EVALUATING THE EFFICACY OF A BRIEF PARENTING INTERVENTION BASED ON VIDEO TAPE MODELLING: EFFECTS ON PARENTAL STRESS AND PARENT-CHILD RELATIONSHIPS

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ABSTRACT

Objectives Well-established links between child adjustment, parenting behaviour and parenting stress have been documented in the literature. The treatment of choice for children with conduct problems is Parent Management Training. One of the most well researched interventions is Webster-Stratton's BASIC programme based on video tape modelling. This includes a component aimed at encouraging more positive parent-child relationships through the use of child-directed play and targeted praise. It was hypothesised that using this component with the parents of children referred to child clinical psychology and psychiatry services would result in decreased parenting stress and that this effect would be mediated by improved positiveness towards the child.

Design A within groups design was used, assessing parents pre- and post-intervention.

Method The parents of twenty referred children were recruited in to the study. Baseline self-report measures of parenting stress, child behaviour and Positiveness towards the child were completed. Participants were offered two sessions using Webster-Stratton's manualised programme as a guide for video tape modelling with discussion. Parents completed outcome measures following the intervention.

Results Positiveness to child was significantly improved in mothers but not in fathers. Changes in parenting stress and child adjustment were in the expected direction but not significant.

Conclusions The brief intervention demonstrated some efficacy in improving parent-child relationships. It was concluded that reduction in child behaviour problems might have more effect on parenting stress than positiveness to child. Methodological weaknesses and implications for future research are discussed.

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DECLARATION

"This thesis has been composed by myself and the work contained herein is my own."

Signed: Date: 6/11/03

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CONTENTS

1 INTRODUCTION

1.1 Overview

Behaviour problems in children constitute a substantial proportion of referrals to child mental health services (Calam et al., 2002). There has been a wealth of literature examining the relationships between child behaviour and parent characteristics (Campbell, 1995). Studies have demonstrated links between child behaviour and parenting when assessed both by parent report (Deater-Deckard, 1996) and coded observations (Baker et al., 2000). In addition, the stress experienced by parents due to the demands of the parenting role has been found to relate to both child adjustment and parenting behaviour (Webster-Stratton, 1990). There has been much debate in the literature about the directionality of such links, and clear evidence on causal relationships has yet to be established (O'Connor, 2002). General consensus is that parenting behaviour mediates the link between stress and child adjustment, although little research has attempted to test this hypothesis explicitly (Deater-Deckard, 1998). Several authors have commented on the transactional nature of parent-child relationships, with parent and child behaviour viewed as both actions and reactions (Deater-Deckard, 1996; Patterson, 1982). Thus child behaviour problems that are exacerbated by aspects of parenting behaviour may lead to further stress on the parent and more compromised parenting.

Several studies have examined the concurrent effects of interventions on child and parent adjustment outcomes (Hutchings et al., 2002; Ireland et al., 2003; Puckering et al., 1996). However, there is little analysis of which components are most beneficial

to the parent. Several established intervention programmes for parents of children with behaviour problems have a two-phase design. A more positive relationship between parent and child is developed before behavioural management strategies are implemented (Foote et al., 1998; Webster-Stratton and Herbert, 1994). This study aims to examine the effects of an abbreviated parent-training programme on parental stress to establish whether improvements occur when the initial phase is implemented in isolation.

Due to the established links between child behaviour, parenting stress and parenting it is difficult to separate out these three factors conceptually. For the sake of clarity I will initially discuss each aspect in turn. Nevertheless, it is acknowledged that there will be some overlap.

1.2 Behaviour problems in children

1.2.1 Definition and Diagnosis

Between a third and a half of all referrals to child and family psychology services are due to child "behaviour problems" (Kazdin, 1995). This term can be used to describe a variety of undesirable or inappropriate behaviours including defiance, non-compliance with commands, causing physical harm to others, bullying, tantrums, lying and stealing. Many of these behaviours can be considered a part of "normal" development and it is only when the behaviours are severe or persistent that they may be considered to constitute a disorder such as Conduct Disorder (CD)

or Oppositional Defiant Disorder (ODD) (Richardson and Joughin, 2002). The population of children with these sorts of difficulties is heterogeneous with several axes of variability (Kazdin, 1995). Children may differ in the severity and chronicity of problems, and also in the degree of family disorganisation or co-occurrence of other difficulties such as attention or hyperactivity problems, mood disorder or specific learning disabilities (Carr, 1999).

The distinction between behaviour problems resulting as a reaction to a specific incident or situation and those that are considered part of a pervasive conduct disorder is far from straightforward (Carr, 1999). However, both common diagnostic classification systems, ICD-10 (World Health Organisation, 1996) and DSM-IV (American Psychiatric Association, 1994), attempt to provide such a distinction. In both ODD and CD the essential feature is hostile and defiant behaviour. DSM-IV defines ODD and CD in terms of the presence of rule-breaking behaviour and the length of difficulties. The presence of difficulties for six months or more is necessary for ODD, while duration of more than twelve months is necessary for CD. ICD-10 does not give a necessary duration for ODD but stipulates that difficulties must be present for at least six months for a diagnosis of CD. Both classification systems specify that difficulties are not to occur exclusively in the presence of a mood disorder in either ODD or CD. Behan and Carr (2000) note that ODD usually occurs in younger children and may be a developmental precursor to CD, onset typically occurring in the pre-school years. Around half of 3-4 year olds identified as hard to manage continue to show difficulties into early adolescence (Campbell, 1995).

1.2.2 Epidemiology

Prevalence rates for CD and ODD vary from 4 to 14 %, but are reported to be twice as common as emotional disorders (Carr, 1999). Studies of prevalence in pre-school children have found rates of behaviour problems to be about 10 to 15%, with difficulties defined using cut-off scores on behaviour check list measures (Campbell, 1995). Gender differences may exist, with estimates of the prevalence of CD in boys ranging from twice to four times that in girls. Although CD and ODD present similarly in boys and girls, symptoms may be more persistent in boys, and may include more confrontational behaviour (Richardson and Joughin, 2002). However, gender differences are not marked in pre-school children, although it is not clear at what stage differences emerge. Campbell (1995) acknowledges the difficulty of applying diagnostic criteria to pre-school children, due to the lack of developmentally appropriate criteria for judging symptoms such as non-compliance.

Richardson and Joughin (2002) suggest that about half of children presenting with CD meet criteria for an additional disorder, with hyperactivity co-occurring in 40 to 70% of those with CD. Carr (1999) reports that in a study using the Child Behaviour Checklist (Achenbach, 1991) with a clinic population, more than 40% of children who scored above the 95th percentile for aggression were also above the 95th percentile for anxiety and depression problems. Campbell (1995) reports that internalising problems are difficult to identify in young children but that they may co-occur.

1.2.3 Aetiology

Theories to explain the aetiology of conduct disorders include biological, psychodynamic, cognitive, social learning and systems theories. These are summarised by Carr (1999).

Possible biological causal factors include a genetic vulnerability to aggression, perhaps though dysregulation of testosterone levels (Dabbs et al., 1991). Genetic theories are supported by the increased concordance of conduct problems in monozygotic rather than dizygotic twins (Plomin, 1991). Arousal theory postulates that low arousal levels in conduct-disordered children makes them less receptive to positive and negative reinforcement (Kazdin, 1995). An alternative biological theory suggests that neuropsychological deficits such as poor executive functioning or verbal reasoning reduce the child's ability to regulate its own behaviour, and contribute to feelings of frustration due to lack of achievement (Moffit, 1993).

Psychodynamic theories include superego deficit theory, whereby the internalisation of parenting standards leads to either an aggressive approach in relationships, or a lack of firm rules to govern behaviour. Attachment theory suggests that conduct problems arise from the lack of an internal representation of moral social interaction due to the absence of a secure attachment during infancy. Bowlby (1944) suggested that children who are separated in infancy from their primary caregiver for a significant period of time fail to develop internal working models for secure, trusting relationships. Carr (1999) expresses the view that, while psychodynamically

oriented interventions do not have proven efficacy in conduct disorders, it is of great benefit to consider how these internal representations impact upon the therapeutic relationship.

Social information processing theory and social skills deficit theory are both cognitive theories in which conduct disorders are thought to be due to cognitive deficits. In the first, aggression arises due to misperceptions of others' intentions due to a hostile attributional bias (Crick and Dodge, 1994). In the second, aggression is used as a solution to social problems in the absence of problem-solving skills. It should be noted that the substantial comorbidity between cognitive problems and behaviour problems found in clinic population was not replicated in a community sample (Plomin et al., 2002).

Within social learning theory, conduct problems are learned when inappropriate behaviour is modelled by others, for example parents or siblings. Coercive parenting may result in negative patterns of interaction within the family (Patterson et al., 1992). Such styles of parenting may be precipitated or maintained by other stressors such as financial strain or marital conflict.

Systems theories include structural family systems theory, sociological theory, and multisystemic ecological theory. In structural family systems theory conduct problems are considered to arise as a result of family disorganisation, due to a lack of clear rules and boundaries or communication and problem-solving skills. Sociological theory espouses that conduct problems arise as a result of economic

disadvantage. The antisocial behaviour is aimed at achieving material goals (Cloward and Ohlin, 1960). In multisystemic ecological theory, conduct problems are maintained at several systemic levels (Borduin et al., 1995). At the individual level there may be a lack of social or cognitive skills. At the family level there may be parent-child relationship difficulties, marital conflict and family disorganisation. These may co-occur with poor academic attainment and deviant community influences.

In relation to each individual case, it is important to gain a thorough understanding of the predisposing, precipitating, maintaining and protective factors which have led the child to its current difficulties. These factors and the different aetiological theories point to a variety of treatment strategies.

1.2.4 Treatment

Carr (1999) outlines several treatment components that may make up individually tailored treatment packages. These include psychoeducation, monitoring, behavioural parent training, family-based skills training, school liaison, counselling for parents' personal difficulties and multi-agency liaison.

The main role of psychoeducation is to reframe the child's behaviour so it can be seen as learnt (and consequently may be unlearnt) as opposed to being due to a stable characteristic. This allows the parents to see the rationale behind adopting a family

approach to the problem rather than focussing treatment solely on the child. Monitoring by keeping records of specific behaviours, antecedents and consequences allows families to begin to identify ways of reducing these behaviours through manipulation of stimuli. Family-based skills training may focus on improving communication and problem-solving in order that rules and routines may be jointly agreed between parents and children. The increased independence that this offers offspring means it may be particularly suited to adolescents. In addition, children with CD may benefit from individual problem-solving skills training to reduce the need to resort to violent behaviour in interpersonal situations.

It may be necessary to address parents' own mental health difficulties or marital distress directly in order for them to possess adequate resources to adopt a consistent family-based approach. Research suggests that there is also a direct link between marital negative conflict management and children's conduct problems (Webster-Stratton and Hammond, 1999). In addition to working with the family, the clinical psychologist should ensure that all professionals involved with the family's care adopt an integrated approach. This may involve liaising with schools to ensure that both conduct and academic difficulties at school are addressed, and school-parent relationships facilitated. Such multisystemic interventions may be essential for older children with CD. However, for younger children with ODD, where difficulties are confined to home situations, behavioural parent training is the treatment of choice (Carr, 1999). Such interventions will be described in more detail later.

1.2.5 Research Samples

Research on conduct and behaviour problems in children uses samples identified by diagnostic criteria or by behaviour checklists. Intervention studies in particular often limit their selection to families with children who meet criteria for CD or ODD. This aids in establishing the efficacy of interventions for tightly defined populations, but may not be representative of the diverse presentations of referrals to clinical psychology services. In addition, there is evidence to suggest that interventions such as parent training programmes can be effective with children who do not have such a diagnosis (Webster-Stratton, 1998). Thus, the population chosen for the current study includes children with behaviour problems warranting referral to mental health services, who may or may not meet criteria for CD or ODD. In this report phrases such as "behaviour problems", "conduct problems" and "children with problem behaviour", will be used interchangeably to refer to such a sample. The term conduct disorder will be used for children who meet criteria for either CD or ODD.

1.3 Parenting Stress

1.3.1 Theory and Definition

Becoming a parent leads to new demands that continue to vary in type and intensity as the child grows. Life stress can be considered "role-specific" (Creasey and Reese, 1996); consequently stress arising from the demands inherent in the parenting role may be seen as distinct from stress in other domains (e.g. work-related stress) and

may be more strongly correlated with parenting behaviour and child adjustment than alternative types of life stress (Deater-Deckard, 1998).

The concept of parenting stress is difficult to define (Webster-Stratton, 1990). Deater-Deckard (1998) described parenting stress as "the aversive psychological reaction to the demands of being a parent" and described it as a complex process linking four components; the task demands of parenting, the parent's psychological well-being and behaviour, the qualities of the parent-child relationship and the child's psychosocial adjustment. This is experienced as negative feelings toward the self and the child or children. An important aspect of the definition of parenting stress is the availability of resources for meeting the demands of parenthood (Deater-Deckard and Scarr, 1996). Parenting is considered to be more stressful when parents have less knowledge, perceived competence, emotional support and social support (Deater-Deckard (1998). Parenting stress can be viewed as a continuum, with all parents experiencing parenting stress to some degree (Crnic and Greenberg, 1990). However, levels of parenting stress have been found to be higher in clinical samples than non-clinical samples (Östberg and Hagekull, 2000).

Deater-Deckard (1998) applied a general theory of stress to aid understanding of the processes linking the demands of parenting, stress in the parenting role and parenting behaviour. Lazarus (1993) described the stress process as consisting of four components; an external causal event or agent, cognitive appraisal of the event or agent, coping mechanisms to reduce the negative impact of the event or agent, and the stress reaction. Deater-Deckard (1998) suggested that, in parenting stress, the

causal agent of stress was either the child itself or the onset of "parenthood" as an event. The dependency of the child leads to a set of novel demands, which change qualitatively as the child develops, rather than abating. The demands are intensified by societal expectations of the parenting role (Alexander and Higgins, 1993).

Individual differences between and within families regarding parenting stress may be due to different cognitive appraisal of the stressor. Attributions about the source of the child's misbehaviour, for example regarding the child's intention and responsibility, may correlate with the strength of the stress reaction (Dix et al., 1989). However, there may be aspects of parenthood that are universally stressful, for example the aversive nature of certain types of infant cry (Zeskind et al., 1985).

A positive coping style may protect against negative consequences of parenting stress. Greater parenting stress has been shown to be related to emotionally-focussed coping strategies, such as denial and rumination, while more problem-focussed coping styles are associated with lower levels of stress (Deater-Deckard, 1998). Coping mechanisms may mediate the association between parenting stress and the quality of the parent-child relationship. Use of positive reappraisal was related to a weaker link between parenting stress and infant attachment security (Jarvis and Creasey, 1991).

In Deater-Deckard's adaptation of Lazarus' model, the stress reaction can be observed as the effect on the parent's behaviour and emotional response. The

relationships between stress, parenting behaviour and child adjustment will be outlined below.

1.3.2 Parenting Stress, Parenting Behaviour and Child Adjustment

There is little evidence to suggest that parenting stress affects child adjustment directly. Much of the literature on parenting stress and child adjustment proposes that the parenting stress reaction manifests itself in inadequate parenting skills. This deterioration in parenting behaviour may lead in turn to poor child adjustment. Deater-Deckard (1998) notes that the assumptions inherent in these assertions give rise to three testable hypotheses.

The first hypothesis is that parenting stress has a causal effect on parenting behaviour. Many studies have found that parenting stress and parenting behaviour covary. Parents with higher levels of self-reported parenting stress are more likely to show authoritarian and negative parenting behaviours (Deater-Deckard and Scarr, 1996; Paterson, 1982; Webster-Stratton and Hammond, 1988) and are less likely to stimulate their children through social interaction (Adamakos et al., 1986). In addition social indicators of stress, such as unemployment, are related to parenting behaviour (Dodge et al., 1994). However, firm evidence of causal links remains hard to find (O'Connor, 2002).

The second hypothesis is that poor parenting causes maladjustment in child behaviour. There is a vast literature on parenting and child behaviour (Deater-Deckard, 1998). Several reviews have shown a consistent link between parenting behaviour and child adjustment, with poorer adjustment associated with higher amounts of harsh, negative and inconsistent parenting (Maccoby and Martin, 1983; Rothbaum and Weisz, 1994). More positive outcomes in child adjustment have been associated with authoritative parenting, i.e. warm and involved with moderate amounts of control (Baumrind, 1993). Possible processes that account for the link between parenting and child behaviour are the internalisation of social rules (Kochanska, 1994); or the effects of greater feelings of being loved and accepted by the parents (Rohner, 1986); or operant conditioning and modelling (Patterson et al., 1992). This issue will be examined further later in the paper.

The third hypothesis is that parenting behaviour mediates the link between stress and child adjustment. Deater-Deckard (1998) notes that little research has explicitly tested this mediation hypothesis. Deater-Deckard and Scarr (1996) found supportive evidence in their study of dual-earner couples with young children. Higher amounts of parenting stress were correlated with more authoritarian parenting behaviour, which was correlated with more behaviour problems in children. However, the mediating role of parenting behaviour can not be assumed. A further variable, such as genetic effects, may be responsible for each aspect (Plomin et al., 1994). Research on particular groups of parents at risk of compromised parenting practices has provided further evidence of the mediating role. The impact of depression in

mothers on children's adjustment has been shown to be mediated through less responsive and involved parenting behaviour (Downey and Coyne, 1990).

Deater-Deckard (1998) notes that previous research has not identified whether relationships between parenting stress, parenting behaviour and parent and child adjustment remain constant across the full range of parenting stress, or whether such relationships are moderated by level of parenting stress.

1.3.3 Within Family Differences in Parenting Stress

Parent gender has been found to be only modestly related to levels of parenting stress, with slightly higher levels of stress in mothers than fathers in some studies (Deater-Deckard, 1998). Partners' levels of parenting stress have been found to be correlated (Deater-Deckard and Scarr, 1996), although fathers' perceptions of their partner's levels of parenting stress were more closely related to their own levels of stress than their partner's actual stress levels (Deater-Deckard et al., 1994). There may be differences, however, in the correlates of parenting stress for mothers and fathers. Noppe et al. (1991) found that the quality of observed parent-child interaction could be predicted for fathers based on their antenatal expectations. The same relationship was not found in the mothers. Several studies examining gender effects in the covariation of parenting stress, parenting behaviour and adjustment, and child adjustment have found little difference between parents (Deater-Deckard and Scarr, 1996; Deater-Deckard et al., 1994). In studies of the parents of disabled

children there has been evidence to suggest that parent gender moderates the covariation of parenting stress and attributes of severity or type of disability in the child (Frey et al., 1989). It is possible therefore that gender differences in parenting stress are only apparent in certain contexts. Studies of marital disharmony have shown a differential effect on parenting stress in men and women, with more negative parenting behaviours occurring in unhappily-married men than women (Deater-Deckard and Scarr, 1996). Women may compensate for an unsatisfactory marital relationship with a greater focus on parenting behaviour, thus weakening the links between parenting stress and behaviour (Deater-Deckard and Scarr, 1996). Parenting stress may be more strongly related to child attributes in women and the marital relationship in men (Stoneman et al., 1989). This differential relationship may be due to the relatively low numbers of single men who are in the parenting role. Similarities in mothers' and fathers' parenting stress were found in the parents of school children (Creasey and Reese, 1996) and the parents of infants and toddlers (Crnic and Booth, 1991). However these findings have not been replicated in other studies. Webster-Stratton (1988) found fathers' perceptions and behaviours to be relatively unaffected by personal adjustment measures. Deater-Deckard (1998) suggests that gender differences within a parenting couple occur only in the context of chronic stress and adversity.

Although siblings are reared in the same home, school and neighbourhood environments, there remain differences between them in temperament and behaviour. These differences mean that parent-child relationships vary within the family (Plomin and Daniels, 1987). It follows that parents should report different levels of

child domain parenting stress in relation to each child, depending on the extent of "difficult" behaviour perceived. Evidence to support this was found by Deater-Deckard (1996) who found that, within families, the child who was perceived to be more difficult was reported to generate more feelings of negativity in the parent, as measured by the Dysfunctional Relationship subscale of the Parenting Stress Index – Short Form (Abidin, 1995).

1.3.4 Model of Parenting Stress

Responding to the identified need to develop more complex and comprehensive models of parenting stress (Webster-Stratton, 1990), Östberg and Hagekull (2000) tested a multidimensional model of predictors of parenting stress. The authors collected data from a population-based sample of 1,081 Swedish mothers of children aged between six months and three years, using structural equation modelling to disentangle total, direct and indirect effects. The authors investigated the predictive strength of constructs found in the literature to be linked to parenting stress, namely life events; caretaking hassles; child temperament; mother's age, education and domestic workload (not counting parenting tasks); number of children in the family; and social support.

