/her to follow. You should have three to four rules. For example, if you are taking your child grocery shopping with you, your rules might be: Stay within arm’s length of the cart, do not take any items off the shelves, and do not touch any items on the shelves.

3) Praise your child for good behaviors

As you have been doing at home, provide your child with positive reinforcement for appropriate behaviors. Make sure to tell your child specifically what you like about his/her behavior and frequently praise your child when he/she is following the preset rules. You may also want to consider providing some reward for your child - perhaps some special time with you at home following the trip or a special treat at the end of the trip.

4) Set up consequences for misbehavior

You must have consequences you can use for misbehaviors. These should be explained to your child. One way to address misbehavior is to use a point system. Prior to your trip provide your child with a predetermined number of points which can later be exchanged for some privilege or treat. As your child misbehaves, subtract points from this total. Your child is allowed to “spend” the points he/she still has at the end of the trip. You should determine what the points can be used to buy (i.e., will you allow the child to buy candy or does the child need to spend the points on a special privilege once at home.)

You should also consider using time out in public if you have successfully used this with your child at home.

5) Give your child something to do

 Often children misbehave because they have nothing to do. When you are out in public with your child, talk to your child frequently and give him/her small tasks to do. For example, if you are grocery shopping you may ask your child to reach items on the lower shelves (only after you have pointed the items out to the child) or you may hand items to the child to put in the cart.

6) If your child throws a tantrum - do not give in

If your child throws a tantrum in an attempt to get candy or some other treat, do not give in. Ignore your child if possible and if necessary, leave the store, restaurant, etc. until your child calms down. (Note: Never leave your child alone - you should always accompany your child when it becomes necessary to leave the public place.)
CURRICULUM VITAE

THERESA L. GUNDERSON

Address
115 Echo Street
Apartment #203
Mankato, MN 56001
(507) 389-8976
theresagunderson@hotmail.com

Education

1998-2003  Ph.D., Combined Clinical, School, and Counseling Psychology, Utah State University, Logan, UT. Major Professor: Gretchen Gimpel.


2002-2003  Pediatric Psychology Intern, Munroe-Meyer Institute for Genetics and Rehabilitation, Department of Psychology, University of Nebraska Medical Center, Omaha, NE.

Certificate Interdisciplinary Leadership Training in Developmental Disabilities, Maternal Child Health/Leadership Education Excellence in Caring for Children with Neurodevelopmental and Related Disabilities, Munroe-Meyer Institute for Genetics and Rehabilitation, Department of Psychology, University of Nebraska Medical Center, Omaha, NE.

1996-1998  M.A., Clinical Psychology, Mankato State University, Mankato, MN.

Thesis: *Introducing the compensatory reinforcer checklist for parents of preschoolers.*

1990-1995  B.S., Summa Cum Laude, Psychology (Minor: Technical Writing), Mankato State University, Mankato, MN. *Honors: Psi Chi National Honor Society, Phi Kappa Phi, Deans List.*
Clinical Experience

2003-Present  Therapist, The Mankato Clinic, Psychiatry Department, Mankato, MN. **Description:** Provide outpatient treatment to children and adults, conduct assessments as needed, consult with on-site psychiatrists regarding patient care. **Clinical Supervision:** Darcie Jacobson, Psy.D., **Clinical Coordinator:** Pat Shortall, RNC, **Department Chair:** Robert Olson, MD.

2002-2003  Pediatric Psychology Intern (APA Accredited Pre-Doctoral Internship Program), Munroe-Meyer Institute for Genetics and Rehabilitation, Department of Psychology, University of Nebraska Medical Center, Omaha, NE. **Description:** APA approved internship in behavioral pediatrics at a University Center for Excellence in Developmental Disabilities, Education, Research and Services (UCD) for children with pediatric health and behavioral concerns. Conduct evaluations of and provide behavioral treatment to children with developmental disabilities, behavioral disorders (e.g., Attention-Deficit/Hyperactivity Disorder), and medical problems (e.g., Diabetes). Provide same services in rural outreach clinics. Conduct comprehensive neuropsychological evaluations of children with neurological concerns and coordinate ongoing assessment probes. Conduct developmental evaluations of infants and toddlers in hospital-based Neonatal Intensive Care Unit follow-up clinic. Provide behavioral and developmental consultation to parents in rural areas via a telephone contact service. Psychological consultant to hospital-based pediatric continuity clinic, Neurobehavioral clinic, and medical residents and students rotating through pediatrics. **Supervisors:** William J. Warzak, Ph.D., Jodi Polaha, Ph.D.

