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Parenting Education for Low-Income Parents of Preschoolers: What is the Most Effective Approach?

Darla Meredith Clayton
Indiana University of Pennsylvania

PARENTING EDUCATION FOR LOW-INCOME PARENTS OF PRESCHOOLERS: WHAT IS THE MOST EFFECTIVE APPROACH?

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Darla Meredith Clayton

Indiana University of Pennsylvania

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Indiana University of Pennsylvania
The School of Graduate Studies and Research
Department of Psychology

We hereby approve the dissertation of:

Darla Meredith Clayton

Candidate for the degree of Doctor of Psychology

July 12, 2007 — Signature on file
Kimberely J. Husenits, Psy.D.
Associate Professor of Psychology, Chairperson

July 12, 2007 — Signature on file
Cora Lou Sherburne, Ph.D.
Associate Professor of Psychology

July 12, 2007 — Signature on file
Donald U. Robertson, Ph.D.
Professor of Psychology

ACCEPTED

Signature on file
Michele S. Schwietz, Ph.D
Assistant Dean for Research
The School of Graduate Studies and Research

Title: Parenting Education for Low-Income Parents of Preschoolers: What is the Most Effective Approach?

Author: Darla Meredith Clayton

Dissertation Chair: Kimberly J. Husenits, Psy.D.

Dissertation Committee Members: Cora Lou Sherburne, Ph.D.
Donald U. Robertson, Ph.D.

Parent education programs have been found to be effective interventions for lower-socioeconomic families. (Baydar, Reid, & Webster-Stratton, 2002). Although research has reliably reported that any parent training is better than no parent training (Helm & Kozloff, 1986), the effectiveness of group parent education programs which emphasize relational improvement is largely unknown. The present study attempted to address this question by comparing archival data collected between the years 1999 and 2004 from two different parent training programs, the Community Parent Education Program (COPE) (Cunningham, Bremner, & Secord-Gilbert, 1994) and Parent-Child Interaction Therapy (PCIT) (Hembree-Kigin, & McNeil, 1995). One hundred eleven parents whose children were registered in a rural Pennsylvania Head Start program completed the Child Behavior Checklist (CBCL) (Achenbach, & Rescorla, 2000) and the Parent Practices Scale (PPS) (Strayhorn, & Weidman, 1988), the Dyadic Parent-Child Interaction Coding System (DPICS) (Robinson, & Eyberg, 1981) tracked play behaviors for parents in the PCIT group. Contrary to the study hypotheses, there were no statistically significant improvements in the PCIT and COPE participants reports of either their child's internalizing or externalizing behaviors or their own parenting behaviors compared with the control group.

An examination of differences in clinical vs. nonclinical children also did not reveal pre-or post-testing differences in these children. In addition, the validity of the PPS as a measure of parenting behaviors was unsuccessfully tested against the DPICS rating indicating that the two measures may not be measuring the same construct. Furthermore, a factor analysis of the PPS only accounted for 37% of the variance.

The data did result in some interesting findings. A relationship between parents' use of harsh punishment and their positive play behaviors was found such that parents engaging in less use of harsh punishment also engaged in fewer positive play behaviors. It was also found that single parents were more likely to drop out of parenting programs than dual parent families. Limitations to the study include the uneven composition of the groups, the lack of random assignment to the groups, and the self selection of those who chose to participate in the programs.

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1: STATEMENT OF THE PROBLEM

Parent education programs have consistently been found to be effective interventions for many families. These education programs offer a variety of parent training styles and include a range of program components. Although research has reliably reported that any parent training is better than no parent training (Helm & Kozloff, 1986), the effectiveness of parent education programs deemphasizing disciplinary techniques and emphasizing relational improvement is largely unknown. The present study attempts to address this question, by comparing two distinct parent training programs, one in which disciplinary techniques are central and one in which the improvement of parent-child interactions is emphasized, on a variety of outcome measures.

Parenting is a demanding task for most parents; however, it can be especially trying for low-income families who are forced to be predominantly concerned with meeting their family's survival needs. Middle class families may have occasional economic concerns, but low-income families battle continual poverty along with the pressures and lack of resources poverty causes. Parenting assistance is especially important for impoverished families who, because of their higher stress levels, are at greater risk for a variety of parenting and child problems. For instance, children in these families are more likely to suffer from child abuse or neglect (Christmas, Wodarski and Smokowski; 1996). Parenting classes may be beneficial as they introduce low-income parents to alternate, non-violent options for disciplining their children. Parenting classes offered in a group format may have the additional benefit of providing low-income families with information that help them understand normal child behavior and therefore

become less punitive for age-appropriate behaviors. Being in a group of parents who have the opportunity to share their parenting frustrations and compare their childrearing strategies in a non-judgmental fashion encourages low-income parents, who are often the focus of scrutiny from the community, to make positive non-abusive changes in their parenting strategies.

Parent isolation has also been linked to child abuse. "Social isolation is considered one of the problems associated with all types of child maltreatment" (Christmas et al, 1996, p.238). Parent training classes offered in a group format can be beneficial in alleviating this risk factor as well. Often parents socialize with each other in these groups thereby using the classes as an opportunity to widen their support networks. Similarly, reducing social isolation has been implicated in reducing maternal depression, another risk factor for child abuse cited by Christmas et al (1996).

The importance and positive impact of parent training for low-income families has been well documented (Goodyear & Rubovits, 1982; Webster-Stratton & Beauchaine, 2002). However, this positive impact cannot reach the families who need it when barriers to attendance keep families from signing up for the classes, or when families drop out of programs prematurely. The most predominant barriers are the financial ones (Wood & Baker, 1999). If participating in parent training will reduce the amount of money available in the family, even if it is an insignificant amount by middle class standards, it may prevent low-income families from seeking services. A lack of childcare availability and/or the expense of childcare are additional financial burdens for low-income families wanting to attend parent training classes (Wood & Baker, 1999). A general lack of trust for professionals who typically facilitate parent training classes is

another often noted barrier to participation for impoverished families. Other reported barriers to group attendance include unavailability of transportation (especially in more rural communities), and classes being offered at inconvenient times (Wood & Baker, 1999). According to Cunningham, Bremner, and Secord-Gilbert (2004) between 25% and 50% of low-income parents drop out of parent education programs.

The majority of parent training classes are designed for parents of young children (Croake & Glover, 1977). Interestingly, children under 6 years of age are at higher risk for injury or death due to child abuse. In fact, The National Clearinghouse on Child Abuse and Neglect (2003) reported that child abuse accounted for 85% of the deaths of preschool children. As reported earlier, children from low-income families are at an increased risk for abuse (Daro, 1988, as cited in Christmas et al, 1996), and children under six are also an at risk group for child abuse. Therefore, preschool children from low-income families are in an exceptionally high-risk category for abuse, and are at greater risk of death due to child abuse (Daro, 1988, as cited in Christmas et al, 1996; National Clearinghouse on Child Abuse and Neglect, 2003). Furthermore, parent training of preschool-aged children is thought to be more effective for four reasons. Firstly, the problems tend to be less ingrained at this younger age. Secondly, parental interventions are more effective because preschoolers lack strong peer influences. Thirdly, young children are more accepting of changes in behavioral contingencies. Finally, young children with severe conduct problems still tend to show affection toward their parents (Hembree-Kigin & McNeil, 1995). Hembree-Kigin and McNeil believe that it is especially important to treat behavioral problems of children at a young age because if

left untreated these problems often get worse over time and interfere with the child's development.

As was related above, parent education for parents of low-income and preschool children has the potential to be a very valuable tool to help reduce behavior problems and potentially child abuse. Problems with attrition and barriers to seeking treatment continue to exist for many low-income families. Yet we know that teaching parents the necessary skills while the child is still of preschool age can lead to a much better quality of life for the child and the parent in the years to come. This research hopes to provide information that might be valuable to future parent education administrators including which type of program is more effective, and what differences might exist between the people who complete programs and those who drop out early.

CHAPTER 2: REVIEW OF THE LITERATURE

History of Parent Training

Parenting education, although currently quite popular, is not a recent trend. In the United States, parent education has been available in one form or another "for as long as we have records" (Brim, 1959, p.17). The first recorded meeting of parent education groups in the United States was in Portland, Maine in 1815 (Croake & Glover, 1977), and these groups have been increasing in popularity since the late 1800's (Brim, 1959). Croake and Glover (1977) reported that prior to the 1920's groups called "maternal associations" provided a format where mothers could meet and talk about the difficulties they faced while raising their children. These early attempts at parent education/support tended to be casual, unorganized meetings of lay people until the 1920's when professionals began to administer what was termed "parent training programs".

A variety of socio-historical changes in family life have likely influenced the upsurge in the popularity of formalized parent education. Grant (1998) described a trend of reduced family size that seemed to have led to a shift in how childrearing was approached. In the seventeenth century, families often raised, on average, seven or eight children (Grant, 1998; Family Planning, 1999). The average number of children per family gradually decreased during the nineteenth century and "…by 1900, the average woman had three or four children at close intervals and ended her childbearing at an earlier age than her grandmother had" (Grant, 1998, p.15). The introduction of the birth control movement and the increased access to contraceptives, as well as an improved understanding of reproduction, were important factors contributing to this decrease in family size (Family Planning, 1999). Grant (1998) contends that a shift in the number of

children per family led to an “intensive” style of mothering compared to the “extensive” type of mothering characteristic of the seventeenth century. “Intensive” mothering meant that mothers concentrated their resources on a smaller number of children thereby putting additional focus on mothers to rear their children in a fashion that would assure healthy and productive adults.

The number of children per family has continued to decrease over time. According to the 2000 U.S. Census, the number of children per family, considering only the families with children, was 1.86. Thus, contemporary families reflect an obvious decrease from the child responsibilities of the 17th century when families typically raised seven or eight children, and the 1900’s when families typically raised three or four children. The intensive mothering ideology is currently the most prevalent philosophy for motherhood in the United States today (Arendell, 2000).

Formal parent education seems to fit well with the more “intensive” style of parenting that has come about with decreased family size. As the size of families has decreased, it has become especially important for families to raise children who will become productive members of society. Having fewer children may lead parents to focus more staunchly on the children that they have, part of which may include parents examining their parenting skills and seeking to make changes where appropriate. Parenting education classes offer information to parents to assist in their accomplishment of this goal.

A second important societal factor influencing the increased need for parent education may be the increase in family mobility. Brim (1959) stated that “…the decline in frequency of intergenerational family relations, [has arose] from the fact that now in

our society most newly married couples established residence apart from their parental homes…" (p.17). In the past, families generally learned about childrearing from relatives and friends, but this became more difficult as they began to move farther and farther from their extended support networks (Grant, 1998). Because women were no longer close in proximity to their mothers, sisters, or friends, whom they might typically ask about important childrearing issues that arose, and because they were less likely to know comparable people in the areas in which they resided, informal meetings of parents eventually grew into more formalized parenting education groups. Parents generally heard about parenting meetings through word of mouth, at their church or at a local store, and found that the groups provided an opportunity to get answers to their childrearing questions.

Economic changes were also important as fathers began working more often outside the home, leaving mothers in charge of most childrearing tasks that had previously been shared by both parents (Grant, 1998). In the early colonial period families worked together for the benefit of the family farm and to complete necessary tasks for the good of the family unit. The work of women and children was considered equal in value to that of the man of the house because of the importance of their labor to the family's survival (Abramovitz, 1976). As industrial production grew and families began moving to the cities, many fathers were forced by financial constraints to work outside the home and frequently worked ten to twelve hours, six days a week (Abramovitz, 1976). Mothers in these families were left with the majority of the responsibility for childrearing, so that when dilemmas with their children's behavior or mental and physical health arose, it was the mothers who received the blame for the

problems (Jones, 1999). An example of the pressure on mothers can be found in the writings of William Buchan, in his 1804 book *Advice to Mothers*. He writes that "…No subsequent endeavors can remedy or correct the evils occasioned by a mother's negligence" (As cited in Grant, 1998, p.17). Thus, as fathers began to have more limited contact with their children, the responsibility for child problems became predominantly mothers' work.

According to Grant (1998), religion also played a role in parents becoming more invested in raising their children in a moral context. According to Abramovitz (1976), throughout much of American history, ministers were the primary source of childrearing advice for families. The Calvinist faith played an especially important role, particularly as theorists began to place importance on parenting as essential for a child to attain salvation (Grant, 1998). This added an additional realm to parental responsibility, to raise their children to become moral and honorable members of their religious community. Other religions likely exerted similar pressures on parents encouraging them to raise their children in a religious sanctioned manner or at least with religion specific goals in mind. This additional pressure from the church likely influenced parents to seek more advice about the moral upbringing of their children. Such advice sometimes came from church officials and sometimes from professionals such as doctors or nurses or from books such as Jacob Abbott's *Gentle Measures in the Management and Training of the Young* published in 1871. Reverend Philips (1865) also wrote a book which outlined the responsibilities of raising children in the Christian faith. He tells parents that:

> Another part of the home-mission is the spiritual and eternal well-being of its members. This is seen in the typical character of the Christian family. It is an

> emblem of the church and of heaven. According to this, parents are called to administer the means of grace to their household, to provide for soul as well as for body, to prepare the child for a true membership in the church, as well as for a citizenship in the state, to train for heaven as well as for earth. (Phillips, 1865, p. 29).

These are weighty responsibilities with which Phillips is charging parents, and having the power of the church behind him strengthened and authenticated his suggestions, thereby increasing the pressure on parents for child outcomes.

Even more confusing for parents is that parenting dictates have changed and shifted over time. Parenting advice provided today may in some cases be in direct conflict with what was being advised in the past. For example, in the early colonial period, ministers often recommended harsh discipline that included the use of sticks or rods to beat children as a way to break down the child's stubborn will (Abramovitz, 1976). This method was considered acceptable childrearing during the colonial period but is clearly deemed child abuse today and is punishable under our current child protective laws. Just as different parenting programs prescribe different methods today, programs in the past did not all espouse the same ideas. Throughout history there have been varied views about childrearing. Plutarch, an ancient Greek priest, said, "Children ought to be lead to honorable practices by means of encouragement and reasoning, and most certainly not by blows and ill treatment." (Riak, N.D.). Conversely, the King James Version of the Bible (Proverbs 23:13-23:14) states, "Withhold not correction from the child: for if thou beatest him with the rod, he shall not die. Thou shalt beat him with the rod, and shalt

deliver his soul from hell". There has seldom, if ever, been agreement on the best way to raise children.

In some cases, contemporary parenting advice may not be all that different from some of the advice offered to parents during the 1800's. Jacob Abbott wrote a book in 1871 entitled: *Gentle Measures in the Management and Training of the Young,* whose basic lessons about effective parenting do not appear much different from what is frequently taught today in some parent education courses. In fact, Abbott's advice and the parent education program used in several current parenting classes share many similarities (Webster-Stratton & Hammond, 1997; Cunningham, 2003). The goals of both Abbott's book and the current parenting programs are to teach parents childrearing techniques that are as gentle as possible while still proposing effective methods for controlling child behavior. Parenting styles and needs have changed over time, but parenting counsel has remained the same in some respects and has changed in ways that generally mirror the socio-historical context.

Low-income Families

The Need for Parent Education

Parenting is a challenging task for most parents; however, it can be especially demanding for low-income families who are forced to be primarily concerned with meeting their family's survival needs. Middle class families may occasionally struggle with economic concerns, but low-income families battle continual poverty along with the pressures and lack of resources poverty creates. Parenting assistance is especially important for impoverished families who, because of their higher stress levels, are at greater risk for a variety of parenting and child problems.