The role of each component of the model was supported, with one exception. Mothers who were older or had several children, a high domestic workload, low social support, an irregular child, saw the child as fussy-difficult, or experienced

more caretaking hassles or negative life events reported greater levels of parenting stress. The one exception was the effect of the mother's educational level. The authors' hypothesis that a lower educational level would be connected with greater levels of stress was not confirmed. This finding contradicted previous research (Pearson and Chan, 1993). In addition, contrary to predictions, social support was found to have a direct effect on parenting stress, but not a moderating effect. It was predicted that higher levels of social support would act as a buffer against the negative effects of the other predictor variables. One reason for the lack of evidence to support this may have been the measure utilised. The authors chose to measure the quantity rather than quality of social support; participants were asked to count the number of persons available to them for specific forms of emotional or practical support. Qualitative aspects of social support have been shown to be a more powerful predictor than quantitative aspects (Fiore et al, 1983). However the authors actively chose to keep measures as objective as possible and therefore chose the latter. They note that including qualitative aspects in preliminary analysis had not affected the model, although the amount of explained variance in parenting stress had increased.

Östberg and Hagekull included two measures of the temperamental construct "difficultness"; child irregularity, and a measure of fussy-difficult characteristics. Child irregularity, measured by the Regularity subscale of the Baby Behaviour Questionnaire or Toddler Behaviour Questionnaire (Thomas et al., 1963), provided a comparatively objective measure based on biologically governed behaviours such as feeding and sleeping. The second measure, the Fussy-Difficult subscale from the

Infant Characteristics Questionnaire (Bates et al., 1979), provided an assessment of maternal perception of temperament. Both temperament measures were found to be associated with parenting stress, however child irregularity was not found to have a direct effect. It had an indirect effect through the variables perceived workload and child fussy-difficultness. The link between child temperament and parenting stress has been identified by other authors (Webster-Stratton, 1990). However, care should be taken to consider the overlap in measures of stress and child temperament. For example the Difficult Child subscale of the Parenting Stress Index – Short Form (Abidin, 1995) includes a measure of parenting stress due to perceived characteristics of the child.

Domestic workload had a strong direct effect on parenting stress and an indirect effect through perception of child's fussy-difficultness. The authors posit that this finding points to intervention priorities, as does the link with social support. They suggest that programmes which aim to reduce domestic workloads and strengthen social networks may be beneficial. They note, however, that the model does not allow for causal links to be assumed.

1.3.5 Measurement

Webster-Stratton (1990) described stress as "so complex, so difficult to define and measure" and noted that parenting stress has been conceptualised differently in different research models. The need for contemporary models of parenting stress to

incorporate proximal and distal, parent, child and contextual variables has been stressed (Östberg and Hagekull, 2000). Reitman et al. (2002) noted the need for sound measurement techniques that can inform clinical practice. Abidin (1995) developed the Parenting Stress Index (PSI) aimed at sampling the diverse range of influences on parenting practices. The PSI comprises 54 parent-focussed and 47 child-focussed items in a Likert scale format. The Parent Domain of the PSI comprises seven subscales; Depression, Attachment, Role Restriction, Sense of Competence, Social Isolation, Relationship with Spouse and Parental Health. The Child Domain comprises six subscales; Adaptability, Acceptability, Demandingness, Mood, Distractibility/Hyperactivity and Reinforces Parent. In addition 19 items covering general life stressors are included. These thirteen subscales represent Abidin's conceptualisation of parenting stress. However the comprehensive nature of the PSI has led to an unwieldy and time-consuming measure, particularly if embedded within a battery of other measures.

To address the need for a briefer measure Abidin developed the Parenting Stress Index – Short-Form (PSI-SF; Abidin, 1995). The 36-item PSI-SF was found to have internal consistency comparable to the full scale (Roggman et al., 1994). The PSI-SF contains three subscales; Parental Distress, Difficult Child and Parent-Child Dysfunctional Interaction. However, the standardisation sample described by Abidin (1995) was criticised as unrepresentative due to the high proportion of married parents and small proportion from an ethnic minority (Reitman et al., 2002). Reitman and colleagues examined the psychometric properties of the PSI-SF in a low-income, predominantly minority population. They criticise the use of

exploratory factor analysis in the development of the PSI-SF and note its tendency to be highly sensitive to sample characteristics. Their use of confirmatory factor analysis indicated that the three-factor model was only marginally superior to the single-factor model. However, the three-factor model may provide important clinical information that would be lost in a single-factor model. For example, different intervention strategies may be more appropriate for parents scoring high on Parental Distress but low on Difficult Child than vice versa (Reitman et al., 2002). Abidin (1983) made the distinction between aspects of parenting stress that are specific to parental attributes and those due to child attributes. Greater severity of child behaviour problems have been shown to be more strongly linked with the child domain of parenting stress, while individual differences in parental adjustment and stressful life events are more strongly linked to the parent domain of parenting stress (Eyberg et al., 1992).

1.3.6 Parenting Stress and Parent Adjustment

Several researchers have provided evidence to support a link between parenting stress and psychological well-being (Deater-Deckard, 1998; Hudson and Rapee, 2001; Webster-Stratton and Hammond, 1988). In addition parenting stress has been linked with more stable characteristics of the parent such as personality or social and economic disadvantage (Deater-Deckard, 1998). The majority of the literature has focussed on maternal depression.

Webster-Stratton and Hammond (1988) compared depressed and non-depressed mothers on measures of personal adjustment, perceived child adjustment, teacher perceptions of child adjustment, and social and environmental stressors. In addition mothers were observed at home interacting with their children and coded using the Dyadic Parent-Child Interaction Coding System (DPICS; Robinson and Eyberg, 1981). Depressed mothers had significantly higher parenting stress scores than non-depressed mothers. There were significant group differences on the parent domain of the PSI but not the child domain. This suggests that depressed mothers report higher levels of stress related to parental functioning but do not perceive their child as less reinforcing than non-depressed mothers. Some differences were found between the two groups in perceived child behaviour problems, although this was dependent on the measure used. Depressed mothers perceived their children as having significantly more behaviour problems than did non-depressed mothers when measured by the Child Behaviour Checklist (CBCL; Achenbach and Edelbrock, 1983), but there were no group differences on Parent Daily Reports (PDR; Chamberlain and Reid, 1987). The PDR consists of a checklist of targeted behaviours. Mothers were telephoned twice a week for two weeks and asked to report on the occurrence of the behaviours during the previous 24 hours. There were no significant differences on observation measures of child behaviour, but there was a tendency for depressed mothers to use more critical statements. Thus, differences in CBCL scores may reflect perceived difficulties rather than an accurate representation of events. The specificity of the PDR may have led to more precise recording of behaviour. The bias in the appraisal of situations is in keeping with cognitive theories of depression (Beck, 1976). Hence it seems surprising that

depressed mothers did not consider their child less reinforcing. However, both groups of mothers scored above the 99th percentile on this measure. A wealth of literature describes the relationship between depression and parenting behaviour (Berg-Nielsen et al., 2002; Downey and Coyne, 1990; Leinonen et al, 2003). This issue will be revisited later.

Depression is not an unavoidable consequence of parenting stress, but may be mediated through other variables. Willner and Goldstein (2001) found significant correlation between measures of parenting stress, depression and perceptions of defeat/entrapment, i.e. failed struggle, loss of rank and escape motivation. After controlling for parenting stress, correlations between depression and defeat/entrapment remained highly significant, however after controlling for defeat/entrapment the relationship between depression and parenting stress was considerably weakened. The authors deduce that there was no direct effect of stress on depression, but that perceptions of defeat/entrapment mediated the relationship between stress and depression. The authors suggest that direction of causality can be inferred due to the low levels of depression compared with high levels of parenting stress, with parenting stress leading to depression via defeat and entrapment. Willner and Goldstein acknowledge the low response rate (76 participants out of 465 questionnaire packs distributed) but assert that a higher response rate is not necessary for the design of the study, i.e. investigating relationships between variables. It could be considered, however that perceptions of defeat and entrapment are not separate constructs from depression, hence the results. Champion and Power (1995) suggest that individuals with vulnerability towards depression will become depressed if there

is a threat to a valued social role or goal. Thus the link between parenting stress and depression may depend on the valence of the social role of parent.

The role of life events has also been considered. In Webster-Stratton and Hammond's (1988) study (outlined above) stepwise discriminant function analysis showed that a model based on two predictors, parent domain PSI score (with depression subscale removed) and a measure of negative life events, best predicted parent depression. Parenting self-efficacy has been found to moderate the effects of parenting stress on the mental health of parents (Kwok and Wong, 2000). However, it could be argued that there is some overlap in the concepts measured.

Individuals may be protected from higher levels of parenting stress where there is greater availability of social support (Abidin et al, 1992; Abidin and Brunner, 1995). However, this "buffering" effect may be culture- or gender-specific (Pearson and Chan, 1993; Deater-Deckard and Scarr, 1996). The link between social support and parenting stress may be stronger in specific high-risk groups, such as adolescent mothers (Richardson et al., 1995), economically disadvantaged parents (Adamakos et al., 1986) or parents of chronically ill or disabled children (Frey et al., 1989; Hauenstein, 1990). Quittner et al. (1990) suggest that, rather than having a buffering or moderating effect on the link between parenting stress and adult adjustment, social support directly mediates the relationship between the two.

The association between mental health and parental stress may differ depending on the gender of the parent. Much of the research has focussed on maternal mental

health. Creasey and Reese (1996) found no differences in how mothers and fathers perceived parenting hassles, yet Webster-Stratton and Hammond (1988) found both non-depressed mothers and depressed mothers to report higher levels of parenting stress. It is possible that gender differences may present in the pathways linking the two factors.

1.4 Parent-Child Relationships

1.4.1 Dimensions of parenting

The role of parent-child relationships, or parenting, in child behaviour problems has been outlined above. Parent-child interactions can be considered as bi-directional (Deater-Deckard, 1998). Effective parents are sensitive to their children's responses to earlier parental behaviour. Particularly in the first and second year, parents are more likely to imitate their children than vice versa (Maccoby and Martin, 1983). A child's attentiveness to an adult has been shown to be linked to the adult's positive attention toward that child (Bell and Chapman, 1986). The child may therefore be driving many of the interactions with the parent. Anderson et al. (1986) asserted that conduct-disordered boys may drive negative interactions with their parents. However their method of observing and coding interactions between mothers and child pairs having matched mothers of conduct-disordered children and mothers of non-conduct disordered children with their own children, children of the same category (conduct-disordered or not) and children of the other category, was methodologically weak, despite its frequent citation. Contrary to Anderson et al.'s

view of conduct-disordered children as directly affecting parenting behaviour, a more interactional view seems appropriate.

In measures of parent-child relationships, a distinction can be drawn between behavioural and attitudinal concepts. The former refers to observable behaviours during parent-child contact. The latter refers to attributions and assumptions made by the parent about the child and vice versa. It should be noted that such distinctions are not always easily made. For example discussion of attachment often includes reference to attachment behaviours and representations of attachment relationships (Greenberg et al., 1993). Deater-Deckard (1998) distinguishes between two dimensions of parenting; warmth and control. These relate to the emotional quality of the parent-child relationship and the constraints applied by the parent to control the child's behaviour. These elements may appear to fit in to the attitudinal and behavioural categories respectively but both warmth and control may contain features of both. In addition, some researchers use the label control to describe punitive and negative behaviour. Therefore, while not ideal, parent-child relationships will be discussed in terms of "positive" and "negative" parenting.

1.4.2 Measurement

Several other studies have demonstrated a link between parental negativity and child behavioural adjustment (Puckering et al., 1995; Berg-Nielsen et al., 2002). In order to study the effects of parenting behaviours on child psychopathology it is important

to have valid and reliable instruments to measure the quality of parent-child relationships (Lange et al, 2002).

The Dyadic Parent-Child Interaction Coding System (DPICS; Robinson and Eyberg, 1981) is a comprehensive observational system. Parent behaviours included in the system are direct command, indirect command, labelled praise, unlabeled praise, positive physical, negative physical, critical statement, descriptive statement, descriptive question, acknowledgement and irrelevant verbalisation. Child behaviours coded include whine, yell and non-compliance. The DPICS has been used in several studies (such as Foote et al., 1998; Webster-Stratton and Hammond, 1988, 1997). The DPICS has demonstrated reliability and validity but involves extensive training and practice before coders can use the system. Studies report an estimated 4-6 months before coders are reliable (Webster-Stratton and Hammond, 1988, 1997). In addition to the expense and time involved in using such measures it could be argued that the systems do not capture parenting behaviour as it naturally occurs. Parents are instructed to behave as they would usually, but with restrictions precluding the use of television or telephone. Gardner (1994) did not impose such restrictions. To further reduce the impact of observer presence she met the child previously and used pen and paper recording. Puckering et al. (1995) do not name the coding system used. Identification of whether behaviours are "positive" may be considered subjective although coders apparently refer to an extensive coding manual.

The Parent-Child Interaction Questionnaire (PACHIQ; Lange et al., 2002) was designed to help clinicians and researchers assess how parents view their relationship with their children and how children view their relationship with their parents. The items cover both interpersonal behaviour and feelings. They were based on structural and behavioural family therapy, where importance is given to the pattern of relationship between family members. Both the child and parent versions of the PACHIQ contain 30 items. The parent version displays a single common-factor structure while the child version contains two subscales; Conflict Resolution and Acceptance. A revised, shorter version of the questionnaire (PACHIQ-R; Lange et al., 2002) was devised and validated with families recruited through schools and mental health services. Both the parent and child versions of the PACHIQ-R have a two-factor structure, with the subscales Conflict Resolution and Acceptance. Items from the parent version include "I am often dissatisfied with ___" and "I compliment____". Parents in the outpatient group were found to show greater negativity in their evaluation of their relationship with the target child than parents in the normal group. The outpatient group were families recruited through mental health services with at least one child requiring treatment for psychological dysfunction. In addition, the authors found an association between PACHIQ-R scores and psychological dysfunction, as measured by the Dutch adaptation of the Symptom Checklist-90 (Derogatis, 1977). Thus, the PACHIQ appears to assess parents' attitudes rather than behaviour.

1.4.3 Negative Parenting

Patterson (1982) suggests that mothers' frequent critical comments or "nattering" are the most important element in the coercive process that characterises families of conduct-disordered children. Patterson et al. (1992) described a coercive cycle of behaviours in which both parent and child contribute. Both behave negatively until one stops and is thus reinforced for the negative behaviour (DeKlyen et al., 1998). In addition to the reinforcement process, conduct problems may be learned through modelling from parents' observed aggression. Parenting practices were shown to be related to both onset and persistence of children's mental health problems in a population level assessment of risk factors (Dwyer et al., 2003).

However the link between maternal behaviour and increased conduct problems was not supported in Webster-Stratton's (1988) study of depressed and non-depressed mothers of children with conduct disorder. Mothers' reports of child behaviour problems, low marital satisfaction and high life stressors were positively correlated with home observations of mothers' critical behaviour. There were no significant correlations between fathers' perception of child behaviour and their own parenting behaviour. However there were no differences between parents in how they interacted with their children. This contradicted previous findings that reported mothers to be more involved and issue more commands than fathers (Patterson, 1982). Webster-Stratton hypothesised that the different findings were due to a generational change in the role of the father. She emphasised the need to obtain father perceptions of children's behaviours as they appeared to be relatively less

contaminated by personal adjustment measures. However, it is possible that father perceptions are contaminated by different variables that have been neglected from the study, e.g. social stigma or self-image.

Brophy (2002) found that the mothers of "hard to manage" children used more frequent negative control than the comparison group when the children were aged three to four years, and more negative control and less positive control when the children were aged five to six years. Negative control was defined as demands which were accompanied by the following; immediate compliance demanded, aversive consequences were implicit or explicit if non-compliance ensued, use of sarcasm or humiliation or criticism, use of close-ended comments or directive comments. Alternatively, direct effort to control behaviour without praise or explanation was also considered negative control. Positive control was defined as direct, reasonable and clearly stated requests, accompanied by use of praise, explanation or open-ended questions, or the use of directing, teaching or suggesting alternatives to structure or scaffold the other's activities. Despite the differences in parenting behaviour observed there were no differences in behaviour observed between the children with behaviour problems and the control group at either time point, despite observed differences in dyadic play at school (Hughes, et al., 2000). Brophy considers that the study results may not compare to naturalistic observations due to the semi-structured novel tasks, the brevity of the observations or inappropriateness of the time points chosen to observe.

Gardner (1994) investigated further the fine detail of mother-child interactions to see if they differed in mothers of children with and without conduct problems. The author found that mothers of children with behaviour problems were less actively involved in joint activity sequences than control group mothers, i.e. they would initiate a lower proportion of activity sequences and use less commands, suggestions and questions to keep the activity going. Mothers of children without behaviour problems were more responsive to their children, i.e. answering their questions and complying with their suggestions to a greater extent. These mothers also used more sensitive forms of control, by couching requests in a gentler form or providing more explanation to justify the request. Both mothers and children on the control group showed higher rates of positive affect than their problem group counterparts. A higher percentage of mothers in the problem group showed negative affect than their controls, although there was no significant difference for the children. A causal relationship between mothers' behaviour and child behaviour cannot be assumed from Gardner's findings. However, the author suggests that maternal deficits in responsiveness, warmth and sensitivity of control may be a causal factor in children's behaviour problems. Due to a lack of observable differences in child behaviour during the sessions, differences in maternal behaviour were not a reaction to difficult child behaviour at the time. The author suggests that the behaviour in mothers of problem behaviour children was a reaction to difficult behaviour shown at other times "spilling over" into times when the child behaves appropriately. Further research is needed to investigate this possibility, using longitudinal approaches to identify how specific parenting behaviours change over time, and how patterns of parenting behaviour become set.

Gardner (1994) acknowledges the link between maternal depression and child problem behaviour found in a number of studies (Berg-Nielsen et al., 2002). Webster-Stratton and Hammond (1988) suggest that parenting mediates this relationship. Gardner outlines the hypothesis that low mood may have contributed to the low involvement in activity, through reduced energy, enthusiasm or sense of competence but gives two reasons why she does not feel this explains the differences found between the two groups. She reports firstly that other studies have found smaller group differences between depressed and non-depressed mothers in the quality of joint activity than were found in her study, and secondly that the observers felt that the minority of mothers in the current study gave the "impression" of having low mood. However, as depression was not measured in Gardner's study it is possible that differences in the two groups in terms of depression explained, to some extent, the group differences in behaviour. As rates of depression are higher in mothers of children with behaviour problems (Webster-Stratton and Hammond, 1988) this explanation seems feasible. There may be an interaction between the effects of depression and of having a child with behaviour problems on involvement in play but this hypothesis needs to be explicitly tested.

Deater-Deckard (1998) emphasises the importance of distinguishing between specific parenting behaviours and more general domains of parenting, e.g. warmth, negativity or control. She describes possible cultural difference in the use of specific parenting behaviours and consequently the values placed on them. For example, the use of physical discipline was found to be related to externalising, aggressive behaviour in European-American children, but not in African-American children

(Deater-Deckard et al., 1996). This difference can possibly be attributed to cultural differences in parenting norms that influence the meaning ascribed to the parenting behaviour by the child. Negative consequences of parenting behaviour are more likely to occur if the behaviour is perceived as harsh and rejecting (Deater-Deckard, 1998). Rohner et al., (1991) found some evidence to support the position that the views of the child mediate the relationship between parental behaviour and child adjustment. However, these findings have been criticised due to potential cultural bias in measures of "harsh" or "positive" parenting (Kelley et al., 1992). Further research is needed in this area.

1.4.4 Positive parenting

Positive aspects of parenting have been studied to a lesser extent. Russell and Russell (1996) found links between child misbehaviour and two types of positive parenting warmth/affection and positive involvement. Positive parent-child interactions may prevent the emergence of serious behaviour problems through modelling prosocial behaviour (Maccoby and Martin, 1983).

Pettit and Bates (1989) found home observational measures of behaviour problems at age four correlated with maternal positive social contact and activity in the child's first and second year, but not with maternal activity when the child was age four. The authors found that the frequency of mother-initiated positive episodes of contact correlated with low child problem behaviour, while the frequency of child initiated

episodes correlated with high problem behaviour. However, due to the longitudinal nature of the study, only 29 families were included encompassing a broad range of functioning. Campbell et al. (1986) found few differences in observed mother or child behaviour during play, especially after controlling for social class. They note, however, that the findings of the laboratory-based study may not generalise to the home due to the lack of competing demands and the supply of novel toys in the experimental setting.