2001-2002  Therapist, Division of Services for Persons with Disabilities, Logan, UT. **Description:** Provide mental health services for children and adults with Developmental Disabilities/Mental Retardation and comorbid diagnoses (e.g., Bipolar Disorder). Provide individual counseling for clients and parent training. Consult with direct care staff and families regarding client’s care and behavior management. Conduct psychological and intellectual assessments. Facilitate support group for parents of children with developmental and physical disabilities. **Supervisor:** Dave Stein, Ph.D.

2001-2002  Student Therapist, Pediatric Practicum, Center for Persons with Disabilities, Logan, UT. **Description:** Work directly with a
pediatrician and nurse practitioner at university-based practice. Consult with medical professionals on psychological factors related to patients, provide direct mental health services for children and families, and conduct psychological assessments with patients. **Supervisor:** Gretchen A. Gimpel, Ph.D.

**2001**

*Student Therapist, Clinical Practicum,* Psychology Community Clinic, Logan, UT. **Description:** Conduct individual psychotherapy, administer and Interpret clinical assessments. **Supervisor:** Sue Crowley, Ph.D.

**1999-2000**

*Child and Family Therapist,* Preschool Head Start, Logan, UT. **Description:** Conduct individual and family therapy with families of Head Start children, consult with parents and teachers, observe Head Start classrooms, give in-service presentations, provide educational groups as needed. **Field Supervisor:** Theresa Christenson, **University Supervisor:** Dave Stein, Ph.D.

**1998-1999**

*Student Therapist, Clinical Practicum,* Psychology Community Clinic, Logan, UT. **Description:** Conduct individual psychotherapy, administer and Interpret clinical assessments. **Supervisors:** Kevin S. Masters, Ph.D., Gretchen A. Gimpel, Ph.D., Sue Crowley, Ph.D.

**1997**

*Clinical Practicum (Completed 300 hours),* Blue Earth County Human Services, Mankato, MN. **Description:** Conduct individual therapy and psychological assessments, observe day treatment group therapy for clients with severe and persistent mental illness. **Supervisor:** Liz Wallin, M.A., L.P.

**School Psychology Experience**

**2000-2001**

*School Psychology Internship,* Logan City School District, Logan, UT. **Description:** School Psychologist for three elementary schools. Assess students' intellectual, academic, emotional, and behavioral functioning; make recommendations to IEP team regarding eligibility for special education services; conduct classroom observations; write reports; consult with parents and teachers regarding behavioral interventions and other problems. **Field Supervisor:** Travis Loosli, M.S., L.S.P., **University Supervisor:** Gretchen A. Gimpel, Ph.D.

**1999-2000**

*School Psychology Practicum,* Logan City School District, Logan, UT. **Description:** Administer, score, and interpret
psychoeducational assessments, observe students in the classroom, write reports, consult with parents and teachers, conduct behavioral interventions, attend IEP meetings. Field Supervisor: Mary Griffin, M.S., L.S.P., University Supervisor: Kathryn Hoff, Ph.D.

Counseling Psychology Experience


Research Experience

2002-present Pre-Doctoral Intern Research Assistant. Munroe-Meyer Institute for Genetics and Rehabilitation, Department of Psychology, University of Nebraska Medical Center, Omaha, NE. Description: Collaborate with supervisor to create new research projects on behavior problems in a clinical sample of Native American children and the relationship between caffeine intake and enuresis in children. Conduct statistical analyses on already-existing data set and assist in writing manuscript for a project concerning what situations make college students vulnerable to unwanted sexual activity. Supervisor: William J. Warzak, Ph.D.