The availability of parent education classes geared towards low-income families is important because children in these families are more likely to suffer from child abuse or neglect (Christmas, Wodarski and Smokowski; 1996). According to the National Clearinghouse on Child Abuse and Neglect (2003), child abuse perpetrators tend to be "…living at or below the poverty level" (p.4). Similarly, Daro (1988, as cited in Christmas et al, 1996) reported that among the children who were primarily physically abused, 77.4% of the families were struggling with money problems and most of the deaths due to maltreatment occurred among the very poor. Thus, children from low-income families are more likely to be abused and are also more likely to die at the hands of their caretakers. Parenting classes introduce low-income parents to alternate, non-violent options for disciplining their children.

Parenting classes offered in a group format can be especially beneficial to low-income families who may have little normalizing information available to them. Being a part of a group of parents who routinely share their parenting frustrations and compare their childrearing strategies in a non-judgmental manner encourages low-income parents, who are often the focus of scrutiny from social service agencies and local community members, to make positive non-abusive changes in their parenting strategies.

Parent isolation has also been linked to child abuse. "Social isolation is considered one of the problems associated with all types of child maltreatment" (Christmas et al, 1996, p.238). Parent training classes offered in a group format can be helpful in alleviating this risk factor as well. Often parents socialize with each other in these groups by this means using the classes as an opportunity to widen their support networks. Goodyear and Rubovits (1982) found that when working with a low-income

population, the parent training classes began to "…represent an enjoyable night out" for the parents, specifically when childcare was offered (p.411). Similarly, reducing social isolation has been implicated in reducing maternal depression, another risk factor for child abuse cited by Christmas et al (1996).

History of Parent Education for Low-Income Families

Initial attempts to provide parent education for low-income families appear to have begun in the early 1900's as a response to a high infant mortality rate in this population (Grant, 1998) and the emergence of the pediatric specialty in medicine (Jones, 1999). According to Jones (1991), these new pediatricians determined that the high infant mortality rate was associated with low-income families who did not understand how to provide appropriate and safe nutrition and therefore, fed their babies spoiled milk because it was often the only milk available to them. The goal of these early parent education attempts was directed at providing health and safety information and changing parents' perceptions about their children's need for a doctor (i.e. to ensure they are healthy rather than utilization only when their child was ill). This movement led to safe milk-stations, infant health and care education, and well-baby medical evaluations (Grant, 1998).

Parent education for low-income families regarding child development and emotional issues was an extension of the well-baby idea as professionals working with these families recognized that low-income families were raising their children quite differently from the middle-class. Low-income families tended to raise their children in a more traditional manner relying on the advice of their mothers and their grandmothers and raising their children in the same way they themselves were raised (Grant, 1998).

Grant proposed that a problem with the traditional childrearing methods was that, when the strategy did not work, the low-income parents, as did their parents, were prone to believe that the child was naturally bad, rather than considering the fallibility of their approach. In describing the causes leading to the parent education movement, Brim (1959) explains that one of the factors was "…a growing belief on the part of many persons that there existed better ways of rearing children than those prescribed by traditions" (p. 18).

During the early to mid 1900's, parent training opportunities for low-income families became more available. Because the informational needs of low-income families in the 1900's tended to be different from those of the middle class parenting group leaders (Grant, 1998), a mismatch occurred between the content of these classes and the situations in which, many low-income families were forced to live.

There were two key complaints about these efforts. First, these parent training classes were typically taught by white women, many of whom did not have children of their own. And secondly, the participants reported that the classes did not provide information that was specifically relevant for the problems of low-income living (Grant, 1998).

Rose (1998) illustrated the difference in thinking between middle class and working class women when she explained how the elite women who worked in child care centers during this time believed that lower-class mothers working outside of the home were depriving their children of a childhood; whereas, the working class women viewed their work outside of the home as nurturing because it enabled them to financially provide for their families. Clearly there were value and experiential differences that

drove each group's ideology about what constituted best parenting practices. While the low-income families were struggling to assure the physiological and safety needs of their families, middle-class child guidance educators were emphasizing the importance of encouraging self-esteem for healthy child development. Therefore, the crucial focus for middle class families was not salient for working class mothers who had to be chiefly concerned with providing food for their children for lunch the next day and maintaining a roof over their children's heads.

This difference in thinking between middle-class and working class women continued during the child guidance movement occurring between 1920 and 1950, as well. The child guidance movement involved clinics that were established for the treatment of problem children as well as the approach used by professionals in ameliorating these problems. For some, the term encompassed all issues that were related to child welfare (Jones, 1999). Jones depicted the middle class professional women working with the low-income families during this time when she wrote "Female experts defined poor mothers as incompetent child care managers and directed their expertise towards establishing the institutional structures necessary to provide these women with professional guidance" (p.108).

According to Jones (1999), there were two types of poor mothers identified during the child guidance era. The first type was believed to be negligent in supervising their children often due to the necessity of their employment. These mothers knew what they should be doing to raise their children but were unable to do so. The second type of mother she described as having an "…absence of appreciation for the uniqueness of childhood and for the importance of the parent's role in sound childrearing" (Jones,

p.178). These two types of poor mothers were considered to be entirely different categories, requiring different types of help. Families fitting into the first category needed help finding a mother substitute who could supervise the children and ensure they were safe while their mother was at work. Families falling into the second category required parent education that would be most appropriate for mothers who lacked the knowledge to provide adequate child care.

Parent education classes are generally offered for one of two reasons. They are either intended to address a specific problem such as providing help to parents whose children are diagnosed with disorders such as autism and ADHD, or they are intended to be a preventative measure for at-risk families who may have deficient knowledge of normal child development information or impoverished parenting. The mental hygiene movement devoted itself to the second category. This movement began around 1908 as a reaction to the autobiography of Clifford Beers who wrote about his difficult experiences in mental institutions (The Columbia Encyclopedia, 2003). According to Pols (2001); "Mental hygienists wanted to expand the domain of psychiatric intervention by including the treatment of behavioral problems in children and psychological problems in adults with social, behavioral, and psychotherapeutic means" (p. 369). Mental hygienists were especially interested in preventing mental illness.

During the Depression of the 1930's, there was a desperate need for preventive mental health measures for children. Special programs that had previously been offered in the public schools were reduced and extreme teacher pay cuts often left teachers with little drive to educate. Anxious parents caused more difficulty for children as well. These circumstances often were responsible for child behaviors symptomatic of a variety of

mental disorders so that the need for community mental hygiene programs during the Depression became especially urgent (Pols, 2001).

Although the short-term poverty associated with the Depression had serious behavioral consequences for children, long-term poverty can lead to even greater negative outcomes for children and families. According to Elder (1999):

> However drastic, economic declines of a temporary nature present different implications for family and child than does a chronic state of deprivation. During the 1960s, the concept of deprivation drew attention to lower-class populations of children and, with few exceptions, tended to link social and economic forms of deprivation with pathological outcomes…(p. 9).

It was during the mid 1960's when the Head Start program was initiated to aid in the healthy development of children from chronically low-income families and to decrease the effects of their social and economic deprivation (Administration for Children & Families, 2003: *Head Start History, N.D.*). Elder's (1999) proposal that children raised in low-income families tended to have more emotional, behavioral and academic problems may be related to the formation of programs such as Head Start and parent education classes. These efforts began to become popular as cost effective, preventative measures for keeping poor children out of special education classrooms and, in the long run, out of prisons.

Contemporary Parent Training for Low-income Families

Non-attendance and Attrition

The importance and positive impact of parent training for low-income families is well documented (Goodyear & Rubovits, 1982; Webster-Stratton & Beauchaine, 2002).

However, there tends to be several common barriers to participation for low-income families.

The most predominant barriers are the financial ones (Wood & Baker, 1999). If participating in parent training will reduce the amount of money available in the family, even if it is an insignificant amount by middle class standards, it may prevent low-income families from seeking services. Holden, Lavigne, and Cameron (1990), found that those participants falling into a lower income group were more likely to drop out of a parent training program than were parents from middle and high socioeconomic statuses. A lack of childcare availability and/or the expense of childcare are additional financial burdens for low-income families wanting to attend parent training classes (Wood & Baker, 1999). Goodyear and Rubovits (1982) reported that offering childcare was extremely important in allowing low-income parents to attend the parenting classes they offered.

A general lack of trust for professionals who typically facilitate parent training classes is another often-noted barrier to participation for impoverished families. Some low-income families are distrustful of people with higher education and may fear that the educated parent trainer will publicly demean their parenting. Goodyear and Rubovits (1982) found while working with low-income families that "…it [was] important to downplay our college affiliation and to emphasize that we did not want to come as the experts who would speak down to them" (p.411).

Other reported barriers to group attendance include unavailability of transportation (especially in more rural communities), and classes being offered at inconvenient times (Wood & Baker, 1999). According to Gross, Julion, and Fogg (2001)

scheduling problems were the most common reason for dropout among a low-income population in their experiences.

Attrition continues to be a lingering problem in parent training groups. According to Cunningham, Bremner, and Secord-Gilbert (2004) between 25% and 50% of low-income parents drop out of parent education programs. One study found that low-income parents tended to express more interest in parent education but were less likely to attend (Wood & Baker, 1999). Although it seems somewhat counterintuitive, participants with more presenting problems had a greater likelihood of dropping out of the parenting classes (Holden, Lavigne, & Cameron, 1990). This suggests that the families with the greatest problems are the least likely to continue involvement in acquiring appropriate parenting information.

Katz, El-Mohandes, Johnson, Jarrett, Rose, and Cober (2001) specifically designed their study to reduce attrition by including incentives for completing study-related activities and ensuring that staff were knowledgeable about working with culturally different clients. They still reported a loss of 41% of their low-income participants. Similarly, Holden, Lavigne, and Cameron (1990) found that culturally different participants were more likely to discontinue their participation in parenting classes.

The findings of Frankel and Simmons (1992) suggest that parents endorsing items reflecting negative beliefs or feelings of helplessness were more likely to drop out of the parenting intervention. Thus, how does parental depression and/or social support factor into their decisions about continuing group participation? It is important to consider the above-mentioned attendance barriers low-income families face and not to assume their

non-attendance or dropping out of parenting education groups illustrates an absence of motivation to improve their parenting skills.

What Attracts Low-Income Parents?

According to Wood and Baker (1999) low-income parents tend to prefer classes that are behaviorally based. Indeed, many available parenting education programs include a behavioral component. According to Croake and Glover, (1977) "…behavior modification has considerable potential as a preventive model of mental health with parents being trained to develop and apply their own programs to improve family relationships and to encourage positive behavior in their children" (p.153). Similarly, Wood and Baker (1999) found that the least-educated parents in their study preferred that the content of parent training be focused on learning how to teach their children to behave. These researchers theorize that providing parents with a program that matches their preferences may empower them.

In addition to learning about behavioral approaches to childrearing, Goodman (1975) found that modeling appropriate parenting also plays an important role when working with low-income mothers of preschoolers. Goodman (1975) reported that "modeling procedures [were] effective in changing the childrearing behavior of low-income mothers in a short time" (p.10). This research indicated that this type of modeling suggests a need to change one's parenting without the negative effect of decreasing parents' self-esteem. Cunningham, Davis, Bremner, Dunn and Rzasa (1993) compared parent-training approaches where participants either saw models engaging in appropriate parenting strategies (mastery modeling) or they saw models using poor parenting strategies and were tasked to find the errors (coping modeling problem solving

- CMPS). While the skills of participants in both groups improved, Cunningham et al found that those in the CMPS group were more frequently present at the meetings, less likely to be late, more likely to complete assigned homework, and rated the program more positively. It is believed that resistance to the program may have been reduced by allowing participants to develop their own solutions to the problems presented (Cunningham et at, 1993).

Thus, some parent education researchers have suggested that parent training programs geared towards a low-income population should include information about behavioral methods of discipline and should model various parenting behaviors for maximum learning effectiveness.

Parent Training for Parents of Preschoolers

According to Croake and Glover (1977), "Parent education is the purposive learning activity of parents who are attempting to change their method of interaction with their children for the purpose of encouraging positive behavior change in their children" (p.151). In general, parent training experiences tend to be positive for families. Helm and Kozloff (1986) reported that parent training seems to have a beneficial effect on most parents by helping them to feel more competent, to know more about modifying their children's behavior, and to develop increased optimistic expectations for their families. Positive changes in parents have been linked to constructive changes in children (Helm & Kozloff, 1986).

The majority of parent training classes are intended for parents of younger children (Croake & Glover, 1977). An important reason for implementing educational opportunities for parents of preschool-aged children is that children under 6 years of age

are at higher risk for injury or death due to child abuse. In fact, The National Clearinghouse on Child Abuse and Neglect (2003) reported that child abuse accounted for 85% of the deaths of preschool children. Children from low-income families are at an increased risk for abuse (Daro, 1988, as cited in Christmas et al, 1996), and children under six are also an at risk group for child abuse. Therefore, preschool children from low-income families are in an exceptionally high risk category for abuse, and are at greater risk of death due to child abuse (Daro, 1988, as cited in Christmas et al, 1996; National Clearinghouse on Child Abuse and Neglect, 2003). Highlighting child development norms may be especially important to assist low-income, low-education parents in recognizing the normalcy of their child's behavior and helping them to adjust their expectations accordingly. Emphasizing the negative effects of physical discipline on children's development coupled with accurate child development information is an additional means to help parents avoid punitive compliance techniques.

Parent training of preschool-aged children is thought to be more effective because: (1) the problems tend to be less ingrained; (2) parental interventions are more effective because preschoolers lack strong peer influences; (3) young children are more accepting of changes in behavioral contingencies; and, (4) young children with severe conduct problems still tend to show affection toward their parents (Hembree-Kigin & McNeil, 1995). Thus, conduct problems such as "…tantrums, aggression, noncompliance, hyperactivity, and verbal defiance towards adults" (Faan & Grady, 2002, p.369) are often easier to deal with when children are younger (Neary & Eyberg, 2002).

Faan and Grady (2002) state that while preschoolers exhibiting conduct problems may not currently meet the criteria for a behavioral disorder; they are at an increased risk

of developing more serious problems when they are older children and teens. "Conduct disorder, attention deficit/hyperactivity disorder, and developmental learning disorders are leading causes of school failure, [and] secondary mental disorders [such as] substance abuse and depression, accidents, injuries, unemployment, physical illness, and criminal activity" (National Institute of Mental Health, 1998, p.32). Child conduct problems tend to be costly for society and have led to a focus on early prevention (Webster-Stratton, Reid & Hammond, 2001). Thus, preventing problem behavior in children has become a priority in this country.

Hembree-Kigin and McNeil (1995) explained the importance of early intervention when they wrote that "For children with serious conduct problems, intervention during the preschool years is critical. Untreated problems displayed by preschoolers tend to get worse over time, interfering with their development of self-help skills, socialization, and early academic skills" (p.6). Therefore, it may be vital to shape parenting practices during the preschool years when child behavior problems are weaker behavioral patterns.

Low-Income Parents of Head Start Preschoolers

According to the Administration for Children and Families *(About Head Start: General Information*, 2003) "The Head Start program has a long tradition of delivering comprehensive and high quality services designed to foster healthy development in low-income children. Head Start grantee and delegate agencies provide a range of individualized services in the areas of education and early childhood development; medical, dental, and mental health; nutrition; and parent involvement" (p. 1). Head Start offers services for infants up to age five; the preschool that is often associated with Head Start is typically for children aged three to five. Head Start offers parents a variety of

opportunities including program related committee work, activities, job opportunities, and in many cases parent education information. Parent involvement is a primary component of the Head Start program and it is actively encouraged by Head Start staff.