Brophy (2002) looked at issues of control and connectedness in mother child pairs to investigate whether mothers of children with disruptive behaviour problems held less frequent connected conversations with their children, and whether they used less positive controlling behaviour and more negative controlling behaviours during their dyadic interactions than did mothers of non-problem children. Children met criteria for the "hard to manage" group if they scored above the 90th percentile on the hyperactivity and conduct disorder subscales of the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997) compared to data from the Avon Longitudinal Study of Pregnancy and Childhood (Golding, 1996) in which parents of 14,000 four year olds completed the SDQ. Control children were recruited from the same schools. Audiotaped home observations were completed for 30 "hard to manage' families and 26 control families. Observations were carried out for twenty minutes while mother and child carried out "their normal, everyday evening routines". Children's nonverbal and verbal abilities were also assessed. Mother-child dyads were observed eighteen months later performing structured and semi-structured tasks. The audiotapes were transcribed and coded for positive control, negative

control, connected communication and remarks. The mothers of the "hard to manage" children scored lower on the "connected communication" measure, i.e. they were less focussed on and involved in their children's activities than control group mothers. Brophy suggests that connected communication may be an important factor in children with behaviour problems, as children may learn responsiveness, focussed attention and internal regulation through their interactions. However, the author does not explain the mechanism through which these skills may be acquired, nor how they might impact on behaviour. It is possible that responsiveness and focussed attention may be learnt through modelling, and may reduce inappropriate behaviour through an increased repertoire of interpersonal skills. It is possible, as the author notes, that parents may reduce inappropriate behaviour through joint activities by keeping the child occupied and "out of trouble" (Maccoby and Martin, 1983; Gardner, 1994). Brophy emphasises the importance of looking at positive parental strategies and examining whether a "harmonious cycle" of interaction could play a role in problem child behaviour as coercive cycles have been hypothesized to do.

Gardner (1987) found that mothers of children without behaviour problems spent three times as long in joint activity with their children as mothers of children with behaviour problems. Joint activity may provide a setting where parent and child can express mutual warmth, sensitivity and responsiveness to each other (Gardner, 1994). Compared with controls children with behaviour problems also spent less time on solo play (Gardner, 1987). This suggests they may have less skill at amusing themselves and consequently may be more likely to misbehave.

The BASIC Parenting Programme (Webster-Stratton, 1982) begins with a focus on play, in order to infuse positive feelings into the parent-child relationship (Webster-Stratton and Hancock, 1998; Webster-Stratton and Herbert, 1994). Parents of children with behaviour problems often play with their children less than other parents as interactions are too stressful. Parents feel frustrated and angry with their children for their misbehaviour; consequently children are negative towards their parents (Webster-Stratton and Hancock, 1998). The importance of play is emphasised to parents and effective ways of playing with children are taught. Parpal and Maccoby (1985) suggest that responsiveness to the child's contributions and wishes may teach the child that their compliance is appreciated and reciprocated and thus impacts on the prevention of behaviour problems.

Webster-Stratton and Hancock (1998) state that regular parent-child playtime helps build warm relationships within the family, helping children to feel loved and promoting parents' feelings of attachment and warmth towards their children. In addition playtime provides an opportunity to teach children important skills such as turn taking, problem solving and empathy, while promoting creativity and feelings of competence (Webster-Stratton and Hancock, 1998). Maccoby and Martin (1983) note that if cooperative styles of interacting are developed through play, these may increase the likelihood of the child complying when disciplined.

1.4.5 Praise

Praise can be defined as positive evaluations of another's performance or attributes (Kanouse et al., 1981). It can be differentiated from acknowledgement and feedback, which provide neutral recognition, and encouragement, which is more future-focussed (Henderlong and Lepper, 2002).

The second component of the BASIC Parenting Programme (Webster-Stratton, 1982) is praise. Parents of children with behaviour problems often use little praise with their children (Webster-Stratton and Hancock, 1998). This may be for several reasons. Parents may feel only particularly good behaviour or exceptional achievements should be praise. They may not know how or when to give praise most effectively. They may feel uncomfortable using praise if they received little praise from their own parents (Webster-Stratton and Hancock, 1998). The praise component of the BASIC programme teaches parents to identify the behaviours they want to promote, to actively seek them and to praise them each time they occur. The aim is for prosocial behaviours to increase through reinforcement and thus reduce the need and opportunity for less appropriate behaviour.

Henderlong and Lepper (2002), however, argue against the assertion that praise acts solely as verbal reinforcement. From an extensive review of the literature they suggest that praise may serve to undermine, enhance or have no effect on children's intrinsic motivation. They caution against the idea that praise should be used liberally and outline the conditions under which praise is more likely to promote

motivation. The authors differentiate between intrinsic and extrinsic motivation, i.e. whether motivation is driven by pleasure or enjoyment, or by external pressures. They suggest that if praise increases a desired behaviour in order to sustain the attention and approval of the praiser (extrinsic motivation), the effects will be transient and will dissipate as soon as praising ends. It should be noted that Henderlong and Lepper specifically focus on the effect of praise on children's motivation. They do not look at other effects, such as those on children's self-esteem which Webster-Stratton (Webster-Stratton and Herbert, 1994) suggests is a longer-term benefit of the consistent use of praise. They note also that much of the research on praise is based on experimental procedures, which remove the context in which praise is typically embedded. Much of the praise literature focuses on the effects of praise on learning educational tasks. There may be different effects and processes when praise is used to reinforce more appropriate behaviour in the home. Webster-Stratton and Herbert (1994) describe creating a "bank" of warm feelings between family members through play and praise. Longitudinal studies are necessary to evaluate empirically the effects of praise over time in naturalistic settings.

Henderlong and Lepper (2002) state that for praise to enhance motivation it should promote autonomy, enhance competence without over-reliance on social comparisons and convey attainable standards and expectations. They report that praise may undermine motivation by creating excessive pressure to do well, discouraging risk-taking and reducing perceived autonomy. They report Grusec's (1991) finding of a negative correlation between the mother use of praise of prosocial behaviour and the degree to which their four year olds acted prosocially. However, it

should be noted that this study depends on maternal ratings of behaviour. Webster-Stratton and Hammond (1988) note that mothers of children with conduct problems may be less likely to notice such behaviour.

Henderlong and Lepper suggest that praise may result in self-worth that is contingent on success. However, Kamins and Dweck (1999) distinguish between person and process praise. They found that praise that conveyed person or trait judgements resulted in more helpless responses than praise that was task-specific. Henderlong and Lepper (2002) report that praise must be perceived as sincere for it to be effective, although they note that this area has received little empirical exploration. Process praise is more likely to be believed than general praise that may be inconsistent with existing beliefs about the self. Non-verbal behaviour that contradicts the praise content may reduce perceived sincerity (Brophy, 1981). O'Leary and O'Leary (1977) state that praise must be contingent, specific and sincere for it to function as a reinforcer. Praise must also be given at the appropriate time (Carton, 1996). Webster-Stratton's guidelines for effective praise (Webster-Stratton and Herbert, 1994) address these factors. Praise is to be given immediately following the desired behaviour, describing specifically which behaviour is being praised and accompanied by the use of appropriate nonverbal behaviour, such as touch. In addition, emphasis is given for effort rather than result. Empirical research findings suggest that children who are praised for ability show poorer performance relative to children who are praised for effort (Mueller and Dweck, 1998). However Henderlong and Lepper (2002) point out that, as in much praise research, a "no praise" control group was not included. Gordon (1989) argues that parental praise

may lead to children only performing tasks that they think will please their parents and thus becoming less creative and innovative. However, the use of praise for effort, emphasised by Webster-Stratton, encourages the development of creativity. In addition the use of praise has been shown to lead to pre-schoolers engaging with a task longer relative to baseline (Anderson et al, 1976).

In summary, despite the caution expressed by Henderlong and Lepper (2002) about the potential detrimental consequences of praise, the use of praise as outlined in the BASIC parenting programme would appear to fulfil the criteria for effective praise. Thus, targeting the use of praise in families with children with behaviour problems has some empirical support, even if research to date has not directly focussed on its use in this setting. The use of praise is a fundamental part of parent-training programmes where the reinforcement of appropriate behaviour through praise is paramount.

1.5 Parent-Training Programmes

1.5.1 Theoretical Background

The central assumption of parent-training programmes is that conduct and behavioural problems are developed and maintained through deficits in parenting skills (Webster-Stratton and Herbert, 1994). Social Learning Theory asserts that people learn behaviours through response consequences or through modelling. Response consequences can have three functions; an informative function, a

motivational function and a reinforcing function (Bandura, 1977). An individual can observe the effects of an action or response and use this information to decide on its appropriateness in specific settings. This acquired information leads an individual to make predictions about the likely consequences of future responses without direct experience of that response. Thus they are motivated to adopt or reject the response. Finally, the reinforcing function of response consequences dictates that responses with a desirable outcome will increase, while those with an undesirable outcome will reduce.

Bandura (1977) notes that consequences do not automatically enhance every response they follow, but that learning occurs only when events are sufficiently salient. In addition, he suggests that reinforcement regulates previously learnt behaviours rather than providing the circumstances for new learning. He considers that it is rare for a behaviour to be learnt that has not been observed being performed by others and asserts that most human behaviour is learned observationally through modelling. Observers gain a symbolic representation of the modelled activities. Four component processes govern the learning process; attentional processes, retention processes, motor reproduction processes and motivational processes. In order to form the symbolic representation the individual must attend to and perceive the significant features of the modelled behaviour, retain the information and convert it into appropriate actions. Motivational processes apply with regard to choosing whether to adopt the modelled behaviour.

1.5.2 Development of Parent Training Programmes

Many of the parent-training programmes widely used today have drawn on the two-stage operant conditioning model of Hanf (1969), for example Forehand and McMahon's (1981) programme. In the first stage of Hanf's programme mothers were taught to allow their child to lead a play activity and to provide positive attention for appropriate behaviour while ignoring inappropriate behaviour. In the second stage mothers were taught to lead the play and increase compliance with the use of clear commands, praise and time-out. Unlike most of the programmes used today, Hanf's programme involved both the parent and child with in vivo training. A similar approach is used in Parent-Child Interaction Therapy (Eyberg, 1988; Foote et al., 1998) where the therapist uses a bug-in-the-ear device to work with the parent and child in the clinic or at home. The majority of parent-training programmes involve working only with the parents. Two commonly used programmes are Webster-Stratton's Parent and Child Series (Webster-Stratton, 1982, 1992) and the Triple P – Positive Parenting Programme (Sanders, 1999). Programmes may also be adapted for the use of specific child populations (Chadwick et al., 2001), parenting populations (Forgatch and DeGarmo, 1999) or for use with larger groups (Cunningham et al., 1995).

1.5.3 Webster-Stratton Programmes

1.5.3.1 Content

Webster-Stratton programmes are the most evaluated parent-training programmes (Richardson and Joughin, 2002). The Parent and Child Video Series (Webster-Stratton, 1982, 1992) is a series of videotapes developed to assist therapists in parent training. The BASIC programme is the original twelve-week parenting programme aimed at the parents of children with conduct problems aged 3 to 8 years. This consists of ten videotapes including more than 250 vignettes of parents interacting with their children and covers several specific topics; play skills, praise, incentives or tangible rewards, limit-setting, ignoring skills, time-out, and natural and logical consequences (Webster-Stratton, 1982). The ADVANCED parenting programme (Webster-Stratton, 1992) was designed to follow completion of the BASIC programme and consists of a further 8 to 10 sessions focussing on parents' communication, anger management and problem-solving. The programme was designed to address issues that affect a family's ability to gain from parent-training, such as parental depression, marital conflict, isolation, and economic and life stresses (Webster-Stratton and Hancock, 1998).

1.5.3.2 Rationale for videotape modelling

Videotape feedback has frequently been used as part of parent-training programmes. Parents are videotaped while interacting with their children. The tapes are then

reviewed with a therapist and discussion takes place on how the interactions may be improved (Webster-Stratton et al., 1988). This process is costly and time-consuming and led to the question of whether a standardised videotape programme could elicit the same results. It was hypothesised that such a programme would also have the benefit of allowing parents to observe parenting behaviours they did not themselves use, and that parents watching standardised videotapes would be less defensive than those watching their own tapes (Webster-Stratton, 1981). Four studies have shown that videotape modelling is superior than other instructional techniques in teaching parents. Nay (1976) found videotape modelling, with and without role playing, to be superior to written or spoken information on the use of time out. O'Dell et al. (1979) also found increased benefit from using videotape modelling over other techniques, including live modelling, when implementing parent training. Flanagan et al. (1979) and O'Dell et al. (1982) found similar results although all 4 studies have focussed on one specific behaviour, i.e. the use of time-out. These findings led to the development of the videotape vignettes used in the BASIC programme. Bandura (1977) stated that modelling was more likely to occur if the observer perceived the model to be similar to themselves, paid attention to the model's behaviour and observed the model receiving rewards for certain behaviour. In order to adhere to these criteria Webster-Stratton ensured that the models in the videotapes were actual parents who had attended a parenting course based on similar principles. In the use of the videotapes Webster-Stratton advocated that the therapist draw attention to specific parenting behaviours and the responses of the children.

1.5.3.2 Group discussion videotape modelling

Several studies have shown that including these videotapes in a group discussion approach is an effective and cost-efficient way of improving parenting skills (Webster-Stratton, 1981, 1984; Webster-Stratton et al., 1988, 1992). The therapist-led group discussion encourages rapport building, reduces feeling of isolation and encourages a collaborative problem-solving approach (Webster-Stratton and Herbert, 1993). The six therapist roles considered essential by the programme's author are: relationship building; empowering; teaching; interpreting; leading and challenging; and prophesising (Webster-Stratton and Herbert, 1993).

Webster-Stratton and Herbert (1993) describe several relationship building strategies including the use of humour, self-disclosure and optimism. The emphasis is on a coping model rather than a mastery model. In addition it is suggested that the therapist can play an important role as an advocate for parents, for example organising and attending meetings with other professionals. It is stressed that the ultimate goal is for the parents to self-advocate and the importance of a collaborative approach remains. The task of empowering parents can be realised through reinforcement and validation of their contributions to the discussion, modifying cognitive distortions, promoting self-empowerment and encouraging the development and utilisation of support systems including other group members (Webster-Stratton and Herbert, 1993).

With regard to the teaching role, the programme author emphasises the importance of adopting a collaborative rather than didactic stance in order to encourage self-confidence and model the approach to be used with their children. Essential tasks in the teaching role include explaining the rationale for each part of the programme, working with families to ensure concepts and skills can be adapted to their specific circumstances, and assigning tasks for parents to complete between sessions in order for them to practise the skills and ensure generalisation. A further way to enhance transfer of skills is to use role-play. This can be done first with the therapist role-playing the parent and then with parents practising the acquired skills (Webster-Stratton and Herbert, 1993). An additional role that the therapist plays is one of interpreter, translating the language of theoretical concepts into words and behaviours appropriate to the family culture and circumstances. Webster-Stratton and Herbert (1993) advocate the use of analogies and metaphors to assist in the translation of abstract principles into concrete behaviours. In addition, the therapist may use cognitive restructuring to reframe a problem from the child's, rather than the parent's, point of view.

The therapist must ensure that the discussion group meets the aims and objectives of the programme by leading the discussion, providing structure and occasionally challenging parents' views. This may seem contrary to the collaborative nature of the programme. Webster-Stratton and Herbert emphasise the importance of allowing the parents to play a role in this process, for example by determining the agenda, and recommend keeping a balance between the needs of the individual parents, the group and the therapist. Patterson (1982) reports that resistance to the treatment process

peaks at a halfway point. There may be several reasons for this; the parents' need to maintain self-efficacy in the midst of changing family dynamics, a lack of adequate understanding of the concepts under discussion, unrealistic expectations of the speed with which behavioural change can be achieved, or not feeling understood by the therapist. Webster-Stratton and Herbert (1993) assert that this resistance should be considered a developmental stage of the process and should be explored in a non-confrontational manner.

Finally, Webster-Stratton and Herbert (1993) highlight the role of the therapist as 'prophesiser', anticipating problems and setbacks, predicting resistance to change in participating parents and other family members, and working with group members to find solutions for each of these difficulties.

1.5.3.3 Research base

Group discussion videotape modelling treatment has been shown to be as effective as one-to-one parent training for parents of children with conduct problems (Webster-Stratton, 1984). A study was carried out to identify whether the videotape modelling, the group discussion or a combination of the two was the active component (Webster-Stratton et al., 1988). Use of the same videotapes for a self-administered videotape therapy was compared with a group discussion only approach, the joint package and a waiting-list control group. All three of the treatment groups showed significant improvements in children's behaviour compared

to the control group. There were relatively few differences between treatment groups, although the joint package showed some superiority. Thus, the relatively less expensive self-administered therapy gained support as a cost-effective intervention. The authors note, however, that further information on whether gains are maintained is necessary. They suggest that the initial effects of self-administered videotape modelling may not be sustained compared to the interventions with therapist involvement.

A modified version of Webster-Stratton's BASIC programme has been developed for use as a preventative programme. The families targeted have a socio-economically deprived background and consequently have been found to have a greater prevalence of factors such as low educational attainment, teenage pregnancy, high levels of stress, history of parental criminality, mental illness, substance abuse and marital conflict. These factors have been linked with increased risk of conduct problems (Webster-Stratton, 1990). The abbreviated version consists of an 8 to 9 week programme using videotape modelling and group discussion. Mothers who had participated on the programme were observed to be more positive and less critical in their parenting compared to a control group. Children of parents who had attended the programme were observed to exhibit fewer conduct problems and more positive affect than the control group. Most improvements had been maintained one year later (Webster-Stratton, 1998).

Although some improvements from the parenting programmes have been found to generalise to the school setting (Webber-Stratton, et al., 1988), other studies have found that children's noncompliant and aggressive behaviour has not reduced in the

classroom following parent-training, even with an additional child social skills-training component (Webster-Stratton and Hammond, 1997). An additional teacher programme was designed to run in combination with parent and child programmes. The programme consists of four sessions, each lasting a full day, covering similar topics to the parenting programme, such as the use of praise and reinforcement, limit setting and time-out. The addition of the teacher-training component resulted in significant decreases in aggressive behaviour in the classroom (Webster-Stratton et al., 2001).

Webster-Stratton herself has carried out much of the research evaluation of the programme. However, studies adopting the programme with British families have also demonstrated success. A multi-centre controlled trial using the BASIC programme with families in London and West Sussex showed significant reductions in antisocial behaviour compared to a waiting list control group (Scott et al, 2001).

1.5.4 The Triple P – Positive Parenting Program

Where additional sources of stress and adversity are present, families are less likely to benefit from behavioural interventions (Webster-Stratton, 1990). It has therefore been considered necessary to include components addressing other forms of parental distress in parent-training programmes (Sanders et al., 2000). The Triple P – Positive Parenting Program, developed in Australia by Sanders and colleagues, is a tiered multilevel model of behavioural family intervention (Sanders, 1999). The five

levels are on a continuum. At level one (Universal Triple P) a coordinated information campaign uses a variety of strategies to disseminate information on parenting and promoting children's development to a wide audience. There may be telephone contact with professional staff, for example a telephone information line. Level two (Selected Triple P) includes the provision of information and advice on specific parenting concerns, e.g. toilet training or bedtime problems. Contact with a professional may be face to face or by telephone or in the form of seminars, but would usually consist of no more than two contacts. Level three (Primary Care Triple P) involves brief parent-skills programmes aimed at targeting discrete child behaviour problems, combining advice with rehearsal and self-evaluation. Level four is a broader parenting skills programme that may be delivered in several formats (Standard Triple P, Group Triple P or Self-help Triple P). The programme provides intensive training in positive parenting skills and techniques to enhance generalisation to different behaviours, settings or children. The final level (Enhanced Triple P) provides additional components to address other difficulties that provide a context to the child's behavioural problems, for example, marital conflict or poor parental mental health. Standard parent-training procedures are integrated with strategies aimed at helping parents manage their own feelings of depression, anxiety or anger. Cognitive therapy is used, along with brief behavioural communication skills training aimed at increasing the amount of support derived from partners, families and friends.

Sanders et al. (2000) targeted families in low-income areas of Brisbane for inclusion in a study to evaluate the effects of the enhanced programme with high-risk families.