2000-Present Dissertation Research Project. Utah State University, Logan, UT. Title: The use of stress management in combination with parent training: An intervention study with parents of preschool children. Description: Provide 11 weeks of parent training and stress management training in group format for parents. One group receives stress management before parent training, while the other group receives parent training before stress management. Chair: Gretchen A. Gimpel, Ph.D.

1998-2002 Graduate Research Assistant. Utah State University, Department of Psychology, Logan, UT. Description: Conduct behavioral treatment for parents of children diagnosed with Attention Deficit Hyperactivity Disorder, conduct research with team members. Supervisor: Gretchen A. Gimpel, Ph.D.

1996-1998 Graduate Research Assistant. Mankato State University Psychology Department, Mankato, MN. Description: Formulate
and conduct research for Master’s Thesis, consult with and conduct research projects with research team members. *Supervisor: Daniel Houlihan, Ph.D.*

**Teaching Experience**

1998-1999 *Graduate Teaching Assistant, Analysis of Behavior.* Utah State University Psychology Department, Logan, UT. *Description:* Write and grade tests, write weekly oral quiz questions, coordinate and supervise animal lab, grade extra projects, record points and calculate final grades, lecture as needed. *Supervisor:* Carl D. Cheney, Ph.D.

1996-1997 *Graduate Teaching Assistant, Introduction to Psychology.* Mankato State University Psychology Department, Mankato, MN. *Description:* Proctor and grade tests, record test scores, show educational films, speak with prospective Psychology Majors when they visit campus. *Supervisor:* Rosemary Krawczyk, Ph.D.

1997- Mankato State University Psychology Department, Mankato, MN.

*Graduate Teaching Assistant, Child Care Psychology.* *Description:* Supervise group projects, lecture as needed. *Supervisor:* Nancy Fenrick, Ph.D.

*Guest Lecturer, Undergraduate Courses.*

- *Course:* Human Operant Behavior, *Title:* Imitation and Instruction
- *Course:* Human Operant Behavior, *Title:* Conditioned Reinforcers and Everyday Situations
- *Course:* Child Care Psychology, *Title:* How to Handle a Demanding Child

**Other Professional Experience**

1997-1998 *Assistant Coordinator of Contract Students.* Learning Center, Mankato State University, Mankato, MN. *Description:* Teach study skills workshops, advise students, tutor as needed, help students to utilize campus resources. *Supervisor:* Audrey Metro, Coordinator of Disability Services.

1992-1998  *Marketing Representative* (Most recent title). Carlson Craft, Mankato, MN (Large national printing company). *Description:* Graphic design and write copy for ads and promotional pieces; write Vice President’s letters for mass mailings; personal account representative for printing franchise headquarters. *Supervisor:* George Wullschleger.

**Awards**

2001  *Travel Grant* ($400); Graduate Student Senate and Department of Psychology, Utah State University.

*Travel Grant* ($400); Graduate Student Senate and Department of Psychology, Utah State University.

*Travel Grant* ($400); Graduate Student Senate and Department of Psychology, Utah State University.

2000  *Research Grant* ($200); Women and Gender Research Institute and Department of Psychology, Utah State University.

*Research Grant* ($200); Women and Gender Research Institute and Department of Psychology, Utah State University.

**Professional Activities**

**In-Service Presentations**

2001  “How to Work with Children with ADHD.” Presented to employees of summer recreation program, Logan Parks and Recreation Department.


“Mental Health Problems in Preschoolers: Symptoms to Look For.” Teacher training for Preschool Head Start
Positions Held

1997-1998  Treasurer of the Graduate Student Organization, Mankato State University, Mankato, MN.

2000-2001  Graduate Student Representative, Utah State University, Logan, UT.

Current Affiliations

American Psychological Association, Student Affiliate
Association for the Advancement of Behavior Therapy, Student Affiliate
Association for Behavior Analysis, Student Affiliate
National Association of School Psychologists, Student Affiliate

Publications


Professional Presentations


Gunderson, T.L., & Galloway, A. (2003). Multiple neuropsychological probes: Coordinating care between parents, neuropsychology, neurology, and medicine: An integrative approach for informing interdisciplinary care. Poster presented at the meeting of the Nebraska Psychological Association, Lincoln, NE.