Head Start classes have been a frequent choice for researchers seeking to work with low-income parents of preschoolers for several reasons. The key factor in determining a child's eligibility for Head Start participation is income. According to the Pennsylvania Department of Public Welfare (2001), the income guideline for a Head Start family with 2 members is $11,610. The income requirements are based on the poverty line such that children are eligible for Head Start benefits if their families' income falls below the poverty line. Thus, Head Start children are required to be representative of low-income families so that income is a constant variable for researchers. Second, children from low-income families, such as those attending Head Start, are more likely to have early conduct problems. Some researchers have reported that as many as 35% of these children have early-onset conduct problems (Chambless & Hollon, 1998, as cited in Reid, Webster-Stratton & Beauchaine, 2002).

Webster-Stratton et al (2001) focused on prevention of conduct problems for Head Start children using a parent-training intervention methodology. They found that children who were displaying excessive risk behavior at baseline were more likely to fall into the normal range for these behaviors at both the post-intervention testing and at the one-year follow-up than similarly matched children. "In fact, at 1-year follow up, 80% of these high-risk experimental children had moved into the 'low-risk' range compared to 48% of control children" (Webster-Stratton et al, 2001, pg. 298). Moreover, mothers who attended 50% or more of these classes reported that their children's at-home

behaviors improved significantly versus only a trend in this direction when considering their entire sample. Thus, attending parents saw the most benefit when they regularly attended the parenting group meetings.

As with parent-training groups in general, drop out is a persistent problem in parent training classes offered to Head Start families. Baydar, Reid and Webster-Stratton (2002) found that Head Start mothers who were more engaged in treatment tended to see more positive effects of the treatment. "Some prior studies voiced pessimism that those parents who actually need parent training most might also be the ones least likely to be motivated, engaged, or involved in parenting intervention programs" (p. 33). The results of this research contradicted this opinion by indicating a high participation rate with a socioeconomically disadvantaged population (Baydar, Reid, & Webster-Stratton, 2002.

Interestingly, Baydar et al (2002) also found that mothers whose parenting style was negative, harsh, and inconsistent were actually likely to be more engaged in treatment. Parents with a positive and supportive style were also likely to be engaged in treatment. These findings suggest that parents at both ends of the risk spectrum are more likely to become the most engaged in treatment.

Parent-training classes are important for low-income families because they tend to be at risk for child maltreatment and for early-onset conduct problems. Parent training is also important for preschool-age children because interventions at this stage are more likely to be effective. According to Christmas et al (1996) "Parenting is the one significant task people can engage in without first demonstrating the knowledge and skills required. Many parents have not learned parenting skills, nor have these skills come naturally to them" (p.246). Parenting-education classes provide an important

opportunity for parents to learn appropriate parenting strategies and correct their skill deficiencies.

Established Parenting Education Programs

Community Parent Education Program (COPE)

The Community Parent Education Program (COPE) was designed for use in a group setting with a non-clinical population. This program is a behaviorally-based intervention which primarily focuses on teaching parents strategies for discipline. According to Charles Cunningham (2003), the program developer, the COPE program evolved from various sources such as Hanf's two-stage model, Forehand and McMahon's "Helping the noncompliant child" program, Barkley's "Defiant Children" program, and Webster-Stratton's videotaped modeling of parenting behaviors.

Hanf's two-stage operant model first taught parents differential reinforcement techniques in which parents would learn to reinforce their children's positive behaviors while ignoring the negative behaviors (Hanf, 1969). During the second phase, parents were taught to give good directions, to praise their children for compliance, and to use time-out for instances of non-compliance (Hanf, 1969). The "Helping the noncompliant child" program was developed in the early 1980's and reported goals of reducing early behavior problems linked to juvenile delinquency by changing coercive parenting interaction, teaching prosocial interactions, and teaching parents behavior modification skills (Forehand & McMahon, 1981). The program was designed to be implemented with families of behaviorally-disordered children between three and eight years of age, on an individual basis (Forehand & McMahon, 1981). Barkley's "Defiant Children" program also sets goals of increasing parents abilities to manage child behavior problems

by teaching parents about the causes of defiant behavior in children, increasing children's compliance, and improving family harmony through increased positive attention and fair discipline procedures for inappropriate behavior (Barkley, 1997). Finally, the COPE program was influenced by Webster-Stratton's videotaped modeling of parenting behaviors (Cunningham, 2003).

The COPE program is generally conducted in large groups lasting between 10 and 12 meetings (Cunningham, 2003). These meetings include videotaped problem-solving sessions during which the group is shown a video of a parent using a misguided approach to parenting followed by a discussion of the model's mistake and what the parent model should have done. The meetings also include role-playing that allows the parents to practice the skills they are being taught with other parents in the group, and the group leader modeling examples of appropriate parenting strategies (Cunningham, Bremner, & Secord-Gilbert 1994). Parents are given homework at the end of the meetings and may be given additional reading if necessary. Cunningham, Bremner, and Secord-Gilbert suggest a variety of positive outcomes that the COPE program may elicit such as: improved child behavior, improved child compliance, increased parental competence, and less parental use of controlling behavior. The COPE curriculum teaches a variety of strategies such as planned ignoring, giving more effective commands, using when-then statements, and appropriate time-out procedures. This course is heavily reliant on point systems and behavior charts, fostering prosocial behavior, and delivery of rewards for desired behavior.

Parent Child Interaction Therapy (PCIT)

Child behavior problems add a great deal of additional stress to a family. These problems often become apparent in early childhood (2-5 years) and can develop into more serious conduct disorders if untreated (Kalb & Loeber, 2003; Schumann, Foote, Eyberg, Boggs, & Algina, 1998). Interventions such as parent training, have been successful in curbing these behavior problems at this early stage (Knapp & Deluty, 1989). Many group parent training programs focus primarily on discipline and behavioral strategies that parents can use to ameliorate their children's behavior (Kalb & Loeber, 2003). While these programs are often successful they tend to ignore the parent-child relationship dynamics. In families where children have behavior problems, the relationship between the child and parents is often more stressed and discipline alone is unlikely to correct the relationship concerns. Parent Child Interaction Therapy (PCIT) is an empirically validated therapy which strives to improve the parent-child relationship as well as teach parents strategies for discipline (Hembree-Kigin & McNeil, 1995). Positive parent-child relationships have been found to predict better self-esteem and fewer internalizing problems in children (Doyle, Moretti, Brendgen & Bukowski, 2004). Doyle et al also found that children with more positive parent-child relationships were likely to have a stronger commitment to education and were less likely to engage in risky behavior such as not wearing a seatbelt or helmet. The findings of this research suggest that parenting practices that work to improve the parent-child relationship are important for healthy child development.

The development of PCIT. PCIT was developed by Dr. Sheila Eyberg and, similar to the COPE program, was adapted from the work of Dr. Constance Hanf (Hembree-Kigin & McNeil, 1995). An important component of Hanf's model included in Eyberg's PCIT program is the immediate feedback to parents through coaching (Hanf, 1969; Hembree-Kigin & McNeil, 1995; Neary & Eyberg, 2002). Dr. Eyberg was also influenced by the developmental research of Diana Baumrind. Baumrind's research found an association between the practices used by parents and the resulting child outcomes, and suggested that positive parent-child interactions were essential for optimal child outcomes to occur (Baumrind 1967, 1972). Dr. Eyberg (Neary and Eyberg, 2002) saw the value of traditional play therapy in the development of positive parent-child interactions and so included this in her program. "She found that just as parents could be taught the operant skill of differential attention, they also could be taught the traditional play therapy skills of following the child's lead, providing undivided attention, describing play activities, reflecting and expanding on child verbalization, and imitation" (Hembree-Kigin & McNeil, 1995, p.2).

Thus, PCIT was designed within a developmental framework that recognized that play is the principal method by which young children learn and develop. Attention to child development, then, is an important aspect of this model because developmental struggles are often the cause of many of the problems found in the parent-child relationship (Hembree-Kigin & McNeil, 1995).

PCIT was designed for use in individual therapy situations with children who are experiencing a variety of both internalizing and externalizing problems and is best used with children who are between two and seven years of age. Families are encouraged to

provide all of their children, even those outside this age range, the opportunity to engage in developmentally-appropriate play with their parents (Hembree-Kigin & McNeil, 1995). While no literature was found using PCIT with a non-clinical sample in a group format, Wood and Baker (1999) have suggested that programs developed for clinical populations are valuable when adapted for use with the general population as well.

The PCIT program consists of two main sections; the relationship enhancement component is introduced first, followed by a section where parents are taught strategies for discipline (Hembree-Kigin & McNeil, 1995). In both sections, parents are taught a variety of specific parenting skills, and then given the opportunity to practice these skills in the therapy session and at home, until they have met criteria for completion of the program. Parents are coached through the interactions with their children by a trained therapist who may make suggestions and/or amend the parents' behavior as well as model appropriate parent-child interactions for the parents.

One of the important strengths of PCIT is the use of parents as co-therapists. This is important because "Parents have enormous influence over their young children's behavioral and emotional development, and some parenting practices may cause or exacerbate young children's problems (Hembree-Kigin & McNeil, 1995, p.3). Hembree-Kigin and McNeil explain that what therapists are able to do working with children for one hour a week is insignificant when compared to the benefits that families can see when parents are also doing the work of therapy at home.

Research supporting PCIT. PCIT has been shown to be an effective intervention for families of young children experiencing behavior problems (Hembree-Kigin & McNeil, 1995; Nixon, Sweeney, Erickson & Touyz, 2003; Schumann, Foote, Eyberg,

Boggs, & Algina, 1998). Schumann, Foote, Eyberg, Boggs & Algina (1998) found that not only did parents change their interaction styles leading to a decrease in child behavior problems, but also that these families tended to be highly satisfied with the subject matter and process of PCIT. When compared to group-didactic parent training programs, PCIT administered individually was found to be more effective (Eyberg & Matarazzo, 1980). In a study where 35% of the families involved were on welfare, PCIT was associated with a variety of positive outcomes such as increased child self-esteem, decreased parental stress, and fewer child behavior problems both internalizing and externalizing (Eyberg & Matarazzo, 1980).

Because preschool-aged children growing up in low-income families are at greater risk for abuse at the hands of their parents, PCIT has a variety of strengths that lends itself for use with abusive families (Ware, Fortson, & McNeil, 2003; Neary & Eyberg, 2002). Not only has PCIT been shown to reduce the behavior problems that are reportedly more frequent in abused children, but the program is specifically designed to improve the parent-child relationship and resolve the negative interaction style often found within abusive families (Ware, Fortson, & McNeil, 2003; Neary & Eyberg, 2002). The frequent review of material found in PCIT may be especially beneficial to abusive parents who are more likely to have cognitive and problem solving difficulties. Because abuse often occurs from the parental perspective of discipline, PCIT additionally teaches parents more appropriate methods for disciplining their children with greater consistency, so that their children are less likely to be left guessing as to how their parents will respond to a given behavior (Ware, Fortson, & McNeil, 2003). As abusive parents begin to play with their children, improvements in the child's affect and in how the parents

perceive the child's behavior have been observed (Neary & Eyberg, 2002). "Parent-Child Interaction Therapy offers abusive families an opportunity to modify their interaction style and gives parents the skills to create a safe, nurturing environment for their children" (Ware, Fortson, & McNeil, 2003, p.381).

Summary and Hypotheses

Parent education through books, informal meetings, individual therapy or groups administered by professionals, has been available in the United States for at least 200 years. Breismeister and Schaefer (1998) sum it up nicely:

> Even before it was well established, parent training was perceived as a viable form of intervention for childhood problems. From its introduction, parent training was hailed as an ingenious and multifaceted format that not only modified negative behaviors of children but also strengthened the family unit and offered parents new resources for enhancing their skills and efficacy in the demanding task of parenting (p.1).

Parent education can be a relatively inexpensive treatment option, especially when administered in a group format and has also been found to be a rather effective intervention in many cases (Gross, Julion & Fogg, 2001). The powerful combination of low cost and outcome effectiveness makes group parent education a frequent choice for use with low-income families. However, the myriad of programs available create difficulty choosing a format for would-be parent trainers in terms of maximum effectiveness for a target parent population.

The primary questions that the present investigation addresses are: (1) whether the parent/child enrichment (PCIT) approach is more, less or equally effective as a discipline

emphasized parent training program (COPE), and (2) what characteristics, if any, differentiate the participants who complete the program from those who discontinue attending.

The professional literature consistently indicates that parent participation in any type of parenting educational program results in improved parenting behaviors when compared with parents having no access to positive parenting information. Based on this literature, it is hypothesized that both the PCIT and COPE participants will each report greater child (lower CBCL scores) and parent improvement (higher PPS scores) than the control group parents. Secondly, since both the COPE and PCIT programs include didactics in disciplinary strategies for effective child behavioral control, a relatively consistent improvement in externalizing behaviors (lower CBCL scores) is predicted to be found for children whose parents participated in either the COPE or PCIT groups but not for the children of control group parents. However, because of the relational emphasis of the PCIT program, it is hypothesized that parents who participated in the PCIT group will show even greater improvement in their self-reported positive parent practices (PPS) than parents who attended the COPE groups and that only the PCIT participating parents will self report improved internalizing behaviors (lower CBCL scores) for their children. In sum, participation in any parenting educational group, whether COPE or PCIT should result in improved PPS and CBCL externalizing scores. However, only the PCIT with its goals for cultivating a more positive parent-child relationship will result in greater parent use of more appropriate parenting practices and improvement in children's internalizing behaviors.

An analysis of pre-test scores of parents completing an 8-week parenting program and those either not attending or dropping out of parenting groups is expected to show that parents who fail to complete the parent training program will have self-reported a greater number of problems at intake (reference) and will have revealed poorer parenting behaviors (reference) than parents who completed either the COPE or the PCIT programs (Tedesco & Husenits, 2004).

CHAPTER 3: METHODS

Participants

The participants for this study were 111 parents whose children were registered in the Indiana County Head Start program in a rural area of southwestern Pennsylvania. Sixty-seven participants attended the PCIT group. A majority of PCIT participants were mothers or other female caregivers (47), although there were some fathers or other male caregivers who participated as well (20). Of the 67 participants, 44 completed the program and 23 dropped out at some point. Of the 23 non-completers, 16 were mothers or female caregivers and 7 were fathers or male caregivers. Of the 44 participants who completed the PCIT program, 31 were mothers or female caregivers and 13 were fathers or male caregivers. The COPE group contained 29 parents, 24 of whom completed the program and 5 who dropped out at some point during the program. Of the 24 participants who completed the COPE program, 13 were mothers or female caregivers, 1 was a father or male caregiver and gender information was not available for the remaining 10 participants who completed the program. Of the 5 non-completers 4 were mothers or female caregivers and 1 was a father or male caregiver. The control group for this study consisted of 15 parents who had been wait-listed during one of the COPE training programs but had completed the same pre and post test measures as the participating parents. These parents were offered participation in the COPE parent training program during subsequent sessions but none of these 15 non-participants elected to participate at the following semester group so their responses are not represented in any of the participant data. Of the 15 participants in the control group, 7 were mothers or female caregivers; gender information is not available for additional 8 participants in this group.