Families assigned to Standard and Enhanced Triple P showed lower levels of dysfunctional parenting and parent-reported disruptive behaviour and greater parental competence than those who were in the waiting list control group and those who had received self-help Triple P. Families who had received Enhanced Triple P showed greater reliable improvement in child behaviour than any other group, but did not show significantly improved parenting compared to Standard Triple P. The authors suggest that the similarity between the effects of Standard and Enhanced Triple P may mean that a more intensive intervention is required, but note the implications that this would have for cost and attrition. The authors point out that families were eligible for inclusion if they had at least one of the following; maternal depression, relationship conflict, low income or low occupational prestige, or were a single parent family. They suggest that better outcomes may have been achieved if families in the Enhanced Triple P group were those with the specific risk factors targeted by the intervention, i.e. marital conflict and poor parental mental health.

1.6 Rationale for current research

Relationships have been demonstrated between parenting stress and parenting behaviour, child behaviour, parental adjustment, life events, social support, and life stressors such as unemployment.

There is a wealth of literature to support the use of parent-training programmes with families under stress (Richardson and Joughin, 2002). Several such programmes

emphasise the importance of beginning intervention with a relationship-building phase (Foote et al., 1998, Webster-Stratton, 1982, 1992). However there has been little research to examine how this phase might impact on parental stress. Parenting interventions have been found to reduce stress in parents in addition to improving child behaviour (Reitman et al., 2002). However it remains unclear whether this is solely as a result of improved child adjustment. Parents who score highly in parenting stress do not find their children to be a source of reinforcement (Webster-Stratton and Hammond, 1988). If parents are taught to focus on the positive aspects of their child's behaviour through play and praise (the first components of Webster-Stratton's (1982) programme) there may be a resulting improvement in parenting stress. Very brief interventions have been shown to be of benefit for parents of children with conduct problems (Olson and Roberts, 1987) although the results may not be maintained. Frequently, families who are referred to family psychology and psychiatry services have to wait several months before they are seen. It is possible that a brief intervention at an early stage during this waiting period may begin to break the coercive cycle (Paterson, 1982) and build mutually rewarding relationships. Play can be considered a way of gaining a better understanding of the child (Mol Lous et al., 2002).

Reducing levels of parenting stress may not only improve the parent's well-being, but may improve the efficacy of interventions targeted at their child's behavioural problems (Kazdin, 1995). A reduction in parenting stress through a brief intervention while a family awaits a full assessment may lead to better engagement with services. The aim is to bring about improved parent-child relationships, not a

sustainable change in child behaviour. Parents experience more positive and less negative emotion if they can coordinate interactions with their child so that mutually satisfactory behaviours and outcomes occur (Dix, 1991).

It has been argued that there are limited staff trained in parenting approaches (Kazdin, 1997). However, this is changing with an increase in other professions facilitating such programmes (Hutchings, 1996). Manualised programmes such as Webster-Stratton's mean such approaches can be more easily trained, although Kazdin (1997) recommends caution is exercised with regard to appropriate training. Although Webster-Stratton's programme was designed to be implemented in a group setting there can be flexibility in its application (Reid and Webster-Stratton, 2001). Evidence suggests that group and individual approaches may not differ in efficacy (Morrison, 2001). Attendance at clinic appointments is often difficult for parents (Foote et al., 1998). Webster-Stratton's videotape programme has been shown to have benefits for child behaviour if self-administered, but not for parenting stress outcomes. Thus it was decided to administer the sessions with parents individually but to include the discussion component. Individual rather than group sessions also means that parents can have sessions at home which may improve engagement (Prinz and Miller, 1991). Behan and Carr (2000) found negligible differences in the effect sizes of group and individual parenting interventions.

Outcome studies for parent-training programmes frequently limit the recruited sample to parents of children with diagnosed conduct disorders (Richardson and Joughin, 2002). However young children are difficult to diagnose (Behan and Carr,

2000) and may benefit from parent training even if they do not meet criteria. Accordingly it was decided not to limit the study to those children with diagnosed conduct disorders. Campbell (1995) described the period of between two and six years as a pivotal period with many developmental changes occurring and leading to either an adaptive transition or the development of behaviour problems. Webster-Stratton's BASIC programme is designed for use with three to eight year olds, although the ADVANCED programme which contains many of the same components is designed for children up to twelve years old. Compromised parenting practices have been found in the parents of children with internalising behaviour (Baker et al., 2000). It is also common for children with internalising disorders to demonstrate externalising behaviour (Campbell, 1995). In addition parent-training programmes have demonstrated efficacy with parents of children with ADHD or attentional problems (Barkley, 1990; Froelich et al., 2002; Hartman et al., 2003). Hence, such an intervention may be beneficial for a heterogeneous population.

This study is aimed as a pilot study to examine the effects of a brief intervention aimed at breaking the coercive cycle of interactions and providing mutually rewarding experiences. It is hoped that in changing the parents' attention to focus on positive aspects of the child, and by proving more reward for these aspects, they will gain more reinforcement from their child and parenting stress will reduce.

1.7 Research Aims

The aims of the study were as follow:

- To identify whether a brief parenting intervention based on the initial sessions of Webster-Stratton's BASIC parent training programme leads to a reduction in parenting stress.

- To identify whether the intervention has an effect on general parent distress.

- To identify whether the intervention results in parents having a more positive view of their child.

- To examine whether any change in parenting stress is due to an improvement in child behaviour.

- To examine whether any change in parenting stress can be attributed to a change in how the parents view their child.

- To establish whether the brief intervention is acceptable to parents in terms of finding it helpful and relevant.

2 METHOD

2.1 Participants

The parents of children on the waiting list of either the Psychology Department or the Department of Family Psychiatry at St. John's Hospital, Livingston were contacted by letter if, from the information given in the referral, they fit the following criteria:

1. Children were between the ages of two and eight years
2. The presenting problem (as outlined in the referral) included behavioural or emotional difficulties
3. The referral had not been prioritised for early intervention

   They were at a point on the waiting list such that there was at least three months before the family would be offered a routine appointment
4. The child was living with at least one natural or adoptive parent
5. The child did not have a diagnosed Autistic Spectrum Disorder or Learning Disability.

Parents were excluded from the study if, on the basis of new information, they required priority for a routine appointment, or if they did not demonstrate the ability to understand the requirements of the study and intervention sessions. Where there were two parents at home, both were encouraged to attend but parents were not prevented from inclusion if this was not possible.

2.2 Procedure

Families were contacted by letter between March and May 2003 (see Appendix A). If the family expressed an interest in participating, either by telephone or by returning a reply slip, an appointment was made for an initial interview with the parents at the Psychology Department, St. John's Hospital. The referred child was not required to be present. Interviews were arranged by telephone or letter and usually took place within a week of the parents' making contact.

A structured assessment interview was performed to ensure eligibility for inclusion and to explain further the requirements of the study. The aim of the interview was to gather further information about the presenting difficulties and establish whether the intervention was appropriate. Participants had the opportunity to ask any questions and were asked to sign a consent form (Appendix B) at this interview after reading the information sheet (Appendix C). The first intervention session was arranged at a convenient time, when parents could make childcare arrangements if necessary. Parents were seen individually or as a couple if both parents were participating. Each intervention session lasted 60-90 minutes. After the initial appointment, parents could choose to have further appointments at home or another location if convenient and if there was access to a videotape player. The second intervention session was carried out at the same location two weeks later. Parents were seen for outcome measure following the intervention and again one month later if this fell within the data collection period of the study (March to July 2003).

2.3 Design

A within subjects design was used. The measures were completed three times where possible. The schedule for assessments was as follows: (i) baseline measures were completed at assessment interview prior to commencing the parenting intervention; (ii) outcome measures were completed two weeks following completion of the intervention; (iii) follow-up outcome measures were completed one month after completion of the previous measures. Due to the small number of families completing the final (one month) outcome measures, these data were not analysed. Hence "post-intervention" scores refer to measures due two weeks after completion of the intervention.

2.3.1 Intervention

Intervention sessions were based on the first two components of Webster-Stratton's (1982) BASIC parent-training programme. These sessions included the use of videotape vignettes and parent-led discussion. The two topics covered (one per session) were 'Play' and 'Praise'. The intervention was carried out by the lead researcher, who had used the videotape based sessions previously with individual families and as a co-facilitator of a parenting group. Clinical supervision was provided by a clinical psychologist with several years experience of using Webster-Stratton's programme.

Play

The main aim of this session was to teach parents the importance of child-directed play. Vignettes were shown of parents controlling play or letting the child take the lead. Parents were asked to observe the behaviour of the parents and notice the reactions of the children. The videotape was stopped periodically for the ideas raised to be discussed. The therapist discussion was guided by use of the accompanying manual (Webster-Stratton, 1982). The following points were emphasised during the session (Webster-Stratton and Herbert, 1994):

- Follow the child's lead.
- Pace at the child's level.
- Don't expect too much – give the child time to think and explore.
- Avoid too much competition with children, especially where the adult always wins.
- Praise and encourage the child's ideas and creativity; don't criticise.
- Engage in role-play and make-believe with the child.
- Be an attentive and appreciative audience.
- Use descriptive comments instead of asking questions.
- Curb the desire to give too much help; encourage the child's problem-solving.
- Reward quiet playtimes with parental attention.
- Laugh and have fun.

At the end of the session parents were given the task of playing with their children for at least ten minutes each day using the ideas discussed in the session. They were asked to keep a brief record of the sessions and their own and the child's reactions. These records were discussed at the beginning of the next session (Appendix E).

Praise

The focus of the second session was the effective use of praise. As in the first session, videotape vignettes were used to demonstrate the salient points and facilitate discussion. Parents were taught to look for positive behaviours and to praise them, with emphasis on the following points (Webster-Stratton and Herbert, 1994):

- Make praise contingent on behaviour.
- Praise immediately.
- Give labelled and specific praise.
- Give positive praise, without qualifiers and sarcasm.
- Praise with smiles, eye contact, and enthusiasm as well as with words.
- Give pats, hugs, and kisses along with verbal praise.
- Catch the child whenever s/he is being good – don't save praise for perfect behaviour
- Use praise consistently whenever you see the positive behaviour you want to encourage.
- Praise in front of other people.
- Don't worry about spoiling children with praise.

- Increase praise for difficult children.
- Model self-praise.

At the end of the session parents were asked to pick one or two specific behaviours to target with the use of praise, in addition to increasing the use of praise generally, keeping in mind the principles discussed. They were asked to record several examples of their use of praise and the child's reactions (Appendix F). The records were discussed at the beginning of the first follow-up appointment.

2.3.2 Intervention Integrity

At each intervention session parents were shown all the requisite vignettes for that topic. Therapist led discussion was facilitated using the manual to ensure all key points were raised. In addition to the specific issues for each topic outlined above, the therapist ensured that behavioural principles such as modelling and positive and negative reinforcement were explained and discussed.

2.3.3 Measures

Baseline questionnaires were completed at the end of interviews with the psychologist. The following measures were used.

Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997)

The SDQ was developed with the aim of creating a brief behavioural screening questionnaire that demonstrated the validity and reliability of the Rutter questionnaires, but included aspects neglected by the Rutter measures, such as having friends, impulsivity and concentration. There are versions of the SDQ for completion by teachers, parents and children themselves. The five dimensions covered are Conduct Problems, Emotional Symptoms, Hyperactivity, Peer Relationships and Prosocial Behaviour. The Parent version alone was used in this study. This is appropriate for use with the parents of three to 16 year olds with a slightly different version for use with the parents of children aged three to four years. This version was used with one mother in the study whose child was almost three years. The SDQ comes with an optional impact supplement (Goodman, 1999) that includes questions about chronicity, distress, social impairment and burden for the family. Impact scores have been found to be better than symptom scores for discriminating between community and clinic samples (Goodman, 1999). In this study the SDQ Total Score was used as a measure of perceived (by the parent) child adjustment. Impact scores were used to assess the effects of perceived child adjustment on the family.

The Parenting Stress Index – Short-Form (PSI-SF; Abidin 1990)

The PSI-SF is directly derived from the full version of the Parenting Stress Index. It consists of three subscales; Parental Distress, Parent-Child Dysfunctional Interaction, and Difficult Child. The Parental Distress subscale describes the distress

experienced by the parent in the parenting role as a function of personal factors that are directly related to parenting, for example impaired sense of parenting competence, restrictions placed on other life roles, lack of social support and conflict with the child's other parent. High scores on the Parent-Child Dysfunctional Interaction subscale indicate that interactions with the child are not reinforcing to the parent, and the parent perceives that their child does not meet their expectations. The parent-child bond is threatened or has never been adequately established, with the parent feeling rejected by or alienated from the child. The Difficult Child subscale focuses on behavioural tendencies of the child including learned behaviour and temperamental characteristics. The PSI-SF demonstrates good test-retest and internal consistency reliability. There is less evidence of validity available, but the PSI-SF is highly correlated with the full scale PSI (r=.92), the validity of which is well examined. In this study the Total Score was used as a general measure of parenting stress, with the subscales used to examine the separate components of stress due to parent, child or parent-child relationship characteristics.

The Family Grid (Davis and Rushton, 1991)

The Family Grid was designed to assess a parent's self-esteem and their relationship with their partner and child. It is derived from construct theory and provides a summary of how the individual views themselves, partner and child as they actually are, and as they would wish them to be ideally. In this study only the child scales were used. Participants were presented with 25 constructs (e.g. Naughty-Good) each of which is rated on a seven-point scale (from extremely naughty to extremely good). Parents complete two sets of constructs, one for the actual child and one for the ideal

child. The discrepancy between the child and ideal child is used as a measure of positiveness towards the child. The Family Grid has good face and construct validity. There is preliminary evidence of internal consistency and test-retest reliability. In this study the discrepancy score was used as a measure of the parents positive feelings towards their child.

The Brief Symptom Inventory (BSI; Derogatis and Melisaratos, 1983)

The BSI was developed from the longer SCL-90-R (Derogatis et al., 1976). It is a brief psychological self-report symptom scale measuring nine primary symptom constructs; somatisation, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation and psychoticism. The BSI has very good test-retest and internal consistency reliabilities, and convergent and construct validity. In this study the BSI was used as a measure of general psychological distress. In addition the anxiety, depression and hostility subscales were examined individually.

2.4 Power Analysis

A prospective power analysis was carried out with the level set at 0.80. A large effect size was used in the calculation of the sample size. This calculation indicated that for a within subjects ANOVA design where df=1, 25 participants would be needed.

2.5 Ethics Approval

The research project was granted ethical approval by the Lothian Research Ethics Committee. Initial approval covered recruitment from the psychology waiting list only and for parents of children aged three to eight. To increase the potential sample size ethical approval was sought to extend recruitment to families referred to the Department of Child and Family Psychiatry, and to the parents of children aged two to nine years. This was subsequently granted.

2.6 Hypotheses

The hypotheses to be tested were as follows:

1. Measures of parenting stress will be reduced between baseline and end of intervention.

2. Measures of the discrepancy between perceived actual and ideal characteristics of the child will be reduced between baseline and end of intervention.

3. The reduction in parenting stress will be mediated by a reduction in discrepancy between perceived actual and ideal characteristics

4. There will be a reduction in parenting stress when improvement in child adjustment is statistically controlled for.

5. Participants will consider the intervention beneficial in terms of global effects on the family.

3 RESULTS

3.1 Characteristics of Sample

The parents of 64 referred children, 20 from the psychology waiting list and 44 from the psychiatry waiting list, were contacted by letter (see Appendix A). Of these 54 were male (84.4%). Twenty-one families responded to the letter and were seen for an assessment appointment. One set of parents attended for assessment interview but did not attend the intervention sessions and did not return their baseline questionnaires. Thus, baseline information was available for 20 families.

Eighteen (90%) of the referred children were male. The age of the children in months[1] ranged from 33 to 106 (M = 78.85, SD = 19.87). Participants included 20 mothers and 13 fathers. No fathers took part in the study alone, hence, at baseline, there were seven mothers participating without a partner and thirteen couples. Mothers were all biological parents of the child, except one grandmother who had adopted the parental role[2]. Eight (61.5%) of the fathers were biological fathers and five were stepfathers. The mean ages of the mothers and fathers in years were 33.60 (SD = 6.57) and 34.69 (SD = 5.66) respectively.

Tables 1 and 2 give baseline characteristics for the recruited sample and those who attended the intervention sessions.

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[1] Age of child at baseline to nearest month.
[2] The terms parent, mother and father will be used throughout to refer to all participants, independent of biological parent status.

Table 1 – Characteristics of recruited sample

	Mothers			Fathers		
	Recruited (N=20)	One Session (N=5)	Two Sessions (N=13)	Recruited (N=13)	One Session (N=4)	Two Sessions (N=6)
Boy referred	18 (90%)	4 (80%)	12 (92.3%)	11 (84.6%)	3 (75%)	5 (83.3%)
Girl referred	2 (10%)	1 (20%)	1 (7.7%)	2 (15.4%)	1 (25%)	1 (16.7%)
Psychology Waiting list	8 (40%)	1 (20%)	6 (46.2%)	5 (38.5%)	2 (50%)	1 (16.7%)
Psychiatry Waiting list	12 (60%)	4 (80%)	7 (53.8%)	8 (61.5%)	2 (50%)	5 (83.3%)
Single parent family	6 (30%)	2 (40%)	3 (23.1%)	3[4] (23.1%)	1 (25%)	0
Reconstituted family[3]	7 (35%)	2 (40%)	5 (38.5%)	6 (46.2%)	2 (50%)	4 (66.7%)
Both parents	6 (30%)	1 (20%)	4 (30.1%)	4 (30.8%)	1 (25%)	2 (33.3%)
Adoptive parents	1 (5%)	0	1 (7.7%)	0	0	0
Unemployed	13 (65%)	3 (60%)	9 (69.2%)	2 (15.4%)	1 (25%)	1 (16.7%)
Employed full-time	2 (10%)	1 (20%)	1 (7.7%)	11 (84.6%)	3 (75%)	5 (83.3%)
Employed part-time	4 (20%)	1 (20%)	2 (15.4%)	0	0	0
Student	1 (5%)	0	1 (7.7.%)	0	0	0

[3] These are families which include a step-parent

[4] In 3 families fathers attending were no longer living with the child, hence family classed as single-parent.

Table 2 – Means/standard deviations of baseline data

	Mothers			Fathers		
	Recruited (N=20)	One Session (N=5)	Two Sessions (N=13)	Recruited (N=13)	One Session (N=4)	Two Sessions (N=6)
Child Age (months)	78.85 (19.87)	88.40 (14.71)	74.92 (20.69)	81.38 (17.12)	92.28 (13.77)	81.17 (18.95)
Parent Age (years)	33.60 (6.57)	32.60 (4.04)	33.54 (7.82)	34.69 (5.66)	31.75 (6.80)	37.67 (5.05)
SDQ Total Score	21.45 (3.49)	21.20 (1.92)	22.08 (3.75)	21.54 (4.27)	19.5 (4.43)	23.50 (3.62)
PSI-SF Total Score	106.70 (16.37)	113.2 (18.07)	103.46 (16.71)	103.17 (18.16)	97.00 (12.96)	103.33 (20.21)
BSI Total Score	51.45 (47.06)	58.00 (58.96)	52.38 (47.35)	35.08 (32.19)	19.25 (12.61)	46.33 (31.88)
Family Grid	1.90 (0.71)	1.48 (0.62)	1.97 (0.69)	1.71 (0.68) (N=11)[5]	1.15 (0.60) N=3	2.01 (0.68)
Follow-up period[6]	-	67.00 (19.91)	47.31 (11.90)	-	53.33 (6.03) N=3[7]	46.50 (12.00)

3.1.1 Attendance

Thirteen mothers and six fathers completed both sessions of the intervention. Five mothers and four fathers completed one session. Outcome measures were collected for all parents who had attended one or both intervention sessions. In addition, a second set of outcome measures was collected for seven mothers and three fathers.

Of the two families who did not attend any intervention sessions, one family withdrew as they felt that they did not require intervention at that time. The single mother in the other family continued to express interest in participating but failed to

[5] Missing data in this measure led to two fathers being excluded from calculation of the mean.
[6] Number of days between completion of baseline and outcome measures.
[7] No follow-up data available for 1 father

attend or cancelled several appointments. Due to time constraints it was not possible to offer further appointments.

In the five families where only one intervention session was carried out, two families withdrew, as they did not consider the intervention to be helpful. In the remaining three families missed and cancelled appointments meant that the second session could not be carried out within the time-scale of the project.

3.2 Effects of Intervention – Mothers

As the majority of measures are completed with regard to the referred child, mother and father report can not be considered independent. In addition, research suggests that differences exist for mothers and fathers in the relationships between parenting behaviour, stress and child adjustment. Consequently results will be considered separately for mothers and fathers.