There was a seven to eight-week period between collection of pre-and post-test data in all groups. Participants were recruited through a flier that was distributed by Head Start personnel. All participants received a five dollars transportation reimbursement from Head Start for each week that they attended the trainings, and those who attended seven of the eight scheduled meetings received a $25 gift card for the local Wal-Mart store. Parenting groups ran for two years using the COPE model (2000-2002) of parent training and then for three subsequent years (2002-2004) utilizing the PCIT approach.

Materials

The Child Behavior Checklist (CBCL) is one of the most commonly used parental report forms developed as part of the Achenbach system (Achenbach & Rescorla, 2000). The CBCL preschool version, normed for children aged 1 ½ to 5 years, was used for the current investigation. This version contains 99 child descriptive statements. Parents are asked to rate these statements as not true (0), sometimes true (1), or very true (2) of their child's behavior during the previous 2 months. The measure provides open-ended questions asking parents to describe their concerns about their child and to identify the best things about their child. The CBCL questions produce 8 syndrome scales: Emotionally Reactive, Anxious/Depressed, Somatic Complaints, Withdrawn, Sleep Problems, Attention Problems, and Aggressive Behavior. The CBCL also contains DSM-IV oriented scales which include: Affective Problems, Anxiety Problems, Pervasive Developmental Problems, Attention Deficit/Hyperactivity Problems, and Oppositional Problems. Scales that differentiate internalizing problems from externalizing problems and a total problems scale are also included on the CBCL protocol. The preschool version of the CBCL reports mean test-retest reliability of

r = .85, and a cross informant agreement mean of r = .61. This scale also reports good content validity, nearly all items are able to distinguish between referred and non-referred children (Achenbach & Rescorla, 2000). "The construct validity of the problem scales was supported by concurrent and predictive associations with a variety of other measures, plus evidence for substantial genetic components of the patterns of the problems assessed by the scales" (Achenbach & Rescorla, 2000; p. 101).

The Parent Practices Scale (PPS) is a 34-item self-report instrument asking about parents' interactions with their preschool children (Strayhorn & Weidman, 1988). According to its authors, items on this instrument were constructed by considering positive parenting skills such as the reduction of unnecessary commands to children, enforcement of commands once presented, providing more attention for positive behaviors than for negative behaviors, not unintentionally rewarding poor behavior, modeling positive behavior, enjoyment of time spent with children, avoidance of overly harsh punishment, and being consistent. The authors report good internal consistency with coefficient alphas of .78 and .79 for the first and second administrations respectively (Strayhorn & Weidman, 1988). The PPS also has been found to be a reliable measure with test-retest reliability reported to be r= .79 (Strayhorn & Weidman, 1988). The authors do not report validity data for the PPS, an issue the present study addresses. Scores on this version of the PPS range from a high of 172.35 to a low of 96.40 with higher scores indicating more positive parenting behaviors than lower scores. See this measure in Appendix A. .

The play assessment used in the PCIT program was conducted using the Dyadic Parent-Child Interaction Coding System (DPICS), clinically modified recording form.

Definitions of the behaviors included in the DPICS can be found in Appendix B. The DPICS has been found to be both a reliable and a clinically practical instrument (Robinson & Eyberg, 1981). This instrument rates parents on the number of times they gave the child a command (separated into direct and indirect), the number of descriptive and reflective statements that the parents used, the number of times parents praised their children (both labeled and unlabeled), the number of questions the parents asked, and the number of times that the parents directed critical statements towards their children while engaged in play.

Procedure

All parent-training sessions were conducted by doctoral students registered in the clinical-psychology graduate program at Indiana University of Pennsylvania and under the close supervision of licensed clinical psychologists. All trainers had Pennsylvania Act 33 and Act 34 clearances. Throughout the course of the parent training sessions being offered different students or faculty led the PCIT and COPE groups. Each group was facilitated by a minimum of two novice graduate students, none of whom expressed specific theoretical investment in other parent education programs aside from the one they led.

During the first meeting for all groups, parents completed the Child Behavior Checklist (CBCL) (Achenbach & Rescorla, 2000) and the Parent Practices Scale (PPS) (Strayhorn & Weidman, 1988). Informed consent was obtained from all group participants (see Appendix C). For parents attending the PCIT groups, an initial baseline play assessment (intake) was conducted at the first meeting during which parents were asked to play as they normally would with their child for five minutes while trainers

recorded the number of times they praised, asked questions, were critical, or gave commands to their child.

PCIT group. The parents in this group participated in a program based on Parent Child Interaction Therapy (PCIT). Groups met for either 7 or 8 sessions. Each three-hour session included group discussion, a play assessment, play coaching, and a presentation of new material (a script for a sample session can be found in Appendix D). Again, baseline assessments of parent-child interaction were assessed at the first session. Play sessions required that parents and children play as they normally would at home for five minutes while being simultaneously observed by two graduate students trained in the use of the DPICS. Once baseline parent-child interaction ratings were determined, parents were taught a new way to play with their child (called 'special play') that included increased praise, more description and imitation of the child's activities, reflections of the child's verbalizations, and enthusiasm. Parents were additionally taught to reduce their questions, critical statements, and commands during special play time.

Each week parents were given a home assignment to spend five minutes each day playing with their child in the newly taught pattern**.** Subsequent weekly sessions included a five-minute play component requiring parents to use the new skills while interactions were coded using the DPICS by two students. Weekly sessions also included a coaching session during which coaches (trained graduate students) watched, praised, and made suggestions for improvements to help the parents learn to play in the new pattern.

Goodman (1975) found that modeling appropriate parenting can have an important role when working with low-income mothers of preschoolers. Thus, modeling

was included in the PCIT sessions in a variety of ways. First, during the parent meetings appropriate interactions were modeled using role plays and discussing behavioral examples. Second, the trainers modeled appropriate interactions with children when coaching parents during assessed play periods. Finally, the graduate students assigned to work with the children modeled appropriate behavior during their interactions with the families.

Adapting PCIT for group and non-clinical populations. Like many other parent training classes, PCIT has been designed for individual use with clinical populations (Hembree-Kigin & McNeil, 1995). However, Wood and Baker (1999) suggested that there may be value in adapting such programs for use with the general population as well. The present study attempted to modify the PCIT program for use in a group setting and with a general, non-clinical population.

Because some aspects of traditional PCIT make it difficult to implement in a group setting, some modifications to the original program were made. For instance, typically parents progress through the program at their own pace and have to meet specific criteria before moving on to the next phase of the program (Neary & Eyberg, 2002). This is a challenge in a group as each parent will likely be ready to advance at varying times. To address this variance in readiness in the group setting, the didactic portion of the program continued to move on while parents were provided with support geared to their individual level of proficiency during the coaching portion of sessions. Accurately coding all the play interactions was also an issue in the group setting if parent-child interactions occurred simultaneously. To address this, the coded play was conducted with 3 or 4 parent-child dyads at a time rather than concurrent observation of

the entire group while playing. Two trainers coded each parent-child dyad in order to improve the reliability of the coding. Thus, the first group of parents played with their children for five minutes while being coded by two observers while other parents supervised their children in another area of the Head Start center. This procedure continued until all parents had been coded while playing with their children.

The discipline component of PCIT generally includes "parent-directed interactions" in which parents are coached through accurately using the discipline skills with their children that they learned in the didactic sessions of the program (Neary & Eyberg, 2002). One PCIT suggested method for practicing discipline is for parents to give commands until the child is non-compliant and then practice putting the child in time-out in the session (Hembree-Kigin & McNeil, 1995). The use of this particular method of teaching discipline strategies was rejected for the current study for several reasons. First, the children in the current study had not been clinically diagnosed and so it was thought that this method would be unnecessarily stressful for the children. Second, the group format of our program increased the likelihood of the children becoming embarrassed. Third, we were concerned that inciting misbehavior may be confusing for those children whose behavior problems were typically not severe enough to warrant its use. However, the practice component was important to the program so the parents continued to play with their children as they had been taught and they practiced the discipline strategies by placing each other and the group leaders in time-out and discussing examples of good commands that they might use with their own children. This "in vivo" practice was thought to aid parents in understanding how appropriate and

inappropriate discipline was experienced from the child's perspective and to give them a script for carrying out the strategies taught.

Knowledge of child development can have an important impact on parenting practices. Wacharasin, Barnard, & Spieker (2003) suggest that when working with low-income families it is important to include information about normal child development. PCIT does not, traditionally, teach parents about child development. Therefore, an additional component of the adapted program was a session outlining normal child development and included the opportunity for parents to ask specific questions related to their own child(ren)'s developmental issues. A particular emphasis was placed on how brain readiness parallels children's gaining new abilities.

Another adaptation included the suggestion of positive means for controlling child behavior. During this portion of the training, parents were instructed in the value of, and guided through creating, a sample behavioral chart for use with a specific problem they identified as having with their child. Parents were taught to use "when-then" statements, such as "when you have finished your lunch then you can play with the toys", to make a game of tasks that need to be done, such as, "I wonder who will be ready first, let's have a race!" and to use their voices in a way that will reward desired behaviors and punish undesired behaviors.

Since research has suggested the importance of providing child-care during parent training meetings for low-income families (Cunningham, 2003; Wood & Baker, 1999), this service was added to the PCIT program. This aspect of the program was actually more than simply child-care because the child curriculum attempted to teach important skills for preschoolers such as listening, talking nicely, and sharing. Webster-Stratton

and Hammond (1997) found that the combination of a training course for parents with a course for children led to the greatest improvements in child behavior and that this combination showed continued success at a one year follow-up.

COPE group. The COPE program is a manualized parent education program established by Cunningham, Bremner, and Secord-Gilbert (1994). The COPE manualized program was used for each group. The program is structured for presentation over 10-12 two-hour sessions. However, it was adapted to fit the 8-week time frame dictated by Head Start by extending sessions to 3 hours each. Thus, all material as outlined in the COPE manual was presented to parents in these groups. All sessions were held at a local Head Start center. The COPE group meetings were comprised of interactive lectures, role playing, group discussion, and group feedback triggered from participants viewing of inappropriate parenting scenarios on video. The videos that accompany the manual for the COPE program illustrates a parent engaging in poor parenting behaviors in a variety of parent-child interaction situations. For example, one video depicts a child trying to garner parental attention in an appropriate manner and the parent ignoring the child, but when the child begins to behave inappropriately the parent attends to the child. At each session participants watched a portion of the video and used the Coping Modeling Problem Solving (CMPS) described by Cunningham, Davis, Bremner, Dunn and Rzasa (1993), in which parents watch others using poor parenting strategies, discuss the parenting effectiveness of what they viewed and brainstorm more successful means for gaining child compliance. The theory is that once parents discuss what they believed the models did incorrectly, the video is played again with the parents using more effective strategies in the same situations. Parents in this program were also

given time to address their specific issues and questions (plans for each COPE meeting can be found in Appendix E). Participants were encouraged to use learned strategies at home with their children but were not given specific parent-child practice during the trainings. At each meeting a resource table was available for parents. These tables contained brochures and flyers providing information about local community social services, books about child-rearing and children's story books that parents could check out to read to their children at home. At the conclusion of the COPE sessions, parents were invited to choose and keep three of the story books for use at home.

CHAPTER 4: RESULTS

Descriptive Statistics

The participants for this study were 111 parents whose children were registered in the Indiana County Head Start program from years 2000 through 2004. A total of 67 participants attended the PCIT group, 29 in the COPE program and 15 in the control group.

PCIT Participants

The mean age of the 67 PCIT subjects was 31.33 (SD= 8.91). A majority of PCIT participants were mothers (43), 17 fathers participated, 2 grandmothers, 1 grandfather, 2 aunts and 2 uncles. A majority of the families in the PCIT group were two parent families (48), although single-parent families (7), and families identifying as 'other' (11), such as grandparents raising grandchildren, were represented as well. Data for family status was missing for one case in the PCIT group.

Of the 67 PCIT participants, 44 completed the program and 23 did not complete the program. Participants included in the completer group missed no more than one PCIT session. Data on educational attainment was missing for 1 participant. Thus, the majority of participants in the PCIT completer group were mothers living in "traditional" parenting situations who had achieved high school educational status and were parenting fewer than 3 children at the time of their PCIT participation. For the 23 participants who did not complete the PCIT program, data for family status was missing for one participant and for both educational level and number of children in home for 3 participants included in this group. However, the composition of this group was similar to the PCIT-completer participants in that they were predominantly mothers living in

"traditional" homes in which two parents who had at least a high school diploma were parenting 3 or fewer children.

COPE Participants

Descriptive data for the COPE group revealed that of the 29 participants, 24 completed the program and 5 did not complete the COPE training. Participants included in the completer group missed no more than one COPE session. Similar to the PCIT participants, the typical demographic for the COPE participants was that they were mothers or female caregivers (17), however, family status was not available for 14 of the 29 participants.

The mean age of the participants in the COPE group who completed the program was 26.91 (SD=2.98). Data was not available for the relationship to their child variable for 10 of the participants, for 13 of the participants for the family status, number of children living in the home and parents educational attainment variables. Similar to the PCIT completer group, the majority of participants in the COPE completer group were mothers living in two parent homes who had achieved at least high school educational status and were parenting fewer than 3 children at the time of their COPE participation.

The mean age of the group of 5 participants who did not complete the COPE program was 35.33 (SD 9.02) years. Again, a majority of participants in the COPE non-completer group were mothers living in two parent households, they had achieved at least high school educational status and were parenting less than 3 children at the time of their COPE participation. The data for educational level, family status and number of children in household was missing for two participants in this group.

Control Subjects

The control group for this study was 15 parents who were wait-listed during one of the COPE training programs but who had completed the same pre-and post-test measures as parents who had become program participants. The mean age of the control group was 28.60 (SD=9.32) years. Missing data on a variety of demographic descriptors was replete in this group. Thus, ten participants did not identify their family status, ten did not identify their level of educational attainment, number of children living in the home was not available for another ten participants, and eight did not identify their relationship to the child. Similar to the makeup of the other groups, the majority of participants for whom data were available in the control group were mothers who had achieved high school educational status, were living in two parent households and were parenting fewer than 3 children at the time of their control group participation.

Table 1 displays the demographic frequencies for all groups used in this study and reveals that mothers comprised the majority of participants in all groups. Of the data available in the COPE groups, most had a high school education, represented two-parent homes and reported three or fewer children living in their homes.

Table 1

Demographic Frequencies across Groups

	PCIT N=67		COPE N=29		Control
	Completers N=44	Non N=23	Completers N=24	Non N=5	N=15
Caregiver Type					
Mother	30	13	13	4	7

Father	12	5	1	1	-
Grandmother	0	2	-	-	-
Grandfather	0	1	-	-	-
Aunt	1	1	-	-	-
Uncle	1	1	-	-	-
Family Status					
Dual Parent	35	13	7	3	3
Single Parent	5	2	4	-	2
Other	4	7	-	-	-
Parent Education					
Masters or higher	1	1	-	-	-
Bachelors Degree	3	1	2	-	-
Associates Degree	4	-	-	-	-
Technical Training	7	5	2	-	-
Some College	4	3	3	1	-
High School Grad	20	9	4	2	3
Junior High Grad	4	1	-	-	2
# Children in Home					
One	17	6	2	1	2
Two	17	11	7	2	1
Three	8	3	-	-	2
Four	2	-	2	-	-

Completer vs. Non-completer Analyses

Demographic Analyses

Analyses of participants' demographic characteristics were completed to evaluate group equivalency. The mean age of the completers was 29.53 (SD = 6.12). As a group those who dropped out of the program had a mean age of 33.61 (SD = 2.54). Completers reported a mean number of children living in the family as 1.95 (SD=0.89) and the non-completers a mean number of children in the household at 1.83 (SD = 0.65).

T-tests revealed no significant differences between the completers and non-completers on parents age [(t(26.6)= -1.53, p=.137) reported with equal variances not assumed] and the number of children living in the household (t(81)=0.607, p=.546).

A chi-square test was used to compare the completers and non-completers on participant relationship to the child $X^2(5,N=87) = 7.427$, p=.191, parents' education $X^2(6, N=82) = 3.88$, p=.69 and family structure $X^2(3,N=85) = 8.13$, p=.043. Only the family structure analysis was significant. An inspection of the completers and non-completers data revealed that more single-parent families, non-parent caregivers such as grandparent-as-parent and 'other' (often an Aunt or Uncle raising nieces/nephews), families constituted subjects in the non-completers groups than in the program completers conditions. Thus, the composition of those who completed or did not complete either of the training programs was equivalent on all variables except caregiver characteristics with more non-parent caregivers dropping out of the parenting programs.

Dependent Measures Pretest Equivalency

Table 2 displays mean scores on the PPS and CBCL internalizing, externalizing and total scores for completer and non-completer subjects at pretesting.

Table 2

Mean Pre-Test CBCL and PPS Scores for Completers and Non-Completers

	Completers	Non-completers
Internalizing	52.89 (SD = 11.90)	55.00 (SD = 11.49)
Externalizing	54.57 (SD = 11.65)	55.53 (SD = 10.07)
Total problems	54.38 (SD = 12.10)	56.00 (SD = 10.89)
Parent Practices Scale	141.93 (SD = 17.96)	139.21 (SD = 19.22)

A series of T-tests were used to test for equivalency of scores on the dependent measures at pretest. Completer and non-completer scores on the CBCL did not differ significantly on their internalizing pre-test scores ($t(90)=-1.83$, $p=.41$), their externalizing pre-test scores ($t(90)=-.77$, $p=.45$), or their total problem pre-test scores ($t(90)=-.82$, $p=.41$). Similarly, a significant difference was not found between the completer and non-completer scores on the PPS ($t(67)=.45$, $p=.66$) at pretest. Although not statistically significant, completers did report experiencing fewer child behavior problems on the CBCL (lower scores) at pretest and using more positive parent practices as measured by the PPS (higher scores) at pretest than the non-completers.

A t-test was used to assess if there was a significant difference in the completion rates between the COPE and PCIT groups. The analysis was not significant ($t(94)= 1.70$, $p=.093$).

Comparison of Programs Analyses

CBCL Pretest Equivalency of Mean Scores

Several one way ANOVAS were used to compare pretest scores across programs on the internalizing ($F(2,103)=5.965$, $p=.004$), the externalizing ($F(2,103)=0.049$, $p=.952$)

and total problem scores (F(2,103)=0.547, p=.580) of the CBCL. These results indicated only that the internalizing scores were significantly different at pretest and found no significant differences for the CBCL total problem or externalizing scales at pretest. A Levene's Test for Equality of Variance was used to further examine the pretest scores on the CBCL internalizing scale across groups. This analysis was non-significant (p= 0.247) indicating that there were no significant differences in group variances on this variable prior to program participation.

PPS Pretest Equivalency of Mean Scores

A one way ANOVA was used to compare pretest scores across programs on the PPS variable (F(2,71)=0.120, p=.887). No significant difference was found between the groups on the PPS variable at pretest. Thus, pretest scores across groups for all dependent measures were deemed equivalent.

Posttest Comparisons

A MANOVA was used to test for between group differences on the PCIT, COPE and control groups on each of the dependent variables; CBCL internalizing, externalizing and total problem scales and the PPS at post testing. The hypothesis that PCIT and COPE participants would report fewer child behavior problems (lower CBCL scores) and greater use of positive parenting behaviors (higher PPS scores) at posttest then control subjects was not supported. No significant differences were found between the groups at post test on any of the three CBCL scales or the PPS scores (see table 3).

Table 3

CBCL and PPS Post Test Scores Across Group

	df	*F*	MS_{error}	*p*
CBCL Int.	2	1.880	258.240	.161
CBCL Ext.	2	1.193	168.502	.310
CBCL Total	2	.100	17.643	.905
PPS	2	.102	19.548	.904

*P > .05

Improvement Analyses

A series of ANOVAs were used to determine whether improvement had occurred from pre to post testing among the groups on the dependent measures. Results of these analyses for the CBCL pre to post test improvement (change scores) for the internalizing, externalizing and total problem scales showed no significant improvement differences between the groups. Table 4 displays these results. Thus, neither of the program groups showed more significant improvement than the control subjects. However, the PCIT group scores revealed greater (albeit nonsignificant) pre to post test mean improvement (change) on the CBCL internalizing, externalizing and the total problem scales than either the COPE or the control groups. Table 5 displays the pre to post mean change scores.

An ANOVA was used to test the hypothesis that the PCIT group would show greater improvement in their reported parenting practices than either the COPE and control subjects. None of the three groups showed significant improvement in their

reported parenting practices. (See Table 4 for this analysis) Therefore, this hypothesis was also not supported. Table 5 displays these means

Table 4

CBCL and PPS Change Scores Across Programs

	df	*F*	MS_{error}	*p*
CBCL Int. Imp.	2	.519	50.665	.598
CBCL Ext. Imp	2	2.07	162.731	.135
CBCL Total Imp	2	1.273	116.946	.287
PPS	2	1.484	19.458	.239

*p> .05

Table 5

Mean Change Scores on Dependent Measures Across Groups

	N	Mean	SD
CBCL/Internalizing			
PCIT	42	- 3.19	9.96
COPE	20	-1.80	10.11
Control	7	.71	8.45
CBCL/Externalizing			
PCIT	42	- 3.90	9.80
COPE	20	- .10	7.57
Control	7	1.85	4.81
CBCL/Total Problem			
PCIT	42	- 3.88	9.00

COPE	20	- .40	9.19
Control	7	.57	10.39
PPS			
PCIT	38	9.68	12.99
COPE	6	.50	8.26
Control	4	6.25	8.53

Between groups effects for parenting practices (scores on the PPS pre to post between groups) was tested with another ANOVA. No significant effects were found in this analysis ($F(2,39)= .874$, $p = .136$). Taken together, these analyses indicated no effect of program and did not support the hypothesized superiority of the PCIT training over the COPE training and of both programs over the control subjects who had not received a parenting curriculum.

Comparison of "Clinical" versus "Non-Clinical" Child Behavior Problems

In order to detect the effect of the PCIT program for children with more severe behavioral problems, those falling in the borderline and clinical ranges of the CBCL, were first compared to children whose scores fell in the non-clinical range on this instrument through a series of Chi Square analyses. Children were deemed to fall into the borderline/clinical range if there score on the total problem scale of the CBCL was 60 or greater, they were included in the nonclinical group if there total problem score on the CBCL was 59 or less. The determined clinical and non-clinical groups were compared on the following demographic variables: age of caregiver, caregivers' education level, number of children living in the home and family structure. No significant differences

were found between the two groups on any of these demographic variables so the groups were deemed to be equivalent with regard to demographic characteristics. T tests compared the groups on the following variables: parents positive play behaviors at intake (as measured by the DPICS), parents problematic play behaviors at intake (as measured by the DPICS), parents positive play behaviors at termination (as measured by the DPICS), parents problematic play behaviors at termination (as measured by the DPICS) and pre and post PPS scores. No significant differences were found on any of the play observation variables between the children identified as falling in the clinical problem range and those scoring in the non-clinical range (see table 6 for these results).

Significant differences were noted for the children falling in the clinical range. This group showed a greater decrease on CBCL internalizing ($t(67)=2.96$, $p=.004$), CBCL externalizing ($t(26)= 2.49$, $p=.019$) and CBCL total problem ($t(30)= 2.667$, $p=.012$). Furthermore, self reported positive parenting practices for families whose children's behavior fell in the clinical range were significantly different at both pre test ($t(67)= 5.264$, $p=.000$) and post test ($t(42)=2.264$, $p=.029$). However, the improvement scores analysis of the PPS was not significant for the clinical and non-clinical groups ($t(36) = -2.007$, $p = .052$) with regard to parenting behaviors. Table 7 displays the results of these analyses.

Table 6

Clinical vs. Nonclinical Comparisons on Demographic and DPIC Characteristics

	N	*df*	X^2
Demographics			
Caregiver age	75	25	.433
Caregiver education	77	6	.686
# children in home	78	3	.842
Family structure	80	4	.942

	df	*t*	*p*
DPICS			
Intake Pos Play Observer 1	55	1.185	.241
Intake Pos Play Observer 2	48	-.178	.859
Intake Prob Play Observer 1	30.66	-.426	.673
Intake Prob Play Observer 2	32.96	-.891	.378
Term Pos Play Observer 1	37	1.43	.160
Term Pos Play Observer 2	37	1.69	.098
Term Prob Play Observer 1	37	.921	.363
Term Prob Play Observer 2	37	.206	.838

*p> .05

Table 7

Clinical vs. Nonclinical Children Comparisons on CBCL and PPS Scores

	df	*t*	*p*
CBCL			
Internalizing	67	2.96	.004*
Externalizing	26.18	2.49	.019*
Total Problem	30.23	2.65	.012*
PPS			
Pre-test scores	67	5.26	.000*
Post–test scores	36	2.01	.052*

*p > .05

Dose Response Analyses

To determine if parents' interactions with their children improved as a result of PCIT instruction during a specific session, a dose response analysis was conducted. Table 8 shows the DPICS scores for poor and undesirable play behaviors by two observers across sessions. As the table illustrates, positive play behaviors increased after the first session during which caregivers learned about "special play" and behaviors expected from them for this parenting activity. Positive parenting behaviors peaked at session four and gradually declined throughout the remainder the program. Also, undesirable play behavior decreased sharply after session one and continued to decrease during session two. It then leveled off at approximately session two and remained relatively stable throughout the remainder of the PCIT program. Figure 1 gives a visual depiction of the trend in positive and undesirable play behaviors across sessions.

Table 8

DPICS Scores for Positive and Undesirable Play Behaviors Across Sessions

	Intake	Session 1	Session 2	Session 3	Session 4	Session 5	Session 6	Termination
Positive Play Behaviors Obs 1	9.9	15.7	16.7	15.6	17.5	17.5	14.6	14.5
Positive Play Behaviors Obs 2	9.8	15.7	16.5	16.5	19.1	17.9	16.5	15.17
Undesirable Play Obs 1	22.3	10.7	6.3	5.7	5.5	6	7	5
Undesirable Play Obs 2	20.5	11.1	7.5	6.5	7.9	4.5	5.5	5.6

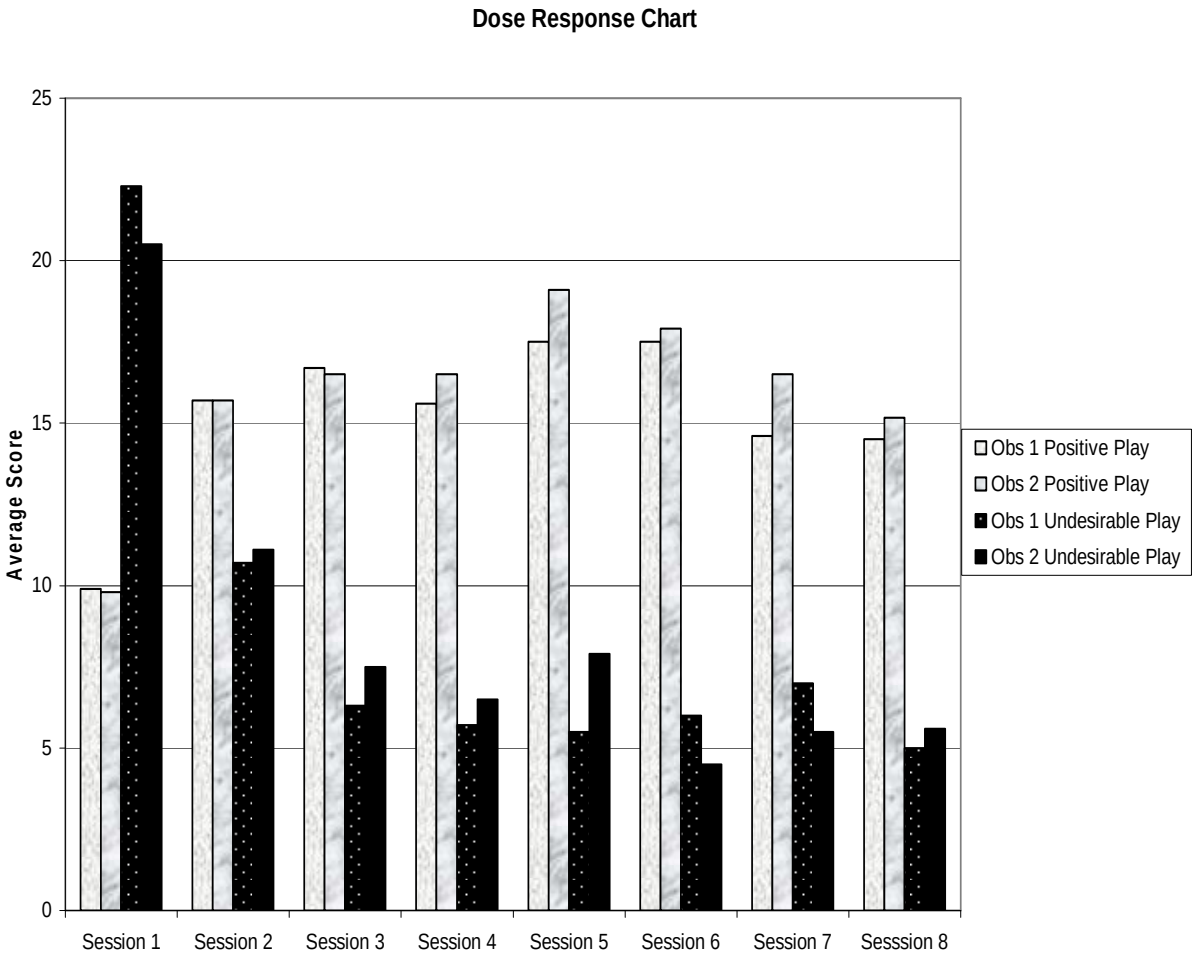

Figure 1. Across sessions DPICS observer scores.

PPS Factor Analysis

The PPS is composed of 34 questions that ask caregivers about their interactions with their preschool aged children (Strayhorn & Weidman, 1988). The authors stated that questions on this instrument were constructed by considering positive parenting skills such as reducing unnecessary commands to children, enforcing commands once presented, providing more attention for positive behaviors than for negative behaviors, avoiding unintentionally rewarding poor behavior, modeling positive behavior, enjoying

time spent with children, avoiding overly harsh punishment, and being consistent. Strayhorn & Weidman claim that the inclusive scale has good internal consistency with coefficient alphas of .78 and .79 for the first and second administrations, respectively. The professional literature does not include an examination of questions representing the parenting constructs reportedly considered in the development of this instrument, so such an analysis was included in the current study.

A factor analysis using a Varimax rotation with Kaiser Normalization produced three independent factors. Questions loading on each of these factors appeared to represent distinct (orthogonal) areas of parenting practices. Table 9 displays the results of this analysis and shows that together the three factors explained 37.34 % of the variance with factor one representing nearly 20 % (19.423) of this total and factors 2 and 3 capturing 9.523% and 8.389%, respectively. Coefficient alphas were .799 for factor 1, .771 for factor 2 and .764 for factor 3.