Due to the limited number of participants who completed one month follow-up measures and the overlap between length of initial and one month follow-up periods, the differences between baseline measures and initial follow-up measures only were analysed.

Analyses were performed using the SPSS statistical computer package, version 11.5. Alpha was set at the more conservative .01 level for all analyses as several comparisons were made.

One-way analyses of variance were performed to examine differences between pre- and post-intervention measures. Post-intervention refers to measures completed after the family had completed all intervention sessions taken up (one or two), usually two weeks after the second session. The number of mothers who completed just one intervention session was small; therefore analyses were carried out first for all mothers who had attended either one or two sessions. This was to examine whether improvements occurred despite failure to receive the complete package. Analyses were then completed for mothers who had attended both intervention sessions. The means and standard deviations for each measure and relevant subscales are given in Tables 3 and 4 with the F values and significance levels for the comparisons.

Evaluations of the assumptions of normality of sampling distributions, linearity and homogeneity of sampling distributions were performed. Logarithmic (LOG) and square root (SQ) transformations were carried out to improve the normality of some variables. Details of revised statistics are given in Tables 3 and 4. Reasons for transformation are given below. Box-plots of the data were examined for extreme outliers. Where outliers could not be eliminated by transformation, analyses were completed with and without outliers. In such cases both pre- and post-intervention scores were removed from the analysis. This was to prevent such cases masking intervention effects.

3.2.1 Hypothesis 1 – Reduction in Parenting Stress

PSI-SF – Total Score

A raw score of 10 or below on the Defensive Responding subscale is said to suggest response bias on the questionnaire, with a potential minimisation of indications of problems (Abidin, 1995). None of the parents scored below 10 at baseline. At follow-up one mother and one father (not a couple) reported scores slightly below 10. This may indicate some defensive responding. However in both cases the parents reported to have observed improvement in the child and did not give other indications of minimised responses.

Logarithmic transformation was performed on the Total Score to eliminate outliers in the scores of mothers who attended both sessions. The difference in mean Total Scores pre-and post intervention was not found to be significant for mothers who attended at least one session or mothers who attended both.

PSI-SF – Parental Distress

Logarithmic transformation eliminated outliers on the Parental Distress subscale for mothers who completed both sessions. There was no significant difference in mean scores pre-and post-intervention for either group.

Table 3 – Statistics for pre- and post-intervention scores: Mothers attending 1 or 2 sessions

Measure		Mean (standard deviation) N=18		F	p
		Pre-intervention	Post-intervention		
PSI-SF	Total	106.17 (17.15)	100.72 (25.48)	0.57	.46
	Parental Distress	32.44 (6.66)	31.28 (9.81)	0.17	.68
	Dysfunctional Interaction	29.39 (7.87)	28.44 (9.98)	.10	.75
	Difficult Child	44.33 (7.59)	41.00 (9.00)	1.44	.24
BSI	Total	53.94 (49.06)	51.39 (56.28)	0.02	.89
	Depression	8.72 (8.23)	8.67 (9.70)	0.00	.99
	Anxiety SQ[8]	5.44 (5.80) 1.88 (1.42)	4.78 (6.49) 1.61 (1.53)	0.11 0.32	.75 .58
	Hostility	7.22 (5.75)	5.94 (6.51)	0.39	.54
Family Grid	Positiveness to Child SQ (N=17)[9]	1.85 (0.69) 1.34 (0.25)	1.35 (0.67) 1.12 (0.30)	4.76 5.22	.04 .03

PSI-SF – Parent-Child Dysfunctional Interaction

Transformation of data was performed where necessary, but no significant differences were found when mothers who attended both sessions were examined separately, or when the results of all mothers who attended at least one session were analysed

[8] Square root transformation. Statistics given for transformed data.
[9] The Family Grid was incorrectly completed by one mother and was counted as missing data.

PSI-SF – Difficult Child

No significant differences were found when mothers who attended one or two sessions were analysed together. Transformation of the data for mothers attending both sessions did not eliminate outliers. However analysis of data with and without outliers did not show the mean Difficult Child score to be significantly lower post-intervention.

Table 4 – Comparison of scores pre- and post-intervention: Mothers attending both sessions

Measure		Mean (standard deviation) N=13		F	p
		Pre-intervention	Post-intervention		
PSI-SF	Total	103.46 (16.71)	94.08 (25.80)	1.21	.28
	LOG[10]	2.01 (0.07)	1.96 (0.11)	1.92	.18
	Parental Distress	32.23 (6.67)	29.92 (10.22)	0.47	.50
	LOG	1.50 (0.09)	1.45 (0.14)	.96	.34
	Dysfunctional Interaction	27.38 (7.35)	25.31 (9.71)	0.38	.54
	No outliers (N=12)	25.75 (4.59)	23.42 (7.22)	0.89	.36
	Difficult Child	43.85 (8.15)	38.85 (9.41)	2.10	.16
	No outliers (N=11)	41.18 (5.38)	35.64 (5.59)	5.62	.03
BSI	Total	52.38 (47.35)	47.54 (57.30)	0.06	.82
	SQ[11]	6.53 (3.25)	5.61 (4.17)	0.39	.54
	Depression	7.92 (8.15)	7.46 (9.68)	0.02	.90
	SQ	2.30 (1.69)	2.09 (1.83)	0.10	.76
	Anxiety	5.38 (5.64)	4.08 (6.33)	0.31	.58
	SQ – outlier	1.88 (1.42)	1.42 (1.49)	0.64	.43
	SQ – no outlier N=12	1.71 (1.34)	1.15 (1.18)	1.19	.29
	Hostility	7.08 (5.02)	4.92 (5.50)	1.09	.31
Family Grid	Positiveness to Child	1.97 (0.69)	1.26 (0.75)	7.30	.01

[10] Logarithmic transformation. Statistics given for transformed data.
[11] Square root transformation. Statistics given for transformed data.

Parenting Stress – Summary

There were no significant differences between pre- and post-intervention scores in the PSI-SF Total Score or on the Parental Distress, Difficult Child and Parent-Child Dysfunctional Interaction subscales for mothers who had attended 1 or 2 sessions, or when only mothers who had attended both sessions were analysed.

Reduction in General Distress

One or two sessions completed

No transformation of the data was necessary for BSI Total Score, Depression or Hostility subscales. Square root transformation of the data for the Anxiety subscale resulted in elimination of an outlier and ensured criteria for normality of distribution were met. No significant differences between pre-intervention and post-intervention scores were found for the Total Score or the three subscales analysed.

Two sessions completed

Square root transformation of Total score and Depression score resulted in elimination of outliers. Square root transformation of Anxiety scores corrected for skewness and kurtosis but did not remove an outlier. The distribution of scores for the hostility subscale was normal. Analysis, using transformed data where

appropriate, did not find a significant difference between mean scores. Analysis of the anxiety scores was performed including the outlier and without.

3.3.2 Hypothesis 2 - Discrepancy Between Perceived Actual and Ideal Child Characteristics

One or two sessions completed

Square root transformation of the data resulted in elimination of an outlier. Scores were lower post-intervention, denoting a reduced discrepancy between perceived characteristics of the actual child and perceived characteristics of the parents' ideal child. However, this difference was not significant at the .01 level.

Two sessions completed

The discrepancy scores met the assumptions of the analysis and did not require transformation. A significant difference was found between pre- and post-intervention scores with a reduced discrepancy between perceived characteristics of the actual and ideal child following intervention ($F(1,24)=7.30$, $p<.01$).

Actual/Ideal Child Discrepancy (Family Grid) – Summary

There was a significant reduction in the discrepancy between perceived actual and ideal child characteristics for mothers who attended both sessions.

3.3.3 Hypothesis 3 – Reduction in Parenting Stress, controlling for Child Adjustment

Table 5 – Means and standard deviations of SDQ scores – 1 or 2 sessions attended.

Measure		Mean (standard deviation) N=18		F	p
		Pre-intervention	Post-intervention		
SDQ	Total	21.83 (3.31)	17.94 (6.51)	5.10	.03
	Impact	3.72 (2.30)	2.39 (2.57)	Z= -2.13 (Wilcoxon Signed Ranks Test)	.03
	Conduct Problems	5.94 (1.70)	4.50 (2.15)	5.01	.03
	Emotional Symptoms	2.87 (4.57)	1.83 (3.50)	3.49	.07
	Without outlier N=17	3.94 (1.48)	2.82 (1.59)	4.51	.04
	Hyperactivity	8.61 (1.72)	7.22 (2.88)	Z= -2.12 (Wilcoxon Signed Ranks Test)	.03
	Peer Problems	3.56 (2.36)	3.56 (2.15)	0.00	1.0
	Prosocial[12]	6.00 (1.88)	6.89 (2.03)	1.86	.18

One-way ANOVAs were performed to compare scores on the SDQ before and after intervention, with the exception of distributions that did not meet the assumptions of parametric tests either with or without transformation. Table 5 gives the means, standard deviations and test statistics for SDQ total scores and subscales including mothers who attended one or two sessions. Non-parametric tests were performed for

[12] An increase in prosocial scores represents increased prosocial behaviour.

the Hyperactivity and Impact scales. Transformation did not remove an outlier in Emotional Symptoms scores so analysis was performed with and without the outlier. No significant differences were found between pre- and post-intervention measures for SDQ Total Score or subscales.

Table 6 – Means and standard deviations of SDQ scores – mothers attending both sessions

Measure		Mean (standard deviation) N=13		F	p
		Pre-intervention	Post-intervention		
SDQ	Total	22.08 (3.75)	16.62 (6.98)	6.17	.02
	Impact	4.23 (1.83)	2.31 (2.90)	4.09	.05
	Conduct Problems	5.92 (1.85)	4.08 (2.36)	4.93	.04
	Emotional Symptoms	3.38 (1.71)	2.31 (1.70)	2.59	.12
	Hyperactivity	8.69 (1.75)	6.62 (3.12)	Z= -2.51 (Wilcoxon Signed Ranks Test)	.012
	Peer Problems	4.08 (2.43)	3.62 (2.36)	0.24	.63
	Prosocial[13]	6.15 (2.03)	7.62 (1.85)	3.67	.07
	Without outlier (N=12)	6.50 (1.68)	8.00 (1.28)	6.06	.02

Table 6 gives the means and standard deviations for SDQ total scores and subscales for mothers who attended both sessions. No significant differences were found between pre- and post-intervention measures.

Multivariate analyses of covariance were performed to compare Parenting Stress scores before and after the intervention using SDQ Total Score as a covariate. Due

[13] An increase in prosocial scores represents increased prosocial behaviour.

to the similarity of results between mother who had attended one or two sessions and those who had attended both, analysis was performed on the larger group (1 or 2 sessions). Controlling for SDQ weakened the effect of the intervention on Parenting Stress for all measures except the Parental Distress subscale. Table 7 gives the F and p vales for the analyses with and without the covariate.

Table 7 – Reduction in Parenting Stress with SDQ as covariate (mothers)

	Without covariate SDQ N=18		With covariate SDQ N=18	
	F	p	F	p
PSI-SF Total	0.57	.46	.42	.52
Parental Distress	0.24	.63	.84	.37
Dysfunctional Interaction	0.69	.41	.01	.92
Difficult Child	0.38	.54	.26	.61

3.3.4 Hypothesis 4 – The role of reduction in discrepancy between perceived actual and ideal characteristics in mediating the reduction in parenting stress

Table 8 – Statistics for multiple regression, PSI-SF Total Score as DV

Predictor variable	Beta	p
Baseline Parenting Stress	0.821	<.001
Change in Family Grid	-.130	.377

A multiple regression using the enter method was performed using post-intervention PSI-SF Total Score as the dependent variable (DV) and pre-intervention PSI-SF Total Score and Change in Family Grid as the predictor variables. Assumptions regarding collinearity were met. Parenting Stress after the intervention was strongly correlated with pre-intervention scores ($r = .838$, $p < .001$). However, entering change in Family Grid did not significantly add to the model (Adjusted R square =.68). Beta and p values are given in Table 8.

Table 9 – Correlation matrix – associations with parenting stress

*p<.05 ** p<.01	Change in PSI-SF - Total	Change in SDQ-Total	Change in Family Grid	Baseline PSI-SF-Total	Baseline SDQ-Total	Baseline Family Grid
Change in PSI-SF - Total	1.00	-	-	-	-	-
Change in SDQ-Total	.621**	1.00	-	-	-	-
Change in Family Grid	.263	.475*	1.00	-	-	-
Baseline PSI-SF-Total	-.271	-.416*	-.132	1.00	-	-
Baseline SDQ-Total	-.229	.142	.592*	.182	1.00	-
Baseline Family Grid	-.259	-.006	.589**	.128	.745**	1.00

Reduction in parenting stress was found to significantly correlate with reduction in reported child difficulties as measured by the SDQ. In addition, significant correlations were found between change in SDQ and change in family grid; change in SDQ and baseline Parenting Stress; and change in Family Grid and baseline SDQ.

3.3.5 Hypothesis 5 – Global view of intervention

The answers to questions in the SDQ Impact Supplement regarding parents' global assessments of their child's difficulties and impact on the family were examined.

SDQ - Child difficulties

Parents were asked to choose one of four responses to the following question:
"Do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?"

One or two sessions completed

The distribution of responses pre-and post-intervention by mothers who had completed one or two sessions of the intervention is given in figure 1.

Figure 1 – Mother's global report of child difficulties – 1 or 2 sessions

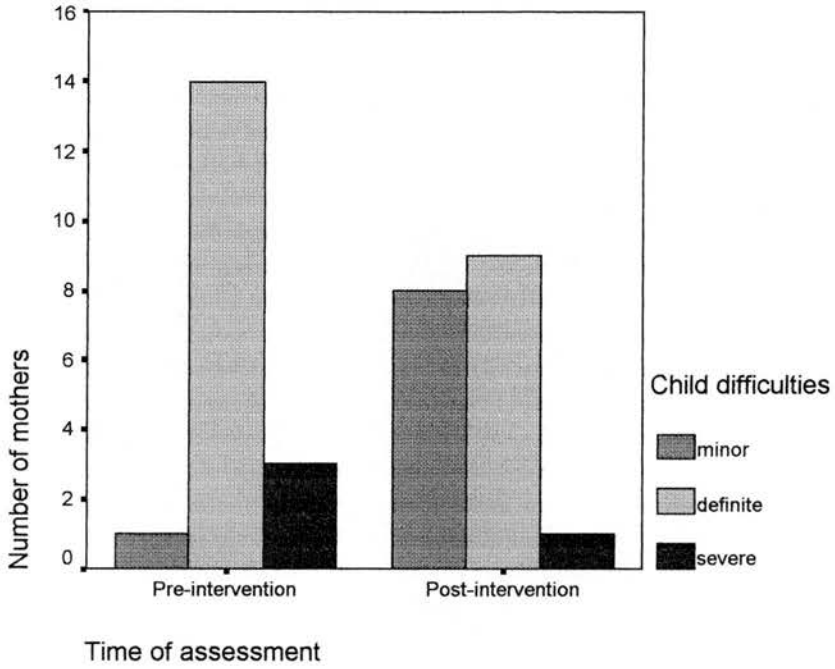


Table 10 – Mother's global report of child difficulties – 1 or 2 sessions

		Post-intervention		
		No/minor difficulties	Definite/severe difficulties	Total
Pre-intervention	No/minor difficulties	1	0	1 (5.6%)
	Definite/severe difficulties	7	10	17 (94.4%)
	Total	8 (44.44%)	10 (55.56%)	18

At baseline 17 out of 18 (94.4%) mothers reported that their child had definite or severe difficulties and one mother reported no or minor difficulties. Post-

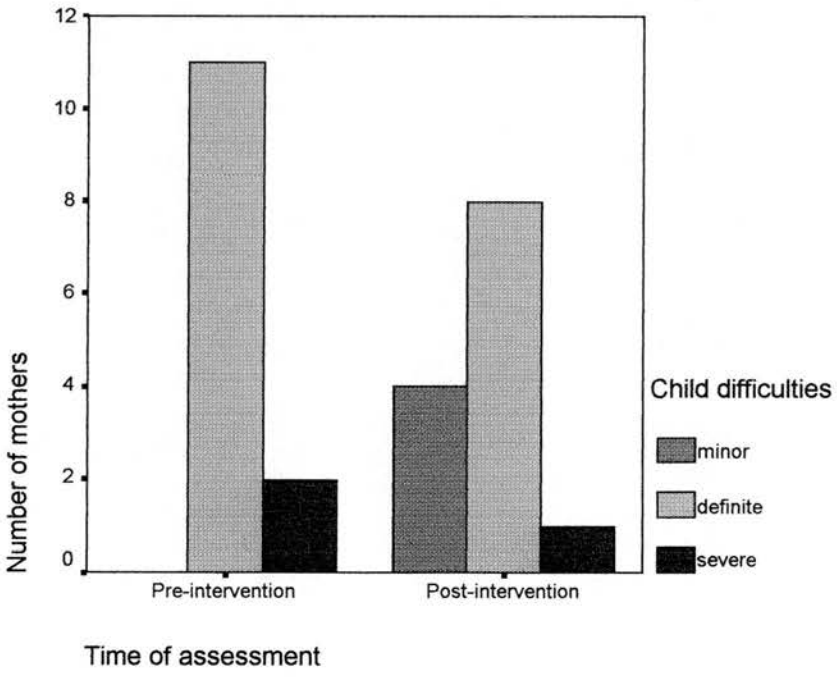
intervention 10 out of 18 (55.56%) mothers reported definite or severe difficulties and eight reported no or minor difficulties (Table 10).

More mothers described their child as having no or minor difficulties post-intervention. The McNemar test using binomial distribution did not show a significant difference between pre- and post-intervention assessment (N = 18, exact p = .02).

Two sessions completed

The distribution of responses pre-and post-intervention by mothers who had completed both sessions of the intervention is given in figure 2.

Figure 2 – Mother's global report of child difficulties – 2 sessions



At baseline all 13 mothers reported that their child had definite or severe difficulties. Post-intervention 6 (46.2%) mothers reported definite or severe difficulties and 7 reported no or minor difficulties (Table 11).

Table 11 - Mother's global report of child difficulties – 2 sessions

		Post-intervention		
		No/minor difficulties	Definite/severe difficulties	Total
Pre-intervention	No/minor difficulties	0	0	0
	Definite/severe difficulties	7	6	13 (100%)
	Total	7 (53.8%)	6 (46.2%)	13

More mothers described their child as having no or minor difficulties post-intervention. The McNemar test using binomial distribution showed there was not a significant difference between pre- and post-intervention assessment (N = 13, exact p = .02).

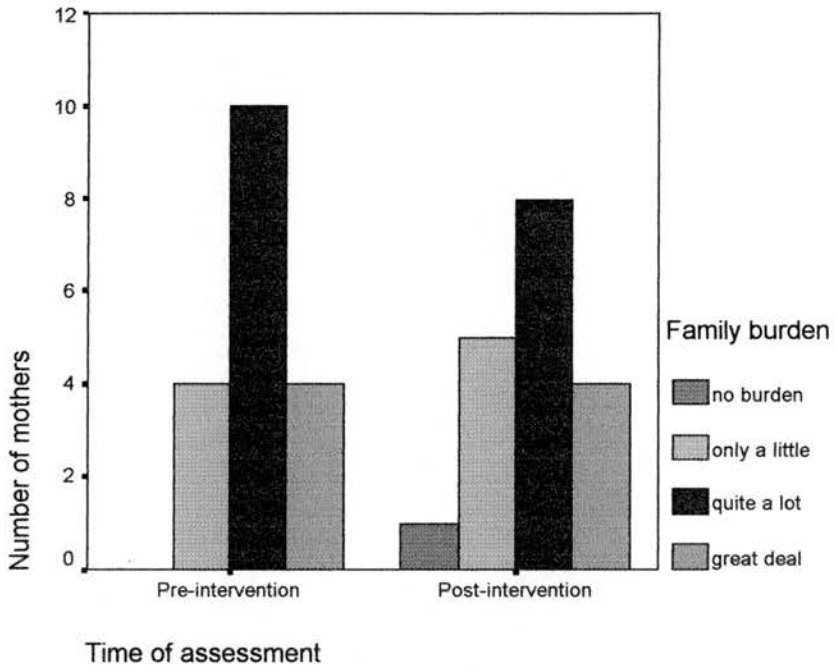
SDQ - Family burden

Parents were asked to choose one of four responses to the following question:

"Do the difficulties put a burden on you or the family as a whole?"

One or two sessions completed

Figure 3 – Mother's global report of family burden – 1 or 2 sessions



The distribution of responses pre-and post-intervention by mothers who had completed one or two sessions of the intervention is given in figure 3.

At baseline 14 out of 18 (77.8%) mothers reported that their child's difficulties put a burden on the family "quite a lot" or "a great deal". Post-intervention 12 out of 18 (66.7%) mothers reported this, with the remainder reporting that the difficulties put no burden in the family or only a little (Table 12).

Table 12 – Mother's global report of family burden – 1 or 2 sessions

		Post-intervention		
		No/only a little	Quite a lot/ great deal	Total
Pre-intervention	No/ only a little	1	3	4 (22.2%)
	Quite a lot/ a great deal	5	9	14 (77.8%)
	Total	6 (33.3%)	12 (66.7%)	18

The McNemar test using binomial distribution did not show a significant difference between pre- and post-intervention assessment (N = 18, exact p = .73). There was no significant difference between the reported burden on the family pre- and post-intervention.

Two sessions completed

The distribution of responses pre-and post-intervention by mothers who had completed both sessions of the intervention is given in figure 4.

At baseline 12 out of 13 (92.3%) mothers reported that their child's difficulties put a burden on the family "quite a lot" or "a great deal". Post-intervention 7 out of 13 (53.8%) mothers reported this, with the remainder reporting that the difficulties put no burden in the family or only a little (Table 13).

Figure 4 – Mother's global report of family burden – 2 sessions

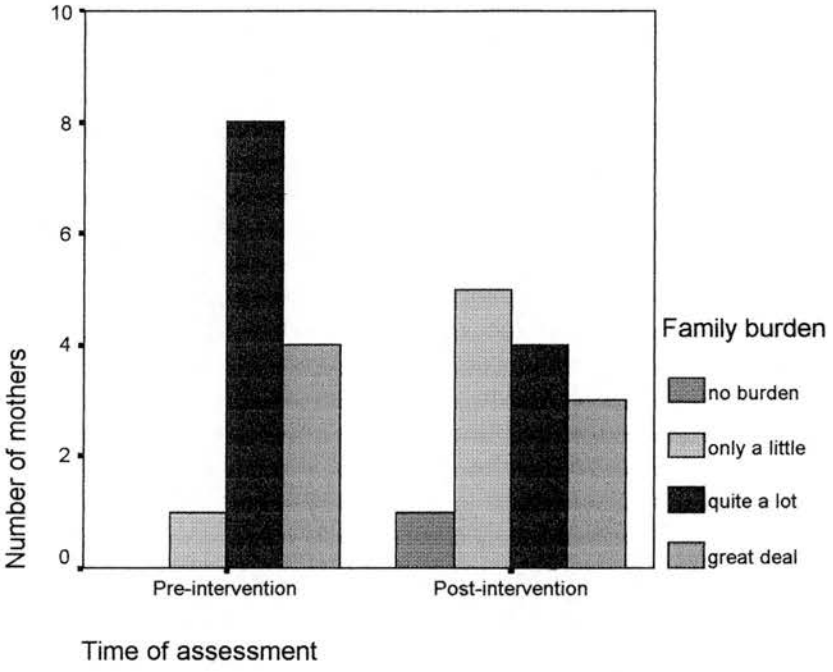


Table 13 – Mother's global report of family burden – 2 sessions

		Post-intervention		
		No/only a little	Quite a lot/ great deal	Total
Pre-intervention	No/ only a little	1	0	1 (7.7%)
	Quite a lot/ a great deal	5	7	12 (92.3%)
	Total	6 (42.2%)	7 (53.8%)	13

The McNemar test using binomial distribution did not show a significant difference between pre- and post-intervention assessment (N = 13, exact p = .06). There were not significantly more mothers reporting the burden on the family to be none or only a little post-intervention compared to pre-intervention.

SDQ - Improvement in child problems

Parents were asked "since coming to the clinic, are your child's problems much worse, a bit worse, about the same, a bit better, much better?" Responses for mothers who attended 1 or 2 sessions are given in figure 5. Responses for mothers who attended both sessions are given in figure 6.

Figure 5 – Perceived improvement in child problems – 1 or 2 sessions

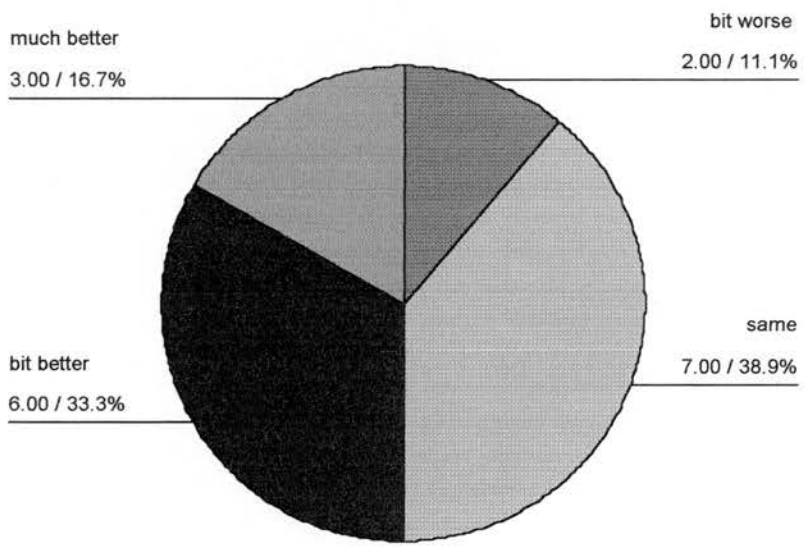
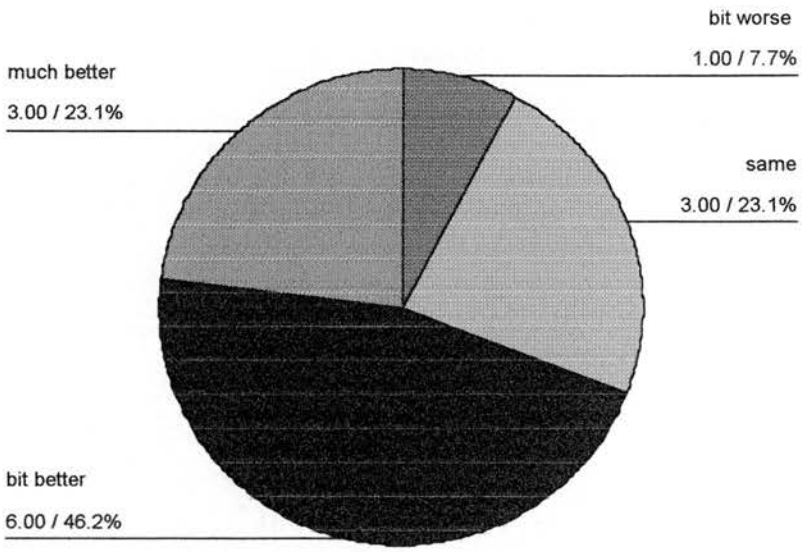


Figure 6 – Perceived improvement in child problems – 2 sessions



The majority of mothers who attended both sessions reported some improvement in their child's difficulties. Half of the mothers who attended one or both sessions reported improvement.

SDQ - Perceived helpfulness of sessions

Parents were asked to choose one of four responses to the following question: "Has coming to the clinic been helpful in other ways, e.g. providing information or making the problems seem bearable?" Responses for mothers who attended 1 or 2 sessions are given in figure 7. Responses for mothers who attended both sessions are given in figure 8.

Figure 7 – Perceived helpfulness of sessions – 1 or 2 sessions

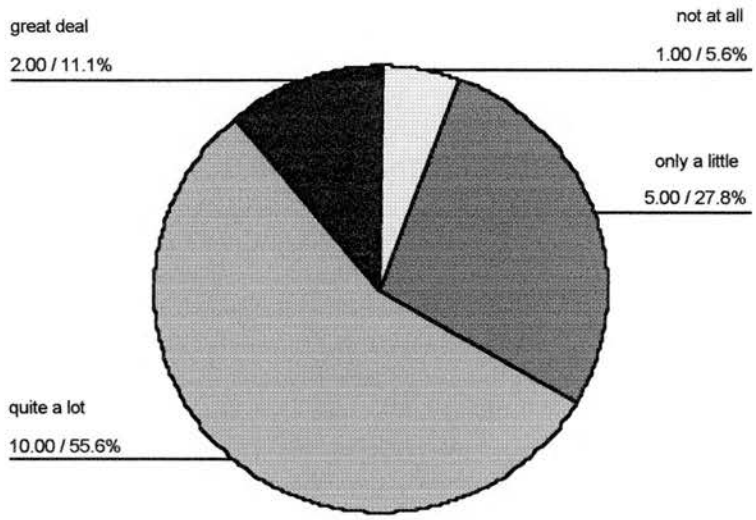
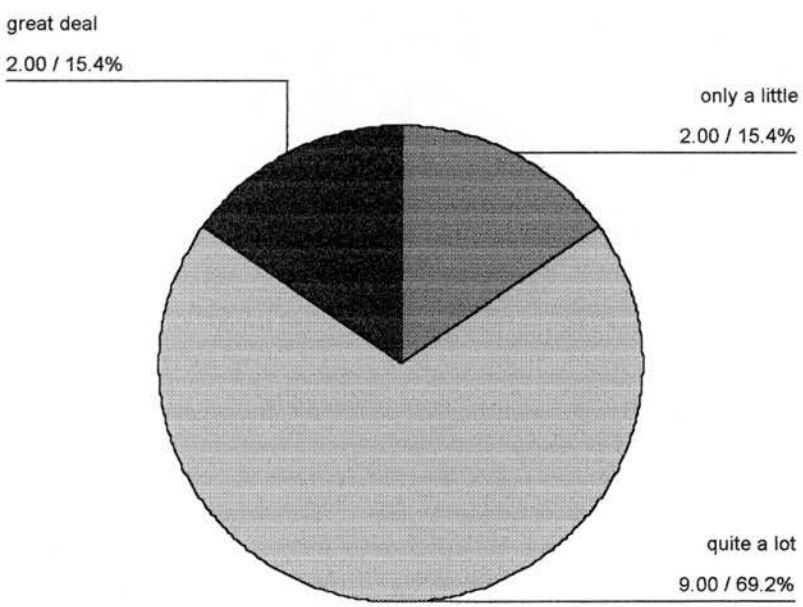


Figure 8 – Perceived helpfulness of sessions – 2 sessions



The majority of mothers who attended both sessions and those who attended one or both sessions reported that they had found attending the clinic helpful.

Feedback on Intervention – Visual Analogue Scales

Parents were asked to indicate their thoughts on the video-based sessions by placing a mark on a 120mm line for each of six questions. Mean responses for mothers attending one session and mothers attending both sessions are given in Table 14.

Table 14 – Mothers' evaluations of intervention

	Attended one session N = 5	Attended both sessions N = 13	F	p
Has there been any change in your child's behaviour since the first appointment? Much worse – much better	51.6 (13.05)	70.46 (14.89)	6.15	.03
Has there been any change in your own level of stress? Much worse – much better	66.00 (36.46)	66.15 (18.53)	0.00	.99
How helpful did you find the video-based sessions? Not at all helpful – extremely helpful	69.80 (36.17)	81.00 (17.12)	0.83	.38
How relevant did you find the sessions? Not at all relevant – extremely relevant	69.80 (36.17)	80.62 (17.86)	0.78	.39
How easy did you find it to put the ideas into practice Extremely hard – extremely easy	48.00 (32.30)	75.92 (19.28)	5.22	.04
Has there been any change in your own behaviour since the first appointment? No change – changed a lot	52.60 (43.57)	70.00 (21.54)	1.33	.27

Based on mean scores, mothers who had attended one session reported worsening of child behaviour (i.e. mean was less than the midway point of 60) but some improvement in their own stress levels. They found the sessions helpful and relevant to some extent, but found the ideas difficult to put into practice. They felt there had been some change in their own behaviour. Mothers who had attended both sessions reported improvement in child behaviour and parenting stress, found the sessions helpful and relevant and found the ideas easy to put into practice.

One-way ANOVAs found mothers did not differ significantly in their responses depending on how many sessions they had attended.

3.3 Effects of Intervention – Fathers

The scores for fathers who attended one session and those who had attended both were analysed together as the results from the mothers suggested similar changes were made.

One way ANOVAS were performed on untransformed data as assumptions for parametric tests were met.

Table 15 gives the means and standard deviations for mean pre- and post-intervention scores with F and p values.

Table 15 – Statistics for pre- and post-intervention scores - fathers

	Pre-intervention	Post-intervention	F	P
SDQ Total Score	21.90 (4.11)	17.55 (6.27)	3.73	.07
BSI Total	37.73 (33.93)	29.18 (22.39)	0.49	.49
PSI-SF Total	104.40 (19.82)	97.18 (22.80)	0.56	.45
Family Grid	1.76 (0.76)	1.38 (0.52)	1.52	.24

There were no significant differences found between pre- and post-intervention scores. Further analyses were therefore not carried out.

Despite the lack of significant results, 9 out of 11 (81.6%) fathers reported that they had found the intervention to help "quite a lot" or a great deal".

4. DISCUSSION

4.1 Rationale

The aim of this study was to investigate the effects of a brief parenting intervention aimed at enhancing the parent-child relationship through a focus on positive parenting practices. Research evidence has shown that differences exist in the parenting behaviours of parents with children with behaviour problems. The majority of studies have focussed on negative behaviours, such as the use of critical comments (Bolton et al., 2003), lack of involvement with the child (Bifulco et al., 2002) and excessive use of control (Brophy, 2002; Webster-Stratton, 1985), although Gardner et al. (1999) suggested that mothers of children with behaviour problems differ from controls in the timing of their strategies rather than the content.

Recently there has been a move towards further consideration of positive parenting. Studies have examined the role of joint activities, warmth and the use of praise. Parents of children with conduct and behaviour problems have been shown to use more negative parenting practices and less positive ones. Such parents have been shown to present with high levels of stress (Webster-Stratton, 1990). This may co-occur with mental health problems such as depression or anxiety (Webster-Stratton and Hammond, 1988) but can be considered distinct from general distress or psychological adjustment. Parenting stress can be considered as stress arising specifically from the demands of the parenting role (Deater-Deckard, 1998). Patterson's (1982) description of coercive cycles of interaction has frequently been applied to families including children with behaviour problems. Maccoby (1992)

describes the process of modelling whereby harsh and punitive parents teach the child to respond aggressively and prevent the formation of more adaptive problem-solving skills. However, directions of causality in the relationships between child behaviour, parent behaviour and parenting stress remain unclear. Such ongoing processes of action and reaction mean different patterns may occur within and between families and across contexts (Deater-Deckard, 1998). With such complicated and circular relationships it might be argued that intervention at any point in the cycle is beneficial. This view may be supported by the evidence-base for a variety of different treatment approaches with such families, targeted at the parents alone, the child alone, the parent and child dyad, the whole family or the wider context (Carr, 1999). Such varied approaches give support to Webster-Stratton's multi-faceted model of parenting stress.

Studies examining the effects of parent training programmes and other interventions aimed at improving child behaviour have begun to examine parenting stress as an outcome measure. However, improvements in parenting stress have generally been considered to be due to improved child behaviour and the consequent reduced demands on the parent. Several approaches emphasise the importance of an initial phase of relationship building between parent and child before specific behaviour management techniques are addressed. Strategies adopted in these early sessions include focussing on child directed play and increasing the use of praise to reinforcement appropriate behaviours and positive qualities. Parents of children with conduct disorder or less severe behavioural disturbance may rarely have mutually rewarding interactions with their child. In addition they may demonstrate a negative

bias, noticing and commenting on any example of misbehaviour while ignoring instances where children display more constructive approaches. This perceptual distortion may occur in the absence of depressive disorder (Webster-Stratton and Hammond, 1988). The current research considered that interventions which seek to alter this bias by providing more opportunities for parents to notice positive qualities may improve parenting stress in the absence of or prior to any marked improvement in behaviour. Abidin (1990) proposed a three-factor model of parenting stress, differentiating between distress arising due to personal factors in the parent directly associated with parenting, difficulties in the parent-child relationship and stress arising due to behavioural characteristics of the child. Parents who scored highly in the difficult child domain do not find their children to be a source of reinforcement. By encouraging the increase of specific situations that may be more reinforcing, e.g. play, one might expect improvements in this domain and the parent-child interaction domains specifically. Such interactions might change the parents' perception of the child and increase their positive feelings for the child. The discrepancy between the child's actual characteristics and how the parent would wish them to be ideally may reduce.

4.2 Discussion of Results

Mothers who attended the intervention sessions did not demonstrate a significant reduction in parenting stress from baseline, nor did they demonstrate any reduction in general distress. However, the reduction in the discrepancy between real and actual

child was found to be significant for mothers who attended both intervention sessions.

It had been predicted that any reduction in parenting stress would be mediated by the reduction in actual-ideal child discrepancy. That is, parents would feel less parenting stress because they were more accepting of and positive about their own child. However, no relationship was found between these two measures. Although non-significant, the changes in parenting stress and child adjustment were in the expected direction. The significant correlation between improvements in parenting stress and in child adjustment suggest that the effect on parenting stress was mediated by the change in child behaviour as measured in the SDQ. However as the SDQ is a self-report measure it is perceived rather than actual child behaviour that is measured.

There has been a lack of agreement in studies about the concordance between mothers' perceptions of child behaviour and actual child behaviour (Webster-Stratton, 1985). Several studies have found depressed mothers to perceive their children's behaviour as more deviant than in observer ratings (Downey and Coyne, 1990). However, in a non-depressed sample mothers may be considered accurate judges of their children's behaviour. There was no evidence to suggest that parents were more depressed at baseline than outcome. Hence it is unlikely that any bias in reporting children's behaviour is due to this. The SDQ parent report of child's behaviour has been shown to relate to teacher's perceptions of child behaviour (Goodman, 1997). This has been used as evidence that the SDQ measures observed rather than perceived behaviour. However, it may not be reasonable to assume that

this is the case. Teachers are often in frequent contact with the parents of young children. This may particularly be true when there are occurrences of inappropriate behaviour. It is possible that parents and teachers develop a shared understanding of the child's difficulties that are maintained by each other's feedback. Hence it can not be assumed that the SDQ is objective. For the purposes of this study, however, it is perceived behaviour that is of interest.

The results found may be more in line with expectations than first thought. It was hypothesised that the intervention would lead to a reduction in parenting stress as a result of parents' viewing their children more positively. Consequently, parents would gain more reinforcement from their child. The intervention appeared to have been successful in changing parents' views of their children as measured by the Family Grid. This could be considered to merely reflect the changes in child behaviour. However, the constructs included in the Family Grid include global dimensions of positive feelings toward the child for example how "lovable" the child is. It is considered to be as much a measure of the relationship as a construction of the child (Davis and Spurr, 1998). As mentioned above the SDQ may measure perceived rather than actual behaviour. Poor correlations were found between change in SDQ and change in Family Grid. Perceptions of child behaviour and perceptions of child characteristics can therefore be considered two separate constructs. The minority of the Family Grid constructs refer to behavioural characteristics or suggest behavioural criteria, although Dunn et al. (1998) note that any overlap in measures may mistakenly contribute to the associations inferred.

It is of note that changes in all subscales of the SDQ approached significance except the peer problems subscale. Studies examining the generalisability of parenting programmes to the school context have reached mixed conclusions (McNeil et al., 1991; Webster-Stratton et al, 1988). Moore et al. (2000) describe parallels between parent-child and child-peer interactions, with a higher frequency of positive verbal reinforcement related to higher frequencies in peer interactions. The nature of interactions between parent and child have been found to relate to peer competence concurrently and longitudinally (Parke and O'Neil, 2000). It is possible that, if parents were able to persevere with the strategies learned, relationships with peers may improve over time.

Relationships between variables were examined with correlations to explore the factors associated with post-intervention change. Change in SDQ was found to relate to baseline parenting stress, with more change in behaviour noted by parents with lower levels of parenting stress initially. Caution must be maintained when making inferences about the processes underlying this relationship due to the exploratory nature of the test and low power. However, it is possible that parents with particularly high levels of parenting stress were unable to implement the changes in their own behaviour prescribed by the intervention. Such programmes require a huge investment of time and effort. Kazdin (1996) describes the burden-of-treatment model to explain the issue of treatment drop-out. Aspects of coming for treatment may increase stress and demands on an already over-burdened family.