Table 9

Total Variance Explained for Factor Analysis of Parent Practices Scale

	Initial Eigenvalues		
Component	Total	% of Variance	Cumulative %
1	6.604	19.423	19.423
2	3.238	9.523	28.946
3	2.285	8.389	37.335

An analysis of items loading on each of the three factors was examined in a search for similarity in the construct each measured. The first factor appeared to be tapping the use of affirmative childrearing behaviors and expression of enjoyment of

one's children. Thus, higher scores on this factor suggested an increased use of desired parenting strategies such as enjoying time with one's children, reading to and participating in imaginary play with one's children or demonstrating kind, friendly or appreciative behavior for one's children. Conversely, the second factor included items which indicated the use of harsh punishment and parents who were easily annoyed by their children. Higher scores on these questions suggest minimal use of abrasive or punitive child discipline of ones' children and fewer instances of caregivers feeling irritated with their children. The third factor seems to represent what might be considered the basics of good parenting such as feeding kids, bathing them, observing regular bed times. Higher scores on these questions indicate that caregivers are exercising greater consistency with their children and attending to the fundamental responsibilities of proper parenting. Table 10 includes the questions loading on each of three PPS factors produced by this analysis and their factor loadings.

Table 10

Items Loading on Each of Three Factors

Item #	Loading
Factor 1: Positive Parenting Behaviors	
1. How often does this child do something that gives you pleasure and enjoyment?	.667
3. How often do you read to your child?	.264
5. How often do you praise your child, by saying something like "Good for you!" "What a nice thing you did!" "Thank You!" or "That's good going!".	.635
6. How often do you tell you child about your own experience, by saying something like "I saw a pretty bird outside a while ago" or	

"I exercised so hard that I got really tired" or "I was able to give some directions today to somebody that got lost" or " I really like the way the sky looks now"?	.612
7. How often do you and your child talk or play with each other, focusing attention on each other for five minutes or more, without your asking or telling the child to do anything?	.649
9. How often do you and your child engage in imaginary play, where you each play the part of a character, and together make up a story to act out to each other?	.618
10. How often do and your child laugh together?	.600
17. What fraction of days are you too worn out and exhausted to do something fun with your child?	.481
23. How often does your child see adults or teenagers in your house physically fighting with or hitting or otherwise trying to hurt each other?	.485
31. How often does the child see an adult in the house raise his voice in anger at some other adult in the house?	.483
32. How often does the child see an adult in the house do something kind, friendly or very much appreciated by another adult in the house?	.613
34. What do you think would be the best thing to do if your child spilled his or her milk?	.403
Factor 2: Harsh Punishment/ Easy Annoyance	
2. How often does this child do something that greatly irritates you and gets on your nerves?	.718
4. How often do you physically punish your child, for example by spanking?	.718
8. How often do you tell your child to do something, with an irritated or angry tone of voice?	.710
11. How often do you yell or speak in a very loud voice to your child, with irritated or angry emotion?	.761
18. How often does the thought go through your mind that you wish you didn't have to spend so much time with this child?	.541

20. Think of all the times that you comment to the child about the child's behavior. What percentage are correction or disapproval? .496

26. How often is your child able to get his or her way by having a tantrum? .417

27. How often do you tell your child you may leave him or her if he or she doesn't behave better? .387

28. How often do you punish your child for crying? .586

29. How often do you punish your child for wetting himself or herself? .378

30. How often do you or does someone else tell the child that he or she is bad or that he or she is not as good as someone else? .606

Factor 3: Basic Parenting Behaviors

12. What fraction of days does your child get three meals, one in the morning, one around noon and one in the evening? .553

13. What fraction of days does your child get a bath or shower at one particular time, known as his or her bath time? .590

14. What fraction of days does your child go to bed at one particular time, known as his or her bedtime? .596

15. What fraction of days does your child eat all of the following: some meat (or other high protein food), some fruits or vegetable, some milk products, and some bread or grain products? .430

16. When you and your child set out to do something fun together, what fraction of the time does it actually turn out to be fun? .576

19. Think of all the times that you comment to the child about the child's behavior. What fraction are congratulation or approval? .550

21. Suppose your child was handling an object that you definitely did not want the child to handle. Suppose you told the child to put the object down, and he or she defiantly said "No!" Of the following options, which do you think would be the most appropriate response, most of the time? .512

22. Do you keep your child from seeing television shows and movies that have a lot of violence or meanness in them?	.391
24. When you give your child a command or order to do something, what fraction of the time do you make sure that the child does it?	.627
25. Have you arranged the objects in your house so that those things that you don't want the child to mess with are not within his reach, so that you don't have to command him to stay out of them?	.414
33. When your child asks you a question, what fraction of the time do you feel like answering it in an enthusiastic and interested way, rather than feeling irritated that your child is bothering you?	.422

PPS Validity Analysis

The PPS has been reported to be a reliable measure with test-retest reliability at r=.79 (Strayhorn & Weidman, 1988). However, the authors of this measure do not report validity data for the PPS. Thus, the current study attempted to establish the construct validity of the PPS by correlating parents responses on the PPS with the play data collected through the DPICS. Inter-rater reliabilities on the total desirable play and total undesirable play variables ranged from a low of .81 (p=.01) to a high of .94 (p=.00), as the correlations between observers are high, the observers scores were averaged together to simplify the validity analysis. Table 10 presents the results of this analysis.

Table 11

Correlations of Desirable (+) and Undesirable (-) Play Behaviors as Measured by DPICS with the PPS Factors

	Intake Desirable Play Behaviors	Intake Undesirable Play Behaviors	Termination Desirable Play Behaviors	Termination Undesirable Play Behaviors
PPS Factor 1 Pre Test	.262	-.015	-.099	-.246
Significance	.09	.93	.57	.15
PPS Factor 1 Post Test	.084	.213	-.186	.057
Significance	.65	.25	.28	.75
PPS Factor 2 Pre Test	.108	-.144	-.323*	.164
Significance	.47	.34	.05	.33
PPS Factor 2 Post Test	-.404*	-.089	-.460**	.252
Significance	.02	.63	.01	.14
PPS Factor 3 Pre Test	-.213	-.236	-.216	-.249
Significance	.17	.13	.21	.15
PPS Factor 3 Post Test	-.312	.274	-.418*	.155
Significance	.08	.13	.011	.37

*P>.05 level (2-tailed).
** P>.01 level (2-tailed)

This analysis produced significant negative correlations between desirable play behaviors at termination and factor 3 post test scores (Basic parenting behaviors). Significant negative correlations were also found between desirable play behaviors at termination and factor 2 pre-and post-test scores (harsh or punitive parent behaviors). At intake, factor 2 post-test scores (harsh or punitive parent behaviors) negatively correlated significantly with desirable play behavior.

It was hypothesized that parents' reports of their parental practices on the PPS scale would positively correlate with the play ratings on the DPICS with respect to positive and undesirable play behaviors. This hypothesis was not supported. The result

of this analysis indicates that the PPS instrument may be measuring different parenting constructs than those measured by the DPICS instrument.

CHAPTER 5: DISCUSSION

Although none of the original hypotheses were supported, the data analysis did reveal some interesting findings which will be discussed below. There were several limitations to this research, including the quasi experimental design and sampling concerns. These will be addressed in greater detail below.

Completers vs. Non-Completers Comparisons

The only significant difference between the completers and non-completers in this sample was in the characteristics of caregivers in the groups. An inspection of the data from both the completers and non-completers revealed that more single-parent families, non-parent caregivers such as, grandparent-as-parent and 'other' (often an Aunt or Uncle raising nieces/nephews) families constituted subjects in the non-completers groups than in the program completers conditions. Some possible explanations for this difference may be that single parents often experience a more difficult time procuring child-care that would permit them to attend the parent meetings. Wood and Baker (1999) suggest that child-care difficulties are a major barrier to parent education participation. Although child-care was offered during the PCIT program for toddler and preschool ages, it is possible that some families did not want to bring their children who were not Head Start participants or who they felt were too young or too old to enjoy the activities provided for children during the parent meetings.

PCIT, COPE and Control Group

None of the hypothesized results related to group outcomes were found. The CBCL or PPS scores were essentially equivalent across groups.

Clinical vs. Non-Clinical Children

No significant differences were found for the clinical and non-clinical groups on the demographic variables or the parent play variables. This indicated that the parent and family characteristics were equivalent and that neither group's parents interacted with their children differently. A significant decrease on CBCL internalizing, externalizing, and total problem scales was found from pre to post testing for children in the clinical group. It is possible that at least part of the explanation in these findings lies in regression to mean. Yudkin and Stratton (1996) write that "Regression to the mean occurs with any variable that fluctuates within an individual, either genuinely or due to measurement error" (p.241). They suggest ways to reduce regression to mean problems in intervention studies: randomized controlled trials, using the mean of several measurements to determine group eligibility, and using different measures for selection and determining treatment effect.

Self reported positive parenting practices for families whose children's behavior fell in the clinical range were significantly different at both pre test and post test. Parent's of non-clinical children reported using more positive parenting practices at pre-test (mean= 148.96) than parents of children in the clinical group (mean=128.46) and this pattern was also seen in post-test PPS scores with the parents of non-clinical children continuing to report the use of more positive parenting practices (mean=154.7) than parents of children in the clinical group (mean=145.5). Although not significantly different, parents in the clinical group showed a mean improvement of 17.04 and the non-clinical group showed a mean improvement score of 5.74. Thus, there is some evidence, at least in this sample, that either the parenting education may have encouraged parents to

engage in more positive parenting behaviors or that parents were informed of what is considered as positive parenting behaviors. A measure of social desirability responding may have shed more light on the accuracy of the self reports of these parents.

Dose Response

An evaluation of parents' play behaviors across sessions showed that they improved immediately after the first session, positive play peaked around session four and then gradually declined during the remaining PCIT sessions. The parents undesirable play behaviors leveled off at approximately session two and remained relatively stable throughout the remainder of the program. Since parents who leave the PCIT program after the first or second session would have been unlikely to have adopted more positive parenting styles. These results suggest that it is important to advise parents about the length of time it takes to learn the desirable parenting skills so as to reduce the attrition rates of these programs. According to Cunningham, Bremner, and Secord-Gilbert (2004) between 25% and 50% of low-income parents drop out of parent education programs. If parents are made aware of the number of session required before most families begin to see changes, we may begin to see a reduction in these attrition rates.

If parents know what to expect and when they might begin to see positive changes (since PCIT assumes a parenting change influencing child behavior) it might prolong parents participation in these programs. Future research in this area might consider collecting a brief child behavior survey on a weekly basis to determine if parents perceive an improvement in their child's behavior problems during the same week as their parenting is observed to become more positive.

Factor Analysis

Strayhorn and Weidman (1988), authors of the PPS, write that the questions on the PPS were constructed by considering positive parenting skills such as reducing unnecessary commands to children, enforcing commands once presented, providing more attention for positive behaviors than for negative behaviors, avoiding unintentionally rewarding poor behavior, modeling positive behavior, enjoying time spent with children, avoiding overly harsh punishment, and being consistent. The data from this study was used to determine if the PPS questions comprised scales that measured different concepts. A factor analysis that used the PPS scores from all groups produced three independent factors which together explained 37.34 % of the total variance. The first factor appeared to be tapping what is considered positive parenting behaviors such as enjoying time with one's children, reading to and participating in imaginary play with one's children or demonstrating kind, friendly or appreciative behavior for one's children. Conversely, the second factor included items which indicated the use of harsh punishment and parents who were easily annoyed by their children, higher scores on these questions suggest minimal use of abrasive or punitive child discipline and fewer instances of caregivers feeling irritated with their children. The third factor produced was unclear but upon inspection seemed to perhaps represent the basics of good parenting such feeding ones kids, bathing them, observing regular bed times etc. Doyle and McCarty (2001) conducted a factor analysis of the Parent Questionnaire, an adaptation of the PPS for parents of school aged children and similarly found three factors. These researchers termed these factors as; "Factor 1: Appropriate / Consistent Discipline", "Factor 2: Warmth / Involvement" and "Factor 3: Harsh / Physical Discipline" and reported that the

results of the confirmatory measurement model were: GFI=.848, RMR=0.071. However, the three factors found in the current analysis did not account for a significant portion of the total variance in this instrument.

Parent Practices Scale Validity

According to Strayhorn and Weidman (1988), the PPS is a reliable instrument boasting test-retest reliability at r=.79. However, the validity of the PPS for assessing parenting behaviors had not been reported in the professional literature. A goal of this study, then, was to determine if the PPS was a valid instrument for such measurement. This analysis correlated the PPS with the play data collected by the DPICS observations. This analysis produced inconsistent results. The PPS factors variably correlated with the positive play ratings of the observers during the intake and termination sessions. It seems that the DPICS which measures play behaviors and codes parents interactions during play as either positive or undesirable may not have been measuring the same construct as the PPS purports. Alternatively, parents' perceptions of their behaviors as measured by the PPS and their behaviors measured by the DPICS may represent different perspectives on the same construct. Continued attempts to validate the PPS might consider using measures consistent with the PPS methodology for a better comparison.

Although the goal of validating the PPS was not accomplished, the correlations between the 3 factors of the PPS and the DPICS play variables did yield some interesting results. Factor 2, which represents harsh or punitive parenting behaviors, correlated with desirable play behaviors at both intake and termination. These results suggest that higher scores on factor 2 (less use of harsh or punitive parenting) are associated with lower scores on the DPIC desirable play behaviors (engaging in fewer positive play behaviors).

A relationship suggesting parents who use more harsh parenting techniques may engage in more desirable play behaviors was unanticipated. Future research to address if this relationship truly exists is recommended.

Sampling Issues

There is some concern about the composition of the sample used in this study. A majority of the participants across the study conditions were mothers (72%) living in dual- parent situations (71.8%) that had achieved at least high-school educational status (91.5%) and were parenting less than 3 children at the time of their PCIT participation (79.5%). An extensive literature search was unable to produce data regarding the demographics of Head Start families in rural Pennsylvania. However, a study was found which described demographic information regarding Head Start families from across the United States during the 2003-2004 school year (Hamm & Ewen, 2005). According to Hamm and Ewen, in 2004, 44% of Head Start families were dual parent households while 56% lived in households headed by a single parent. In the current study, 71.8% of households were dual parent while only 15.3% of our sample were single parents with the remainder of families identifying themselves as being in the "other category" and most often headed by grandparents. Therefore, the sample used in this study was not consistent with the reported nation-wide population of parents whose children are enrolled in Head Start programs. Moreover, according to Hamm and Ewen (2005)

> Most Head Start parents had limited formal education. One-third of Head Start parents had not completed high school or an equivalent degree. An additional 44% had a high school diploma or G.E.D. Twenty percent had some college course work, an A.A. or a vocational degree. Just 3% held a B.A. or higher. (p.4).

In the current sample only 8.5% had not completed high school, 46.3% had completed high school, 13.4% had reported some college attendance, 17.1% had completed technical training, 4.9% had attained an associates degree, 7.3% has completed a bachelors degree and 2.4% had completed a masters degree or higher.

Thus, a majority of the participants in the current study had obtained a high school education (46.3%) and another 45.1% had completed some type of post secondary education. It is possible that the make up of the Head Start population in the rural area of Pennsylvania where the data was collected differs from the national demographics. Differences may also have been related to self selection. For some reason, parents who have attained more education may have been more inclined to choose to participate. Also, dual parent families may have been more likely to self select to participate.

National statistics were not found regarding the mean number of children living in Head Start affiliated households, so any discrepancy in the current sample with national Head Start enrollments could not be determined. Also, because data regarding Head Start enrolled family demographics for rural communities could not be found in the literature, the current sample could not be compared to rural Head Start family figures.