Change in Family Grid was found to relate to baseline SDQ. Mothers who reported more problems at baseline reported a greater change in their Positiveness toward their child. This is probably a feature of the high correlation between baseline SDQ and change in SDQ, with a greater change occurring with mothers who reported more problems at baseline.

Parents appeared to consider the intervention beneficial. Mothers reported less child difficulties globally following the sessions, and mothers who had attended both sessions reported a reduction in perceived burden in the family. Over two thirds of mothers who attended both sessions reported improvement in their child. Fathers described similar global accounts although there was no significant change in SDQ or Family Grid.

4.3 Methodological Issues

4.3.1 Intervention

The Webster-Stratton BASIC Programme is a manualised package with guidelines on what questions the therapist should ask the parents and what salient points in each vignette must be brought out. However, each family brings with it its own particular strengths and concerns. As the issues arising from the vignettes must be discussed in the context of each parent's own goals, it can not be assumed that each family received the programme in exactly the same way. Outcome studies have often attempted to ensure treatment adherence through the use of independent coding of

observation or recordings of the sessions. Such measures were evidently outwith the resources of this study, but strategies to increase consistency such as keeping a checklist of points to raise in each session may have been beneficial.

Participants were restricted to two sessions. This was an extremely brief intervention, although there was evidence that it was of benefit. Generally, parents who attended both sessions seemed to gain more benefit, suggesting that it was more than the effect of initially making contact. Some parents evidently found the ideas harder to put into practice than others. It may have been beneficial to adopt "criteria of mastery" as have Foote and colleagues (1998). Criteria are used to decide when the parent is ready to move on to the next stage of the programme depending on the acquisition of target skills. However, as Foote et al.'s intervention involves parent and child together it is easier to see whether techniques have been mastered than in this study.

The intervention centres on the use of video tape vignettes. Bandura (1977) stated that modelling was more likely to occur if individuals perceived the models as more similar to themselves. The video tapes used in the programme were filmed more than twenty years previously and used American families. Some parents commented that the tapes were dated. Ideally, vignettes involving families more similar to the participants in the study would have been used, but this would evidently involve vast practical and financial resources. Parents did not seem to find it difficult to translate the ideas in the tape to their own circumstances because of the models used.

Although developed in America, the BASIC programme has been widely used in Great Britain and has been found to be beneficial (Scott et al., 2001).

Duck et al. (2002) note the competing demands from others that can face the child. Several mothers reported during the sessions that they found it difficult to find time for the play intervention sessions as their children were busy with friends. This is one example of an obstacle to implementation of techniques, which may obstruct improvement over such a short space of time. This may be due to a vicious circle. Children are used to the unavailability of parents so take advantage of other positive interactions. This leaves even less opportunity for positive contact to be initiated.

4.3.2 Design

The repeated measures design of this study was aimed at establishing the efficacy of the brief intervention with a typical clinic-referred sample. The lack of a control group means that improvements in child or parent adjustment can not necessarily be attributed to the intervention. However, the study was designed as a preliminary investigation into the feasibility of applying the programme to a broad cross-section of the clinical population. Thus, it would not be appropriate or ethical to employ a randomised controlled trial at this stage.

It was planned for the intervention to span four weeks with two weeks between sessions and two weeks before outcome measures to allow time to put the ideas

discussed into practice. However, due to frequent cancelled appointments the majority of the participants were assessed over a much longer time-frame. Participants were not excluded from the study on the basis of contact with other professionals, although no parents were also attending other parenting programmes. For these reasons it is possible that other factors may explain any improvements. More detailed information gathered on other supports the family was accessing would allow this factor to be taken into consideration.

The author was responsible for both the implementation of the intervention and collecting baseline and outcome measures. Parents may have been more likely to report a favourable outcome as they had built up a relationship with the author. However, if this were true some change may have been expected in measures of general distress. Demand characteristics might particularly influence the responses of individuals to direct questions about the helpfulness of the intervention. These responses were completed with the psychologist present. This may explain the high proportion of participants who reported sessions to be helpful and highlights the importance of ensuring outcome and feedback data is collected by an independent assessor in future research. It should be noted that this might not eliminate completely the bias in responses.

Duck et al. (2000) note that the decision to study certain aspects of relationships involves presumptions about the nature of these relationships. In this study it was assumed that parents were not already involving their child in regular child-directed play or using targeted praise. No formal assessment of these specific behaviours was

performed, either to establish cut-offs for inclusion or to assess change. This may have been beneficial and have more face validity than targeting attitudes and perceptions with a behavioural intervention. Routh et al. (1995) note that when the specific inclusion criterion of "difficulties with parent management techniques" was set, no parents were excluded on that basis. Anecdotally, across the participants in the study all parents felt that there were some ideas that they were not currently putting into practice.

4.3.3 Measures

As mentioned above, inclusion of more appropriate measures may have enabled more analysis of the change processes. It is possible that the PSI-SF and the SDQ were measuring the same construct, i.e. perception of child behaviour. However, the SDQ may assess perceived behaviour while the PSI-SF measures feelings regarding those behaviours. Deater-Deckard (1996) emphasises the need for measures of parenting stress to discriminate between stress reactions to the demands of parenting and general symptoms of distress. The stability of general distress, as measured by the BSI, compared with the small change in PSI-SF found in this study suggest that they were not measuring the same type of distress. Parents were assessed over a relatively brief period. It is possible that the PSI-SF was not sensitive enough to pick up the changes that occur during this time. Conversely, the small changes identified may have been due to an increased likelihood in parents to give a favourable response, as that has been the approach adopted during the intervention sessions.

Abidin (1992) notes that if using personality measures to predict behaviour they must tie in to a specific belief system that can predict and define behaviours.

The Family Grid has been used as a measure of clinical change in several studies. Duck et al. (2000) note that a parent's parenting style can vary depending on the issue in question or as a function of their own mood and circumstances that day. They note that the researcher's quest for reliability of measures neglects this appreciation of the nature of relationships. In terms of the design of the current study, the Family Grid may not adequately represent change over longer periods of time. It would be interesting however to use the Family Grid on several occasions over time to glean more information about the nature of variation in Positiveness to child. As participants have to rate characteristics separately for actual and ideal child it may be less likely that the Family Grid is subject to social desirability bias. Participants are giving relative rather than absolute responses.

Duck et al. (2000) note that isolating specific aspects of relationships to study may be to the detriment of other aspects. In using a global measure of "positiveness to child" a more coherent view of the relationship may be gleaned from the Family Grid. Duck et al. (2000) warn against relying solely on self-report measures. They describe the insider as enmeshed in the experience of the relationship and consequently not giving full picture. However in this study it is parents' perceptions that are examined. An unbiased perspective is therefore not necessary.

4.3.4 Sample

It is acknowledged that the sample size of the study was small leading to under-powered analyses. Any conclusions must therefore be approached with some caution.

Attempts were made to ensure that the recruited sample represented the "typical" families presenting to child mental health services. This was to ensure the applicability of the results to a standard sample. There is evidence to suggest that parent-child relationship-building interventions can be of benefit to a wide range of families that typically present to child and family psychology and psychiatry services. Although the majority of the parent training programme evidence-base is for parents of children with conduct disorder, the literature suggests their utilisation with other client groups, such as the parents of children with ADHD or internalising disorders. However, in a small sample inclusion of one participant who demonstrates characteristics greatly different from the rest may exert undue influence over the results. In this study the inclusion of one participant who was the child's grandmother may have affected the results. However, her profile of results was not dissimilar to the rest of the sample.

Fathers were encouraged to attend the intervention sessions where possible. Firestone et al. (1980) found no increased benefit in having fathers involved in parent training. However, their study involved a sample of parents selected for their motivation to work together on their child's difficulties. DeKlyen et al. (1998) found

positive and negative dimensions of fathering to relate to children's adjustment, although clear details were not given of the criteria for rating parenting behaviour. The results would suggest that the brief intervention would have relevance for fathers as well as mothers.

Fathers who attended at least one session were included in the results. However the extent of discussion between mothers and non-attending partners regarding the ideas discussed was not assessed. Mothers were asked to involve their partners in the approaches learned but no measure of this was taken. DeKlyen et al. (1998) reported a case study in which the mother subtly undermined the father's attempts to follow parent-training advice. A similar situation arose with parents in this study, whereby a mother criticised her husband's lack of interest in his step-son but was reluctant for him to impinge on her close relationship with her son. Involvement of both parents in the parenting intervention allows such issues to become apparent more easily.

Further information regarding the extent of the absent partner's involvement would have allowed for analysis of the relative benefit of involving both parents. Abidin (1992) reported on the concept of parenting alliance, whereby both parents can function well in the parenting role although not be satisfied with their relationship with each other.

4.3.5 Sampling

A third of families who were approached about the study responded to a letter. This means that the sample may not be representative of the general waiting list population as information was not gathered from these families. Members of 18 of the 21 families who responded had at least one intervention session. However only 13 of the 21 completed the intervention. This drop out rate is less than the reported premature termination rate in family mental health services of 40 to 60%, although this was an extremely short intervention.

4.4 Implications for Clinical Practice

The brief intervention appears to have some benefit for parents of children referred to psychology and psychiatry services. It is not a stand alone treatment but may begin to bring about more harmonious parent-child relationships while families wait for treatment. The manualised nature of the treatment means that it could be implemented by other health professionals. Davis and Rushton (1991) note that training health visitors in parent counselling skills can be beneficial. However, Kazdin (1997) cautions against adopting a cook book approach. He argues that more than a "passing familiarity" with the principles underpinning interventions is necessary. Taylor and Biglan (1998) suggest that to improve equity of access to parenting programmes, interventions need to be flexible, not merely occurring during office hours. This preliminary programme could be implemented more flexibly by a variety of professionals and may serve to engage families with services. However, a

contrasting situation would be families who are frustrated by the brevity of the intervention and become hopeless about their ability to change.

Pettit and Bates (1989) found that a positive parent-child relationship at age one to two was related to the occurrence of behaviour problems at age four. They noted the implications of early intervention. This brief component may be of benefit as a preventative measure to encourage positive parent-child interactions by providing specific means. At follow-up assessments parents reported feeling more confident in dealing with their children. This is an important point as parents who did not feel in control of their negative parenting have been found to be at risk of physically abusive caregiving (Bugental et al., 1989).

Wootton et al. (1997) reported that conduct problems in children were not associated with ineffective parenting in those children who had significant levels of callous and unemotional traits. Such children may prove unresponsive to parenting programmes leading parents to feel undermined by the offer of such a brief intervention. The parenting literature has been criticised for its "mother bashing" approach (McGaw, 2002). Care should be taken that this type of approach is not seen as an attempt to pedal easy answers to complex and longstanding difficulties. There is evidence to suggest that difficulties arise from an interaction between environment and temperament (Bates et al., 1998). Thus, the parent should not be made to feel that their child's difficulties stem only from them. Webster-Stratton (1990) notes that if additional sources of stress are not targeted, results from parenting interventions will not be maintained.

4.5 Future Research

Much research has focussed on socioeconomic and cultural factors that may affect the mental health of the child or parent-child relationship (Grant et al., 2003). Duck et al. (2000) stress the importance of examining the context of relationships. This was not done in this study as the aim was to ensure applicability to the general clinical sample. However further research could pay more attention to these factors.

All information in this study was gleaned from the parents. Future research could incorporate the impressions of children of the changes in their relationship with the parent during the intervention. Even young children have been able to report opinions using structured prompts (Bihun et al., 2002).

Duck et al. (2000) note that researchers frequently make the assumption that parenting is consistent across siblings. Deater-Deckard (1998) notes that there can be a large degree of within family variability. Several of the parents involved in the study had other young children. They were informed that the techniques discussed in the intervention sessions could be used with other children. Indeed this was encouraged as a way of practising strategies, such as the use of specific praise, until they were second nature. The parents reported seeing some benefits in sibling behaviour as a result of changes that they were making. Children spend time observing interactions between other family members (Parke and O'Neil, 2000). Consequently gains may have been possible through modelling prosocial behaviour with siblings. However, no formal measure was made of sibling effects. Further

research could investigate the differing relationship dynamics between family members during the intervention. Such research could adequately take place during implementation of the full BASIC programme in order to investigate process.

4.6 Conclusion

The results suggest that this brief parenting intervention may be of some benefit to parents. Mothers who attended both sessions reported an increase in positive feelings towards their child. There was a non-significant trend in improvement of parenting stress and perceived child adjustment after intervention. However, improved parenting stress appears to be due to the perceived improvement in child behaviour rather than reduced discrepancy between actual and ideal child. No reported change on general distress supports the view that parenting stress is role-specific, but suggests that the parent-child relationship is strongly influenced by perceived behaviour of the child. Further exploration of this brief intervention is necessary before it is routinely delivered, but this can be achieved during implementation of the whole package.

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6 APPENDICES

Appendix A

[Name]
[Address]

[Date]

Dear [Name]

Re: Brief Parenting Intervention

Your child, [name], has recently been referred to the Psychology Department and is on the waiting list for an appointment. From the information given, we think you may be appropriate for the project that I am currently carrying out.

We would like to see whether there is any benefit to families using a brief video-tape based parenting programme with the parents of children between 3 and 8, who are referred to the department. The enclosed information sheet explains more about this project. I would be very grateful if you would take the time to read this sheet.

If you are interested in taking part in the project, **please return the slip below in the stamped addressed envelope provided by 10th March 2003**. You will be offered an initial assessment interview with myself to ensure the programme will be appropriate. This will also provide you with the opportunity to ask further questions.

If you do not wish to take part in the study, please tick the relevant box on the slip below and return it in the envelope provided. This decision will not affect your family's treatment in any way, and you will be offered a standard appointment as usual as soon as one is available. If you have any questions, please do not hesitate to contact me on **01506 422769**.

Yours sincerely

Susan Baxter
Trainee Clinical Psychologist
In supervision with Artemis Curran, Clinical Psychologist

Please tick whichever is relevant

I am interested in taking part in this research study and would like an appointment to discuss this. ☐

I am not interested in taking part in this research study. I would prefer to wait for standard treatment. ☐

Name of parents:_____ Contact telephone number: :_____

Name of child referred:_____ d.o.b. :_____

Appendix B

Patient Identification Number: _____

CONSENT FORM

Title of Project: Evaluating the efficacy of a brief parenting intervention

Name of Researcher: Susan Baxter, Trainee Clinical Psychologist

Please initial

I confirm that I have read and understand the information sheet dated 4th November 2002 for the above study and have had the opportunity to ask questions. _____

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected. _____

I understand that sections of any of my medical notes may be looked at by responsible individuals from regulatory authorities where it is relevant to my taking part in research. I give permission for these individuals to have access to my records. _____

I agree to take part in the above study. _____

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Researcher	Date	Signature

1 for patient; 1 for researcher; 1 to be kept with hospital notes

Appendix C

PARTICIPANT INFORMATION SHEET (4th November 2002)
Research project: Brief Parenting Intervention

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with friends, relatives and your GP if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

Waiting lists for appointments with a child clinical psychologist are extremely lengthy, with families frequently having to wait for several months. We are looking at different ways of offering help to families. In the past the child psychology department has run several parenting groups. These are based on a package using video-tapes showing different ways of dealing with children's behaviour problems. The early part of this group programme focuses on building a positive relationship between parent and child by setting aside time for interactive play sessions and increasing the use of praise. These videotapes are also often used as a basis for family work carried out by clinical psychologists with individual families. Parents have reported that they find these sessions helpful.

We would now like to investigate whether there is any benefit to families from using just the initial sessions of the package (play and praise) with the parents of children between 3 and 8, who are referred to the department. We also would like to see if these are of benefit to the parents of children with other difficulties. We hope that the sessions will have an effect on parents' mood as well as children's behaviour. It is our experience that the parents of children referred to the department are often under a lot of stress. It is hoped by encouraging more positive relationships between parents and children this will help all concerned.

What does the treatment involve?

The parenting programme will consist of two sessions two weeks apart. Each session will last 60-90 minutes. Susan Baxter, Trainee Clinical Psychologist will carry out the sessions, which will be under the clinical supervision of Artemis Curran, Clinical Psychologist. These will take place in the Psychology Department at St John's Hospital or in your home if there is a video-tape player available and this is preferable. The sessions will involve watching the video-tapes and discussing the ideas presented and how they might apply to your family. It is hoped that both parents will be available for these sessions as this increases the likely benefits. It is not necessary for your child to be present. You will also be asked to try out the techniques at home and to keep a record of how successful this has been. We know that practising the techniques is a vital component to helping families. You have

been selected for this study as you have already been referred to the psychology department for help with your child's difficulties.
You will also be asked to complete questionnaires about your child's difficulties and your own mood and thoughts before the sessions take place, after the sessions and four weeks later. This is to evaluate how successful it has been.

What happens if I decide to take part?

If you decide to take part, please tick the relevant box on the slip provided, sign the consent form and return both of these in the envelope provided. You will then be offered an initial interview with Susan Baxter. Assuming that you meet criteria for inclusion into the study she will ask you to complete the first set of questionnaires and make an appointment for the first session.

We hope that his treatment will help you. However, this can not be guaranteed. The information we get from this study may help us treat future families with similar difficulties better.

What happens if I decide not to take part?

Taking part in this study is completely voluntary. If you decide that you do not want to take part in this study, or if you decide to withdraw from the study, your decision will not affect the current or future treatment of your family in any way. You will be treated in exactly the same way as anyone else referred to the psychology department.

What about confidentiality?

Any information about you or your child remains confidential, and is subject to the usual practice in the Psychology Department. Notes about your family will be kept in mental health records which are held separately from the general hospital records. Your General Practitioner will receive notification that you have elected to take part in this study, and will be informed of the outcome of the intervention. When the research results are published, your identity will be completely protected.

I'm not sure if I want to take part....

If you are unsure about whether to take part in this study, or have further questions please feel free to talk to the Lead Researcher, Susan Baxter or the independent advisor listed below, who is not directly involved in this study.

Local independent advisor:

Dr Helen Griffiths
Clinical Psychologist
Psychology Department
St John's Hospital

Livingston
Tel no: 01506 422769

Many thanks for taking the time to read through this information. Please feel free to contact me should you have further questions.

Lead Researcher:
Susan Baxter
Trainee Clinical Psychologist
Psychology Department
St John's Hospital
Livingston
Tel no 01506 422769

This research is being conducted in part fulfilment of the Doctorate in Clinical Psychology.

Appendix D

GP INFORMATION SHEET (4th November 2002)
Research project: Brief Parenting Intervention

Date:

Dear [GP]

Re: [child details]

You recently referred [name] to the Psychology Department. On the basis of the information provided in the referral letter, [name]'s family appeared to be appropriate for inclusion in a research project that I am currently carrying out. Accordingly they have been invited to participate.

Aims of the study

Waiting lists for appointments with a child clinical psychologist are extremely lengthy, with families frequently having to wait for several months. We are looking at different ways of offering help to families. In the past the child psychology department has run several parenting groups. These are based on a package using videotaped vignettes and are often used as a basis for family work carried out by clinical psychologists with individual families.

We would now like to investigate whether there is any benefit to families from using just the initial sessions of the package (play and praise) with the parents of children between 3 and 8, who are referred to the department. We also would like to see if these are of benefit to the parents of children with other difficulties. We hope that the sessions will have an effect on parents' mood as well as children's behaviour. It is our experience that the parents of children referred to the department are often under a lot of stress. It is hoped by encouraging more positive relationships between parents and children this will help all concerned.

The parenting programme will consist of two sessions lasting 60-90 minutes. I will carry out the sessions under the clinical supervision of Artemis Curran, Clinical Psychologist. Parents will also be asked to complete questionnaires about their child's difficulties and their own mood and thoughts before the sessions take place, after the sessions and four weeks later. This is to evaluate how successful it has been.

Research Design

Participation in this study is entirely voluntary. If the family decide they do not wish to participate, they will receive treatment as usual from the Psychology Department. Should the family require further clinical psychology after this intervention they will be allocated to the next available clinician.

Participants will be selected on the basis of referral information. Parents will be asked to attend for an initial appointment to ensure suitability. Parents not able to make informed consent will be excluded, as will families requiring to be prioritised for earlier intervention. Parents will be asked to complete assessment measures prior to the sessions, after the sessions and four weeks later. You will be kept informed about whether the family have decided to take part and the outcome of the intervention.

If you have any questions, or have concerns about this family entering the trial, please do not hesitate to contact me on 01506 422769.

This research is being conducted in part fulfilment of the Doctorate in Clinical Psychology.

Yours sincerely

Susan Baxter
Trainee Clinical Psychologist
In supervision with

Artemis Curran
Clinical Psychologist

Appendix E – Sample Responses on Play Record Sheets

Instructions: Record times you spent playing with your child, what you did, and any reaction you noticed in yourself or your child.