Demographic information regarding race, ethnicity and primary language spoken in the home were not collected from the current sample. This information is available from the national Head Start enrollment databank and would have provided an interesting comparison had it been collected. However, given the restricted ranges of these variables in the rural county where this information was collect, the sample sizes would have not likely yielded significant information.

Another potential sampling problem with the current study is that nearly three-quarters of the sample were mothers despite a majority of the participating families identifying themselves as dual-parent. Budd and O'Brien (1982) noted that fewer than 15% of parent education studies included paternal involvement. However, a study by Bagner and Eyberg (2003) compared families who participated in PCIT who had father involvement with those who did not and concluded that father participation may help to maintain the benefits of PCIT. It is difficult to say whether father participation in the two parent education classes offered would have improved the outcomes. Important to note is that all child caregivers were invited to attend both the COPE and PCIT trainings yet predominantly mothers choose to participate. Thus, the self-selected aspect of participation in these groups may have skewed the results in a systematic fashion so that these results are not particularly generalizable.

Conclusion

In conclusion, this study was conducted using a quasi experimental design and thus lacked random assignment of participants to groups. Participants self selected to participate in the offered programs and no data was available for those parents whose children were registered in area Head Start programs and did not choose to participate. The uneven group compositions impair the generalizability of the results to other parenting education programs in general and to Head Start families in particular. Interesting correlations were found associating the use of less harsh discipline techniques with engaging in fewer positive play behaviors. In the future, research may attempt to clarify this relationship between harsh parenting and parents play behaviors. Future research may also look at the relationship between single parents and attrition from

parent education programs. Possibly providing parents with information regarding when improvement typically occurs during parent education programs may reduce attrition rates. It is recommended that this be addressed in future studies.

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Appendices

Appendix A

Parent Practices Scale (Strayhorn and Weidman, 1988)

1. How often does this child do something that gives you pleasure and enjoyment?

0. Never
1. Less than once a week
2. About once a week
3. About three or four times a week
4. About once a day
5. Several times each day
6. Many times each day

2. How often does this child do something that greatly irritates you and gets on your nerves?

0. Never
1. Less than once a week
2. About once a week
3. About three or four times a week
4. About once a day
5. Several times each day
6. Many times each day

3. How often do you read to your child?

0. Never
1. Less than once a week
2. About once a week
3. About three or four times a week
4. About once a day
5. Several times each day
6. Many times each day

4. How often do you physically punish your child, for example by spanking?

0. Never
1. Less than once a week
2. About once a week
3. About three or four times a week
4. About once a day
5. Several times each day
6. Many times each day

5. How often do you praise your child, by saying something like “Good for you!”, “What a nice thing you did!”, “Thank You!”, or “That’s good going!”?

0. Never
1. Less than once a week
2. About once a week
3. About three or four times a week
4. About once a day
5. Several times each day
6. Many times each day

6. How often do you tell you child about your own experience, by saying something like “I saw a pretty bird outside a while ago” or “I exercised so hard that I got really tired” or “I was able to give some directions today to somebody that got lost” or “I really like the way the sky looks now”?

0. Never
1. Less than once a week
2. About once a week
3. About three or four times a week
4. About once a day
5. Several times each day
6. Many times each day

7. How often do you and your child talk or play with each other, focusing attention on each other for five minutes or more, without your asking or telling the child to do anything?

0. Never
1. Less than once a week
2. About once a week
3. About three or four times a week
4. About once a day
5. Several times each day
6. Many times each day

8. How often do you tell your child to do something, with an irritated or angry tone of voice?

0. Never
1. Less than once a week
2. About once a week
3. About three or four times a week
4. About once a day
5. Several times each day
6. Many times each day

9. How often do you and your child engage in imaginary play, where you each play the part of a character, and together make up a story to act out to each other?

0. Never
1. Less than once a week
2. About once a week
3. About three or four times a week
4. About once a day
5. Several times each day
6. Many times each day

10. How often do and your child laugh together?

0. Never
1. Less than once a week
2. About once a week
3. About three or four times a week
4. About once a day
5. Several times each day
6. Many times each day

11. How often do you yell or speak in a very loud voice to your child, with irritated or angry emotion?

0. Never
1. Less than once a week
2. About once a week
3. About three or four times a week
4. About once a day
5. Several times each day
6. Many times each day

12. What fraction of days does your child get three meals, one in the morning, one around noon and one in the evening?

0. Never
1. Some, but less than a quarter of the time
2. Between a quarter and half of the time
3. Between half and three quarters of the time
4. Not all of the time, but more than three quarters of the time
5. All the time

13. What fraction of days does your child get a bath or shower at one particular time, known as his or her bath time?

0. Never
1. Some, but less than a quarter of the days
2. Between a quarter and half the days
3. Between half and three quarters of the days
4. Not all of the time, but more than three quarters of the days
5. All the days

14. What fraction of days does your child go to bed at one particular time, known as his or her bedtime?

0. There is no regular or official bedtime kept
1. There is an official bedtime, never kept
2. There is an official bedtime, kept some, but less than a quarter of the time
3. Official bedtime kept between half and three quarters of the time
4. Official bedtime kept half and three quarters of the time
5. Official bedtime kept not all the time, but more than three quarters of the time
6. Official bedtime kept all the time

15. What fraction of days does your child eat all of the following: some meat (or other high protein food), some fruits or vegetable, some milk products, and some bread or grain products?

0. Never
1. Some, but less than a quarter of the days
2. Between a quarter and half the days
3. Between half and three quarters of the days
4. Not all of the time, but more than three quarters of the days
5. All the days

16. When you and your child set out to do something fun together, what fraction of the time does it actually turn out to be fun?

0. Never
1. Some, but less than a quarter of the time
2. Between a quarter and half of the time
3. Between half and three quarters of the time
4. Not all of the time, but more than three quarters of the time
5. All the time

17. What fraction of days are you too worn out and exhausted to do something fun with your child?

0. Never
1. Some, but less than a quarter of the days
2. Between a quarter and half the days
3. Between half and three quarters of the days
4. Not all of the time, but more than three quarters of the days
5. All the days

18. How often does the thought go through your mind that you wish you didn't have to spend so much time with this child?

0. Never
1. Less than once a week
2. About once a week
3. About three or four times a week
4. About once a day
5. Several times each day
6. Many times each day

19. Think of all the times that you comment to the child about the child's behavior. What fraction are congratulation or approval?

0. No approval
1. Less than a quarter of the comments are approval
2. Between a quarter and a half are approval
3. Between half and three quarters are approval
4. Not all, but greater than three quarters are approval
5. All are approval

20. Think of all the times that you comment to the child about the child's behavior. What percentage are correction or disapproval?

0. No disapproval or correction
1. Less than a quarter of the comments are disapproval
2. Between a quarter and a half are disapproval
3. Between half and three quarters are disapproval
4. Not all, but greater than three quarters are disapproval
5. All are disapproval or correction

21. Suppose your child was handling an object that you definitely did not want the child to handle. Suppose you told the child to put the object down, and he or she defiantly said "No!" Of the following options, which do you think would be the most appropriate response, most of the time?

0. Spank the child
1. Send the child to a room for half an hour or more
2. Yell at the child
3. Repeat the request until the child obeyed
4. Ignore the child
5. Send the child to a room for two to five minutes
6. Show some disapproval in your voice and in your face, and physically get the object from the child, and from then on, if possible, keep the object in a place the child couldn't reach.

22. Do you keep your child from seeing television shows and movies that have a lot of violence or meanness in them?

0. I don't try to do this
1. I try to do this but don't succeed at all
2. I try to do this but only succeed a little bit
3. I try to do this and succeed fairly well
4. I try to do this, and the child sees almost no violence on television

23. How often does your child see adults or teenagers in your house physically fighting with or hitting or otherwise trying to hurt each other?

0. Never
1. Less than once a week
2. About once a week
3. About three or four times a week
4. About once a day
5. Several times each day
6. Many times each day

24. When you give your child a command or order to do something, what fraction of the time do you make sure that the child does it?

0. Never
1. Some, but less than a quarter of the time
2. Between a quarter and half of the time
3. Between half and three quarters of the time
4. Not all of the time, but more than three quarters of the time
5. All the time

25. Have you arranged the objects in your house so that those things that you don't want the child to mess with are not within his reach, so that you don't have to command him to stay out of them?

0. Many things are in reach that the child should leave alone
1. A good number of things are in reach that the child should leave alone
2. A few things are in reach that the child should leave alone
3. Almost no things are in reach that the child should leave alone
4. No things are in reach that the child should leave alone

26. How often is your child able to get his or her way by having a tantrum?

0. Never
1. Less than once a week
2. About once a week
3. About three or four times a week
4. About once a day
5. Several times each day
6. Many times each day

27. How often do you tell your child you may leave him or her if he or she doesn't behave better?

0. Never
1. Less than once a week
2. About once a week
3. About three or four times a week
4. About once a day
5. Several times each day
6. Many times each day

28. How often do you punish your child for crying?

0. Never
1. Less than once a week
2. About once a week
3. About three or four times a week
4. About once a day
5. Several times each day
6. Many times each day

29. How often do you punish your child for wetting himself or herself?

0. Never
1. Less than once a week
2. About once a week
3. About three or four times a week
4. About once a day
5. Several times each day
6. Many times each day

30. How often do you or does someone else tell the child that he or she is bad or that he or she is not as good as someone else?

0. Never
1. Less than once a week
2. About once a week
3. About three or four times a week
4. About once a day
5. Several times each day
6. Many times each day

31. How often does the child see an adult in the house raise his voice in anger at some other adult in the house?

0. Never
1. Less than once a week
2. About once a week
3. About three or four times a week
4. About once a day
5. Several times each day
6. Many times each day

32. How often does the child see an adult in the house do something kind, friendly or very much appreciated by another adult in the house?

0. Never
1. Less than once a week
2. About once a week
3. About three or four times a week
4. About once a day
5. Several times each day
6. Many times each day

33. When your child asks you a question, what fraction of the time do you feel like answering it in an enthusiastic and interested way, rather than feeling irritated that your child is bothering you?

0. Never feel like answering enthusiastically
1. Feel like answering enthusiastically some, but less than a quarter of the time
2. Between a quarter and half the time
3. Between half and three quarters of the time
4. Not all of the time, but more than three quarters of the time
5. Feel like answering enthusiastically all the time

34. What do you think would be the best thing to do if your child spilled his or her milk?

0. Clean up the milk without criticizing the child
1. Get the child to clean up the milk and scold him or her
2. Send the child to a room for two to five minutes
3. Yell at the child to not be so clumsy
4. Send the child to a room for thirty minutes
5. Give the child a spanking.

Appendix B

Dyadic Parent-Child Interaction Coding System Definitions

Descriptive Statement: a declarative sentence or phrase that gives an account of the objects or people in the situation or the activity occurring during the interaction

Reflective Statement: a declarative phrase or statement which immediately repeats the child's verbalization. The reflection may be exactly the same words the child said, may contain synonymous words, or may contain some elaboration upon the child's statement, but the basic content must be the same as the child's message.

Labeled Praise: any specific verbalization that expresses a favorable judgment upon an activity, product, or attribute of the child.

Unlabeled Praise: A nonspecific verbalization that contains one or more positive evaluative words or phrases is an unlabeled praise.

Direct Command: a clearly stated order, demand, or direction in declarative form. The statement must be sufficiently specific as to indicate the behavior that is expected from the child.

Indirect Command: an order, demand, or direction for a behavioral response that is implied, nonspecific, or stated in question form.

Criticism: a verbalization that finds fault with the activities, products, or attributes of the child.

Question: a comment expressed in question form. It gives an account of the objects or people in the situation or the activity occurring during the interaction. This question follows a child's activity rather than attempting to lead it.

Parent Behaviors Tracked with DPICS for the present study:

Desirable Parent Behaviors:

Labeled Praise
Unlabeled Praise
Reflective Statement
Descriptive Statement

Undesirable Parent Behaviors:

Criticism
Direct Command
Indirect Command
Question

Appendix C

INFORMED CONSENT FORM

Parent Version (PCIT)

You are invited to participate in this research study because you are the parent of a child attending an Indiana County Head Start preschool program. The following information is provided in order to help you to make an informed decision about whether or not to participate in this study. If you have any questions please do not hesitate to ask.

The purpose of this study is to test the effects of a parent-child interaction program on parents' reported satisfaction with their parenting skills and their report of child behavior problems. Participation in this study will require a seven to eight week commitment of three hours weekly of your time. You will be asked to complete several questionnaires describing how you use discipline and generally relate with your child. All parents will be observed at each group session while playing with their child. At the end of the program you will again be asked to complete several questionnaires asking you about your child's behavior and how you use discipline.

There is no penalty to either you or your Head Start enrolled child for non-participation in this study. The answers provided by you and by your child's teacher on study questionnaires will not be identifiable. That is, you will be assigned a number that will be used to compare your responses over the course of the Parenting Skills Program. These numbers will make specific identification of your family impossible for anyone except the experimenters.

There are no known risks or discomforts associated with this research. Parents generally share information concerning their parent-child interactions and parenting practices in these meetings as they are comfortable doing, but it is not a mandatory requirement to benefit from the program. We believe you will find the group meetings enjoyable and the information may be helpful to you in current and future parenting situations.

Your participation in this study is ***voluntary.*** You are free to decide not to participate in this study or to withdraw from this study at any time without adversely affecting your relationship with the investigators or Head Start. You may also participate in the Parenting Skills Program and elect to NOT participate in this study. Your decision will not result in any loss of benefits to which you are otherwise entitled and you may still participate in the Parenting Skills Program. If you choose to participate in the research, you may withdraw at any time by notifying the Project Directors, Dr. Kim Husenits (724-357-7978) or Dr. Robert Gallen (724-357-4520). All information will be held in strict confidence and have no effect on you or your child's Head Start standing. Your responses will be considered only in combination with those from other participants. The information obtained in the study may be used in future studies, published in scientific journals or presented at scientific meetings but your identity will be kept strictly confidential.

Informed Consent Form (continued)

If you are willing to participate in this study, please sign the statement below and return to the investigators. Take the extra unsigned copy with you. If you choose not to participate, return this consent unsigned to the investigators.

Project Director
Kim Husenits, Psy.D.

Assistant Professor
Indiana University of Pennsylvania
238A Uhler Hall
Indiana, PA
724-357-7978

Project Director
Robert Gallen, Ph.D.

Assistant Professor
Indiana University of Pennsylvania
205 Uhler Hall
Indiana, PA
724-357-4520

This project has been approved by the Indiana University of Pennsylvania Institutional Review Board for the Protection of Human Subjects (Phone: 724/357-2223).

VOLUNTARY CONSENT FORM:

I have read and understand the information on the form and I consent to volunteer to be a subject in this study. I understand that my responses are completely confidential and that I have the right to withdraw at any time. I have received an unsigned copy of this informed Consent Form to keep in my possession.
(Please check all that apply)

I agree to participate in this study _____

Name (PLEASE PRINT)

_____

Signature

_____

Date _____

I certify that I have explained to the above individual the nature and purpose, the potential benefits, and possible risks associated with participating in this research study, have answered any questions that have been raised, and have witnessed the above signature.

_____ _____

Date Investigator's Signature

Appendix D

Sample PCIT Script

Session 1:

Objectives

1. Introductions
2. Complete paper work – CBCL & PPS.
3. Attain an initial play assessment.
4. Discussion about development
5. Introduce PCIT -- expectations
6. Field and questions or concerns parents have
7. Assign Homework

Introductions:

Hi, I'm _____ (Group Facilitator) and I am a doctoral trainee at IUP. I have been working with Head Start parents for _____ and am hopeful that we will all learn and grow while working together. I want to talk about confidentiality first thing so we all understand how it will work here. This is _____ (introduce co-facilitator), who has been working with Head Start families for _____. Firstly, I want to tell you that myself and _____ (co-facilitator) consider what we talk about here to be confidential and will not share anything that you talk about or the questionnaires that you complete with anyone. If the questionnaires you complete are used for research there will be no information that could be used to identify you included in that research. In some cases what we talk about is not confidential because we are mandated reporters. That means that if we have a reason to believe that children are being abused, that you might hurt yourself or that you

might hurt someone else, we would need to report these issues to the authorities. We would like to ask that you respect each other's privacy and not share information that you learn about one another in the group with anyone outside of the group. This makes it easier for everyone to feel comfortable and be able to share their experiences.

Most weeks we will meet on _____, from _____ we may be finished earlier sometimes, and we may need a little extra time some weeks. Please excuse us for a moment while we go and get the people who will be working with your children to come and introduce themselves to you and tell you a little about the program they will be using with your children while we are working in here. We will be playing with the children for a few minutes while they introduce themselves to you. The group you are about to meet will also be working with you each week during coaching sessions so it is important to get to know them and feel comfortable with them. (leave to supervise children while child group meets parents).

Well now that you know all of us, let's go around and have you tell us about yourselves, please tell us your name and your children's names and ages.

One important thing that we do here is keep track of how things are changing and improving in your family. To do this we need to have you complete some paperwork so that we have something to compare to at the end of the program. Another reason for the paperwork is to help us to learn how to make this program better, for that reason I am asking for your help by allowing us to use the information you give us in a research study. If that is alright with you please sign the informed consent form included in your packet. Does anyone have any questions about this? If you need any help completing the

questionnaires or have any questions please feel free to ask. We will be taking a five-minute break once everyone is done, when you are finished feel free to start your break.

Break (5 minutes)

Something that we will be doing each week here is watching you play with your children. This is important because we are going to be working to help you play in a different way as part of what we are leaning here. Tonight all we want you to do is play for five minutes with your Head Start child the same way that you normally would. Let your child decide what to do and what to play with. Someone will be watching you play and taking notes, this is so that we can compare how you play now to how you play at the end of these classes. Can I answer any questions about this before we get started? (pause for questions) We are going to break up into groups to play and when it is not your turn to play; please supervise your children in the other room, is everyone ready?

(Conduct initial play assessment with the DPICS).

Development Discussion:

You all did a great job playing! It was really nice to see you having fun with your kids! One of the things I want to talk about tonight is how your child's development or their readiness, plays a role in your parenting. The issue of development and whether or not your child is ready for a certain part of the parenting program will be talked about regularly in our meetings. We want you to feel free to adjust any aspect of this program when necessary to meet the specific needs of your family, and we would be happy to help you make any changes that will help the program fit better with your family. Please feel free to bring up any concerns or questions that you have about adapting the program, it is likely that other parents are having the same sort of thoughts or questions.

In terms of children's readiness, when most children are born they have a lot of things programmed into their brains that they will eventually be able to do. Things like rolling over, crawling, walking and running. Before the child is able to actually do these things some connections need to be made in their brains. (Draw circle [brain] with approximately 30 dots on it). Let's pretend this is a picture of a brain. In order for the child to roll over some connections need to be made (connect 3 dots), for the child to crawl more connections need to be made (connect 4 dots), and to walk more connections need to be made (connect 5 dots). It is unlikely that the child will crawl before they rollover or run before they walk, in most cases kids develop in a chain like this. Connections need to be made for kids to be able to do other things as well like talking, saying the alphabet, playing with toys in a certain way, telling the truth, toilet training, sharing, and being patient. As your child develops they will at times be more likely to behave in certain ways, they may grow into throwing tantrums or tattling and then stop these behaviors as they continue to develop. It is important to realize that your children are most likely not doing these things because they are trying to get on your nerves or to upset you, it is a part of growing up, and as they continue to grow up the behaviors will change. It is very important that we don't expect our kids to be able to do things that they aren't able to because their brains have not made the connections yet. For example, a parent who expects their toddler to be able to share all of the time will most likely be disappointed very often. Most toddlers still have a really hard time with sharing, and while it is important to practice and teach sharing, it is also important to understand that your toddler is simply not ready to share all of the time. As kids get older and mature they will make the connections and will be able to do these things more often, expecting

too much too early sets both you and your child up for a lot of frustration and unpleasantness. What questions do you have about readiness and development? What can your children do now that they couldn't do last year? What sorts of things have your children grown out of? What did they do when they were 2 that they don't do anymore?

Intro to PCIT

We will be spending most of our time here working on a program called parent child interaction therapy; you might also here us calling it PCIT for short. The basis of this program involves first strengthening your relationship with your child through play and then learning skills to help with discipline. This program has been used effectively by many parents whose children have had a variety of problems such as not listening, being too clingy, and having difficulty paying attention. What specific issues would you like to mention that you are hoping this program may be able to help with? The first thing that we are going to work on is something called special play time, it is a specific way to play with your child that kids really enjoy and is usually a very positive experience for both of you. Special play is done each day but only for 5 minutes, we can all find five minutes at some time during the day to spend focusing on our children. Take a moment and think about when you will be able to play with your child for 5 minutes each day (pause for about 60 seconds). Let's go around and share our ideas (have each parent tell the group when they will be doing special play this week, provide ideas if needed: before bath, after dinner, when they arrive home from Head Start etc.). If possible both parents should be involved in special playtime, each playing for 5 minutes. We will be practicing special play here each week and we will watch you play and record your progress as we did tonight. Once we have learned special play we will be moving

on to the discipline part of the program. The program lays out a very specific order of events to go through when your children need to be disciplined and takes the guesswork out of what to do when your child misbehaves.

The skills that we are going to work on have been successful for many other parents and have been proven to be effective when used consistently. Though for some people just changing the way you play and interact with your children will have a big impact on their behavior, for others the use of the discipline component will be very important. I don't want you to feel discouraged and give up if your child's behavior is not changing right away. It took a few years for your child to learn these behaviors so it will probably take some time and some hard work on your part to help your child learn new ways to behave. Typically it takes at least a few weeks before you will begin to see changes. It is really important for you to practice the skills that we are learning here every day and to be really consistent with your children. I have seen great success with this program when parents work hard at using the different parts of the program with their families. For this reason I am asking you to stick with us and work hard at home to try the skills we are talking about. If you have a serious problem that you don't think you can live with for a few more weeks, please bring it up during our question time and we will try to provide suggestions to address it.

We will also be talking about other approaches and specific concerns and problems that you have. This class is an opportunity to have 2 therapists at your disposal to ask any questions about your family that you may have and we will do our best to answer your questions. We are supervised by licensed psychologists and if we can't address your questions or concerns we can bring them to our supervisors or you can

contact them directly. On that note, what questions or concerns do you have about what I have been talking about or about your children or family in general? Discussion – 15 minutes.

Home Work:

Each week we will ask you do a little bit of homework, practicing the skills we talk about at home with your children. This week the homework is to practice working special play into your schedules. Find 5 minutes each day to play with your child. Record on this sheet (hand out play recording sheet) whether or not you played and if you had any problems during play time and please bring it back next week so we can talk about them.

Appendix E

COPE Sample Script

Session Three

Introduction

Welcome to Session Three. Today we are going to talk about helping your child make daily transitions, such as going from watching television to getting their bath in the evening. Turning off the television, coming to the dinner table, or getting ready for bed are challenging times for many families. Some children seem to have particular difficulties anticipating and controlling their emotional response to transitions between daily activities. In this session, therefore, we will explore strategies for preparing children for managing their responses to everyday transitions. In addition, you be able to try out a simple but effective strategy which encourages planning, anticipation of consequences, and motivation through immediate and logical consequences and rewards. An example of this strategy would be saying "WHEN you finish your chores THEN you can pick a television program."

Then we are going to make strategies to encourage our kids to develop plans, rules, and strategies for behavior before problem situations come up. Some children often forget to remind themselves of rules, do not think of other options for behavior, or do not predict potential consequences of an action before doing it. Therefore, we are going to talk about helping our child plan and problem solve, and learn to discipline themselves.

Community Resource Sharing

Did anyone bring in anything for the resource table? (IF YES, HAVE THEM SHARE WHAT IT IS AND SOME INFO ABOUT IT) Has anyone used any helpful resources this past week that they would like to share with everyone? (5 minutes)

Homework Review

We are going to start by reviewing what we did last week. We'll go around the room and ask each group for one thing that we covered last week. Ok, Group One, can someone tell me one concept that we went over last week? (Go around room).

Pull out your home assignment sheets from last week and then turn to page 11 in your manual, to where it says Home Assignment Review Topics.

Now, in your groups, talk about how you gave balanced attention to each of your children this week. What sort of obstacles hindered you from giving attention to all of your children? What did you do to solve these problems? Give an example of how you selectively ignored a behavior that you found disruptive. Talk about what you thought to yourself to prevent giving in to your child. Group leaders should write down examples that are given. (10 minutes)

Group One, can you tell the larger group about one of the ways a member of your group used the balanced attention strategy we discussed last week? Group two, any different way? (Ask some groups). Obstacles and solutions (Other

groups). Selective ignoring example? (Ask some groups). Self talk? (Ask other groups). (10 minutes)

Videotape segment one

Now we are going to move on to the video section of this session. Look at page 11 in your manual. Please watch the video, and try to pick out any errors that you see the parent on the video makes. (Show 1st video)

What you are going to do now is discuss the types of errors and their consequences that you saw in the videotape in your groups.

Group One, could you share one of the errors and its consequences that your group found? Does everyone agree on this error? Group Two? (Go around room) (Be listing them...see **error description p. 77)** (10 minutes)

Now that we've listed some errors, in your groups, suggest an alternative to each error. You should ask yourself "What advice would I have for the parent on the tape" or "What would have been a better approach to this situation?" Then, talk about the advantages of using the alternatives you suggested, rather than the ones that were used on the videotape. Ask yourselves "What lesson would this teach?" or "What are you saying to your children?" or "What difference might this make if you used it consistently over several years?"

What sort of alternative strategies did you come up with, Group One? (Be listing them) What is an advantage of this strategy? (Be listing them) (Go around room) (10 minutes) (**Alternative strategies listed on p. 79)**

Leader Models Strategy (use page 79 scenario) (5 minutes)

Application Exploration

Now, turn to page 12 in your manual. We are going to think of transitional warnings that we can give our children. An example of a transitional warning would be "In 5 minutes it will be time to take a bath." or "When the phone rings in the next few minutes it will be time to play in the other room." Go ahead and think of 10 different warnings in your groups that you can give to your child to warn them what will be happening in the future. (5 minutes)

Now, we are going to list when-then and if-then statements in the chart just below the one you were working on. An example of a when-then statement would be "When you pick up the toys in the living room then you may play outside.". An example of an if-then statement is "If you turn off the television then you may have a snack." In your groups, try to think of ten other when-then and if-then statements. (5 minutes)

Group One, could you give me one example of a transitional warning that your group thought of? Does this sound like a good thing to say to your kids? (Go around room) Group One, could you give me one example when-then/if-then statement? (Go around room) (5 minutes)

Role Playing

OK, break yourselves into groups of two for this next exercise. We are going to pretend to be parents and kids again. You should practice using

transitional warnings and when-then or if-then statements. For example, if the parent says “In five minutes it will be time to turn off the television and make your bed”, the person playing the child should respond and then the “parent” should wait a few moments and pretend that five minutes has been up. Then the parent should remind the child that it is time to turn off the television and say a when-then statement to the child, such as “when you are finished making your bed, you may have a snack”. When the child follows through with the request, reward the child. (10 minutes)

Now switch (10 minutes)

Turn to your partner now, and tell them which strategies you thought that they did well.

5 Minute Break

Video segment two

Now we are going to move on to the second video section of this session. Turn back to page 11 in your manual. Please watch the video, and try to pick out any errors that you see the parent on the video makes. (Show 2nd video)

In your groups, discuss the types of errors and their consequences that you saw in the videotape.

Group One, could you share one of the errors and its consequences that your group found? Does everyone agree on this error? Group Two? (Go around room) (Be listing them...see error description p. 90) (10 minutes)

Now that we've listed some errors, suggest an alternative to each error. You should ask yourself "How would I handle this situation?" or "What would have been a better approach to this situation?" Then, talk about the advantages of using the alternatives you suggested, rather than the ones that were used on the videotape. Ask yourselves "How would the child respond to different alternatives?" or "What would different approaches say to your children?" or "What difference might this make if you used it consistently for several years?"

What sort of strategies did you come up with, Group One? (Be listing them) What is an advantage of this strategy? (Be listing them) (Go around room) (10 minutes) (Alternative strategies listed on p. 91)

Leader Models Strategy (use page 92 scenario) (5 minutes)

Application Exploration

Now, turn to page 13 in your manual. We are going to think of situations where your child forgets rules or acts without thinking that you might plan ahead for. An example would be if your child always seems to yell for you while you are talking on the phone. Go ahead and think of 10 different situations that you can help your child to plan for. (5 minutes)

Now, we are going to pick one of the situations you just listed and develop a planning strategy. Fill in the chart just below the one you just filled out. Talk about the sorts of things that are listed on the chart, such as when a good time to plan ahead would be and what sort of thing to say to your child. (5 minutes)

Group One, could you give me the example that you made a planner for? (Go around room) (5 minutes)

This is really going well. Lets take a quick 5 minute break before we go on to the next part of our session.

Role Playing

OK, break yourselves into groups of two for this next exercise. We are going to pretend to be parents and kids again, just like earlier. You should practice planning with your child for situations like the ones you just discussed. The person playing the parent should bring up the rule or request that should be remembered and have the person playing the child repeat the rule. Then, pretending that the situation is about to occur, the parent should remind the child of the rule and have the child repeat it. Then, during the situation, whoever is playing the child should slip up and forget the rule. The parent should nicely remind the child of the rule, who then does what the parent says. Then the parent should reward the child when the situation is over. You may begin by thinking of a situation, and then acting it out. (10 minutes)

Now switch (10 minutes)

Turn to your partner now, and tell them what you thought that they did well.

Homework planning

We are going to talk about how we can begin to apply these new skills at home. It is good to apply these strategies as often as possible. You should

remember that you should not expect an immediate improvement in your child's behavior. Often, children take a while to adjust to new ideas and discipline.

Turn to page 14 in your manual. On your own, fill in 5 transitional warnings that you want to try this week. This is just like the exercise we did earlier. You can use some of the examples your group came up with, or think of new ones you'd like to try out.

Now, on your own, fill in 5 situations when/then or if/then statements that you could use this week.

Next, think of 5 situations where you could use a planning ahead strategy and fill those in on page 15 of your manual. (10 minutes)

Think about a location in your home where you could put up these sheets to remind you all through your week. Make sure you give yourself a checkmark every time you use a transitional warning, a when/then or if/then statement, or a planning ahead strategy. Maybe you could set a goal for yourself, such as 20 checkmarks. If you get that goal, you could give yourself a treat, such as a warm bath away from the kids or a big ice cream cone.

Now, it would be great practice for you if you used one of these strategies on the way home. Think of a situation where you could use one of these strategies on the way home tonight.

Closing & Questions