Mother/ Father	**Time Spent**	**Activity**	**Child's Response**	**Parent's Reaction**
Mother	30 minutes	Bayblading	Excited, happy, laughing	Having great fun. Getting excited.
	15 minutes	Snakes and ladders	Stuck to the rules of the game. Quite happy to play even though he didn't win	Kept to the rules and was happy playing the game
	15 minutes	Computer game	Was pleased that someone was there to listen and help	Encouraging him to play, talking and listening.
Mother	25 minutes approx.	Lord of the Rings trump cards	(Name) says "I well like you spending time with me mum".	(Name)'s response made me enjoy better than what I thought.
	20 minutes approx.	Spiderman trump cards	(Name) liked it.	I kept letting him win as I was bored.
	10 minutes	Colouring in	He liked it	Bored
	2 hours	Swing ball	(Name) loved it as there was a group of us	It was fun
Father	15 minutes	Dinosaurs	(Name) enjoyed me playing with his toy dinosaurs.	He seemed to enjoy me playing at his level.
Father	20 minutes	Face game – we used different glasses, noses ears etc. to disguise	Found it funny, thought that he looked like a monkey	He enjoyed it until his disguise fell apart and then started crying. I enjoyed the game until then.

Appendix F – Sample Responses on Praise Record Sheets

Instructions: Write down some examples of ways you praise your child. Notice what kinds of behaviours you praise and how your child responds.

Mother/ Father	**Examples of praise statements**	**Types of child behaviours praised**	**Child's response**
Mother	I like it when you get dressed right away. What a wonderful job you have done. That's good of you (name).	Getting dressed without me asking him repeatedly. Tidying his room without being asked to. Playing quietly when watching TV.	Was happy and said "I know you do mum". Gave mum a hug and thanked mum. Sat and played his game and was smiling.
Mother	None	Tidying his room 2 ½ hours	(Name) hated it
Father	I like the way you helped (brother). Thank you for doing what I asked.	Helped brother tidy his mess. Came in when instructed.	Liked being praised. Enjoyed positive praise.
Mother	Great share – you're very kind for sharing. You're great at sleeping in your own bed now.	Sharing with his friends (toys) even when it's hard to get them back. (Name) no longer getting up during the night.	Developing quite a considered approach to sharing. Working towards his goal- he has really taken this task to heart.
Mother	Thank you for playing quietly. I really appreciate you being quiet. It's nice that you are polite to other people, that's a very good thing.	Sitting quietly playing with his toys while brother asleep. Was playing outside but old lady stopped to talk to him.	Seemed happy to be noticed doing something right. Embarrasssed
Father	Well done, good effort, fantastic.	Doing a difficult jigsaw – logical thinking, teamwork, trying hard.	Really enjoyed doing the puzzle.

PSI Short Form

Instructions

This questionnaire contains 36 statements. Read each statement carefully. For each statement, please focus on the child you are most concerned about, and circle the response that best represents your opinion.

Circle the SA if you strongly agree with the statement.

Circle the A if you agree with the statement.

Circle the NS if you are not sure.

Circle the D if you disagree with the statement.

Circle the SD if you strongly disagree with the statement.

For example, if you sometimes enjoy going to the movies, you would circle A in response to the following statement:

I enjoy going to the movies. SA (A) NS D SD

While you may not find a response that exactly states your feelings, please circle the response that comes closest to describing how you feel. YOUR FIRST REACTION TO EACH QUESTION SHOULD BE YOUR ANSWER.

Circle only one response for each statement, and respond to all statements. **DO NOT ERASE!** If you need to change an answer, make an "X" through the incorrect answer and circle the correct response. For example:

I enjoy going to the movies. SA A NS (X) (SD)

Before responding to the statements, write your name, gender, date of birth, ethnic group, marital status, child's name, child's gender, child's date of birth, and today's date in the spaces at the top of the questionnaire.

_____ Gender ____ Date of birth _____ Ethnic group _____ Marital status_____

s name_____ Child's gender _____ Child's date of birth_____ Today's date_____

SA = Strongly Agree **A = Agree** **NS = Not Sure** **D = Disagree** **SD = Strongly Disagree**

I often have the feeling that I cannot handle things very well.	SA	A	NS	D	SD
I find myself giving up more of my life to meet my children's needs than I ever expected.	SA	A	NS	D	SD
I feel trapped by my responsibilities as a parent.	SA	A	NS	D	SD
Since having this child, I have been unable to do new and different things.	SA	A	NS	D	SD
Since having a child, I feel that I am almost never able to do things that I like to do.	SA	A	NS	D	SD
I am unhappy with the last purchase of clothing I made for myself.	SA	A	NS	D	SD
There are quite a few things that bother me about my life.	SA	A	NS	D	SD
Having a child has caused more problems than I expected in my relationship with my spouse (or male/female friend).	SA	A	NS	D	SD
I feel alone and without friends.	SA	A	NS	D	SD
When I go to a party, I usually expect not to enjoy myself.	SA	A	NS	D	SD
I am not as interested in people as I used to be.	SA	A	NS	D	SD
I don't enjoy things as I used to.	SA	A	NS	D	SD
My child rarely does things for me that make me feel good.	SA	A	NS	D	SD
Sometimes I feel my child doesn't like me and doesn't want to be close to me.	SA	A	NS	D	SD
My child smiles at me much less than I expected.	SA	A	NS	D	SD
When I do things for my child, I get the feeling that my efforts are not appreciated very much.	SA	A	NS	D	SD
When playing, my child doesn't often giggle or laugh.	SA	A	NS	D	SD
My child doesn't seem to learn as quickly as most children.	SA	A	NS	D	SD
My child doesn't seem to smile as much as most children.	SA	A	NS	D	SD
My child is not able to do as much as I expected.	SA	A	NS	D	SD
It takes a long time and it is very hard for my child to get used to new things.	SA	A	NS	D	SD

e next statement, choose your response from the choices "1" to "5" below.

I feel that I am: 1. not very good at being a parent 2. a person who has some trouble being a parent 3. an average parent 4. a better than average parent 5. a very good parent	1	2	3	4	5
I expected to have closer and warmer feelings for my child than I do and this bothers me.	SA	A	NS	D	SD
Sometimes my child does things that bother me just to be mean.	SA	A	NS	D	SD
My child seems to cry or fuss more often than most children.	SA	A	NS	D	SD
My child generally wakes up in a bad mood.	SA	A	NS	D	SD
I feel that my child is very moody and easily upset.	SA	A	NS	D	SD
My child does a few things which bother me a great deal.	SA	A	NS	D	SD
My child reacts very strongly when something happens that my child doesn't like.	SA	A	NS	D	SD
My child gets upset easily over the smallest thing.	SA	A	NS	D	SD
My child's sleeping or eating schedule was much harder to establish than I expected.	SA	A	NS	D	SD

e next statement, choose your response from the choices "1" to "5" below.

I have found that getting my child to do something or stop doing something is: 1. much harder than I expected 2. somewhat harder than I expected 3. about as hard as I expected 4. somewhat easier than I expected 5. much easier than I expected	1	2	3	4	5

e next statement, choose your response from the choices "10+" to "1-3."

Think carefully and count the number of things which your child does that bother you.	10+	8-9	6-7	4-5	1-3

BSI®

Brief Symptom Inventory™

onard R. Derogatis, PhD

Name First MI

umber

Gender Test Date

DIRECTIONS:

1. Print your name, identification number, age, gender, and testing date in the area on the left side of this page.
2. Use a lead pencil only and make a dark mark when responding to the items on page 3.
3. If you want to change an answer, erase it carefully and then fill in your new choice.
4. Do not make any marks outside the circles.

NOT SEND TO NATIONAL COMPUTER SYSTEMS
USE ONLY FOR HAND SCORING

NCS™

Product Number
05627

INSTRUCTIONS:

On the next page is a list of problems people sometimes have. Please read each one carefully, and blacken the circle that best describes HOW MUCH THAT PROBLEM HAS DISTRESSED OR BOTHERED YOU DURING THE PAST 7 DAYS INCLUDING TODAY. Blacken the circle for only one number for each problem and do not skip any items. If you change your mind, erase your first mark carefully. Read the example before beginning, and if you have any questions please ask them now.

	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY	EXAMPLE HOW MUCH WERE YOU DISTRESSED BY:
1	0	1	2	●	4	Bodyaches

	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY	HOW MUCH WERE YOU DISTRESSED BY:
1	0	1	2	3	4	Nervousness or shakiness inside
2	0	1	2	3	4	Faintness or dizziness
3	0	1	2	3	4	The idea that someone else can control your thoughts
4	0	1	2	3	4	Feeling others are to blame for most of your troubles
5	0	1	2	3	4	Trouble remembering things
6	0	1	2	3	4	Feeling easily annoyed or irritated
7	0	1	2	3	4	Pains in heart or chest
8	0	1	2	3	4	Feeling afraid in open spaces or on the streets
9	0	1	2	3	4	Thoughts of ending your life
0	0	1	2	3	4	Feeling that most people cannot be trusted
1	0	1	2	3	4	Poor appetite
2	0	1	2	3	4	Suddenly scared for no reason
3	0	1	2	3	4	Temper outbursts that you could not control
4	0	1	2	3	4	Feeling lonely even when you are with people
5	0	1	2	3	4	Feeling blocked in getting things done
6	0	1	2	3	4	Feeling lonely
7	0	1	2	3	4	Feeling blue
8	0	1	2	3	4	Feeling no interest in things
9	0	1	2	3	4	Feeling fearful
0	0	1	2	3	4	Your feelings being easily hurt
1	0	1	2	3	4	Feeling that people are unfriendly or dislike you
2	0	1	2	3	4	Feeling inferior to others
3	0	1	2	3	4	Nausea or upset stomach
4	0	1	2	3	4	Feeling that you are watched or talked about by others
5	0	1	2	3	4	Trouble falling asleep
6	0	1	2	3	4	Having to check and double-check what you do
7	0	1	2	3	4	Difficulty making decisions
8	0	1	2	3	4	Feeling afraid to travel on buses, subways, or trains
9	0	1	2	3	4	Trouble getting your breath
0	0	1	2	3	4	Hot or cold spells
1	0	1	2	3	4	Having to avoid certain things, places, or activities because they frighten you
2	0	1	2	3	4	Your mind going blank
3	0	1	2	3	4	Numbness or tingling in parts of your body
4	0	1	2	3	4	The idea that you should be punished for your sins
5	0	1	2	3	4	Feeling hopeless about the future
6	0	1	2	3	4	Trouble concentrating
7	0	1	2	3	4	Feeling weak in parts of your body
8	0	1	2	3	4	Feeling tense or keyed up
9	0	1	2	3	4	Thoughts of death or dying
0	0	1	2	3	4	Having urges to beat, injure, or harm someone
1	0	1	2	3	4	Having urges to break or smash things
2	0	1	2	3	4	Feeling very self-conscious with others
3	0	1	2	3	4	Feeling uneasy in crowds, such as shopping or at a movie
4	0	1	2	3	4	Never feeling close to another person
5	0	1	2	3	4	Spells of terror or panic
6	0	1	2	3	4	Getting into frequent arguments
7	0	1	2	3	4	Feeling nervous when you are left alone
8	0	1	2	3	4	Others not giving you proper credit for your achievements
9	0	1	2	3	4	Feeling so restless you couldn't sit still
0	0	1	2	3	4	Feelings of worthlessness
1	0	1	2	3	4	Feeling that people will take advantage of you if you let them
2	0	1	2	3	4	Feelings of guilt
3	0	1	2	3	4	The idea that something is wrong with your mind

THE FAMILY GRID

INSTRUCTIONS

In this questionnaire you are asked to think about your child. You are asked to consider what they are like and rate them on a number of scales.

If you think they are Extremely Happy, put a circle around the 7.

If they are Generally Happy, put a circle around the 6.

If they are Quite Happy, put a circle around the 5.

If they are Extremely Miserable, put a circle around the 1.

If they are Generally Miserable, put a circle around the 2.

If they are Quite Miserable, put a circle around the 3.

When you have completed this first scale, continue down the list, circling one number for each of the scales that follow.

Please work quickly and give your very first impression.

My Child

	Extremely	Generally	Quite		Quite	Generally	Extremely	
Happy	7	6	5	4	3	2	1	Miserable
Has a temper	7	6	5	4	3	2	1	Does not have a temper
Anxious	7	6	5	4	3	2	1	Not anxious
Concentrates well	7	6	5	4	3	2	1	Concentrates poorly
Learns quickly	7	6	5	4	3	2	1	Learns slowly
Naughty	7	6	5	4	3	2	1	Good
Healthy	7	6	5	4	3	2	1	Unhealthy
Needs everything done	7	6	5	4	3	2	1	Manages on own
Likes people	7	6	5	4	3	2	1	Does not like people
Communicates well	7	6	5	4	3	2	1	Communicates poorly
Has problems	7	6	5	4	3	2	1	Does not have problems
Over-active	7	6	5	4	3	2	1	Under-active
Lazy	7	6	5	4	3	2	1	Not lazy
Noisy	7	6	5	4	3	2	1	Quiet
Interested in surroundings	7	6	5	4	3	2	1	Disinterested in surround
Affectionate	7	6	5	4	3	2	1	Not affectionate
Determined	7	6	5	4	3	2	1	Not determined
Disobedient	7	6	5	4	3	2	1	Obedient
Difficult to control	7	6	5	4	3	2	1	Easy to control
Has a strong personality	7	6	5	4	3	2	1	Not a strong personality
Clinging	7	6	5	4	3	2	1	Independent
Sociable	7	6	5	4	3	2	1	Shy
Not loveable	7	6	5	4	3	2	1	Loveable
Predictable	7	6	5	4	3	2	1	Unpredictable
Spiteful	7	6	5	4	3	2	1	Not spiteful

7

My Child as I would like Her/Him to be Ideally

	Extremely	Generally	Quite		Quite	Generally	Extremely	
Happy	7	6	5	4	3	2	1	Miserable
Has a temper	7	6	5	4	3	2	1	Does not have a temper
Anxious	7	6	5	4	3	2	1	Not anxious
Concentrates well	7	6	5	4	3	2	1	Concentrates poorly
Learns quickly	7	6	5	4	3	2	1	Learns slowly
Naughty	7	6	5	4	3	2	1	Good
Healthy	7	6	5	4	3	2	1	Unhealthy
Needs everything done	7	6	5	4	3	2	1	Manages on own
Likes people	7	6	5	4	3	2	1	Does not like people
Communicates well	7	6	5	4	3	2	1	Communicates poorly
Has problems	7	6	5	4	3	2	1	Does not have problems
Over-active	7	6	5	4	3	2	1	Under-active
Lazy	7	6	5	4	3	2	1	Not lazy
Noisy	7	6	5	4	3	2	1	Quiet
Interested in surroundings	7	6	5	4	3	2	1	Disinterested in surroundings
Affectionate	7	6	5	4	3	2	1	Not affectionate
Determined	7	6	5	4	3	2	1	Not determined
Disobedient	7	6	5	4	3	2	1	Obedient
Difficult to control	7	6	5	4	3	2	1	Easy to control
Has a strong personality	7	6	5	4	3	2	1	Not a strong personality
Clinging	7	6	5	4	3	2	1	Independent
Sociable	7	6	5	4	3	2	1	Shy
Not loveable	7	6	5	4	3	2	1	Loveable
Predictable	7	6	5	4	3	2	1	Unpredictable
Spiteful	7	6	5	4	3	2	1	Not spiteful

Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child's behaviour over the last six months

Child's Name ..... Male/Female

Date of Birth .....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other children (treats, toys, pencils etc.)	☐	☐	☐
Often has temper tantrums or hot tempers	☐	☐	☐
Rather solitary, tends to play alone	☐	☐	☐
Generally obedient, usually does what adults request	☐	☐	☐
Many worries, often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other children or bullies them	☐	☐	☐
Often unhappy, down-hearted or tearful	☐	☐	☐
Generally liked by other children	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous or clingy in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often argumentative with adults	☐	☐	☐
Picked on or bullied by other children	☐	☐	☐
Often volunteers to help others (parents, teachers, other children)	☐	☐	☐
Can stop and think things out before acting	☐	☐	☐
Can be spiteful to others	☐	☐	☐
Gets on better with adults than with other children	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Sees tasks through to the end, good attention span	☐	☐	☐

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No	Yes - minor difficulties	Yes - definite difficulties	Yes - severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
☐	☐	☐	☐

- Do the difficulties upset or distress your child?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

- Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

- Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

Signature ..... Date .....

Mother/Father/Other (please specify:)

Thank you very much for your help

Strengths and Difficulties Questionnaire

P4-16

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child's behaviour over the last six months.

Child's Name ..... Male/Female

Date of Birth .....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other children (treats, toys, pencils etc.)	☐	☐	☐
Often has temper tantrums or hot tempers	☐	☐	☐
Rather solitary, tends to play alone	☐	☐	☐
Generally obedient, usually does what adults request	☐	☐	☐
Many worries, often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other children or bullies them	☐	☐	☐
Often unhappy, down-hearted or tearful	☐	☐	☐
Generally liked by other children	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous or clingy in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often lies or cheats	☐	☐	☐
Picked on or bullied by other children	☐	☐	☐
Often volunteers to help others (parents, teachers, other children)	☐	☐	☐
Thinks things out before acting	☐	☐	☐
Steals from home, school or elsewhere	☐	☐	☐
Gets on better with adults than with other children	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Sees tasks through to the end, good attention span	☐	☐	☐

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No	Yes - minor difficulties	Yes - definite difficulties	Yes - severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
☐	☐	☐	☐

- Do the difficulties upset or distress your child?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

- Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

- Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

Signature ..... Date .....

Mother/Father/Other (please specify:)

Thank you very much for your help

Strengths and Difficulties Questionnaire

P3/4
FOLLOW-UP

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child's behaviour **over the last month**.

Child's Name ..... Male/Female

Date of Birth .....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other children (treats, toys, pencils etc.)	☐	☐	☐
Often has temper tantrums or hot tempers	☐	☐	☐
Rather solitary, tends to play alone	☐	☐	☐
Generally obedient, usually does what adults request	☐	☐	☐
Many worries, often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other children or bullies them	☐	☐	☐
Often unhappy, down-hearted or tearful	☐	☐	☐
Generally liked by other children	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous or clingy in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often argumentative with adults	☐	☐	☐
Picked on or bullied by other children	☐	☐	☐
Often volunteers to help others (parents, teachers, other children)	☐	☐	☐
Can stop and think things out before acting	☐	☐	☐
Can be spiteful to others	☐	☐	☐
Gets on better with adults than with other children	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Sees tasks through to the end, good attention span	☐	☐	☐

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Since coming to the clinic, are your child's problems:

Much worse	A bit worse	About the same	A bit better	Much better
☐	☐	☐	☐	☐

Has coming to the clinic been helpful in other ways, e.g. providing information or making the problems more bearable?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

Over the last month, has your child had difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No	Yes - minor difficulties	Yes - definite difficulties	Yes - severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

- Do the difficulties upset or distress your child?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

- Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

- Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

Signature ..... Date .....

Mother/Father/Other (please specify:)

Thank you very much for your help

Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of your child's behaviour **over the last month**.

Child's Name ..... Male/Female

Date of Birth .....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other children (treats, toys, pencils etc.)	☐	☐	☐
Often has temper tantrums or hot tempers	☐	☐	☐
Rather solitary, tends to play alone	☐	☐	☐
Generally obedient, usually does what adults request	☐	☐	☐
Many worries, often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other children or bullies them	☐	☐	☐
Often unhappy, down-hearted or tearful	☐	☐	☐
Generally liked by other children	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous or clingy in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often lies or cheats	☐	☐	☐
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Often volunteers to help others (parents, teachers, other children)	☐	☐	☐
Thinks things out before acting	☐	☐	☐
Steals from home, school or elsewhere	☐	☐	☐
Gets on better with adults than with other children	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Sees tasks through to the end, good attention span	☐	☐	☐

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Since coming to the clinic, are your child's problems:

Much worse	A bit worse	About the same	A bit better	Much better
☐	☐	☐	☐	☐

Has coming to the clinic been helpful in other ways, e.g. providing information or making the problems more bearable?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

Over the last month, has your child had difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No	Yes - minor difficulties	Yes - definite difficulties	Yes - severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

- Do the difficulties upset or distress your child?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

- Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

- Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

Signature ..... Date .....

Mother/Father/Other (please specify:)

Thank you very much for your help