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Common Sense Parenting (CSP) Learn at Home Kit: A Clinical Effectiveness Evaluation of a Commercially Available Video Training Program for Parents

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COMMON SENSE PARENTING (CSP) LEARN AT HOME KIT: A CLINICAL EFFECTIVENESS EVALUATION OF A COMMERCIALLY AVAILABLE VIDEO TRAINING PROGRAM FOR PARENTS

by

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Sean T. Smitham, Ph.D.

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Much has been made of the gap between psychotherapy research and clinical practice. Most current psychotherapy research is focused on what could be viewed as macro-level efficacy type issues, while practicing clinicians are often most concerned with micro-level effectiveness questions. The current study - an evaluation of a parent training (PT) program provides an example of how scientist-practitioners can contribute meaningfully to psychotherapy research by conducting small scale clinical effectiveness studies. Parent Training (PT) is a well established efficacious treatment approach for child disruptive behaviors and non-compliance. Recent research has also established that self-administered videotape PT programs may also be efficacious. A popular, commercially available, self-help video training program for parents – the Common Sense Parenting: Learn-at-Home Kit published by Boys Town Press – was the subject of this study. The results indicate that the CSP Learn-at-Home Kit was largely ineffective in reducing child disruptive behaviors. Results are discussed in the context of the efficacy/effectiveness distinction and the clinical research/clinical practice gap. Hypotheses about why the CSP Learn-at-Home program may be minimally effective are provided.

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Chapter 1

Introduction

"At present, clinical research has little or no influence on clinical practice. This state of affairs should be particularly distressing to a discipline whose goal over the last 30 years has been to produce professionals who would integrate the methods of science with clinical practice to produce new knowledge. (p.147)" - D.H. Barlow (1981)

Despite the prolific output of psychotherapy research over the last 50 years, the clinical activities of most psychotherapist remain largely unaffected by findings from empirical research. However, there is a growing number of psychotherapists trained as scientist-practitioners who provide direct clinical care. They ply their wares in the gap that exists between clinical research and clinical practice – some surviving, some thriving amidst the creative tension between psychotherapy research and psychotherapy practice. Many, like the author, are interested in applying their training not only in the service of providing the most effective treatment possible for clients, but also in contributing meaningfully to the scientific and philosophical discourse surrounding the art and science of therapy. The current study is an attempt to meet both goals by serving as: a) a model for the type of effectiveness evaluations that may be feasible for busy clinicians and b) a catalyst and data point for furthering the discussion concerning the relationship between psychotherapy practice and psychotherapy research. The related domains of child conduct problems and parent training provide the context for this investigation.

Conduct problems in children (including minor compliance problems like whining, tantrums, backtalk, and failure to follow adult instructions) are one of the

most frequent reasons for clinical referrals in child and adolescent treatment service settings accounting for one-third to one-half of referral cases in those settings. One of the most effective treatments for child conduct problems is Parent Management Training (PMT) or simply Parent Training (PT).

Parent training is traditionally provided through individual consultation with a therapist or a group training format. Both training formats have utilized videotape technology - either to provide specific performance feedback to individuals or illustrate correct and incorrect use of parenting skills. However, training parents using videotape technology in this manner is quite expensive as it requires a trained professional to provide specific coaching during the review of the tape. Recent research has established the efficacy of a self-administered videotape modeling training program for parents; however, the program is still rather expensive and it is not widely available to parents. By contrast, there are a number of commercially produced, reasonably priced parent training videos that profess to provide effective parenting strategies and incorporate videotape modeling of these strategies. These "self-help" parenting tapes are readily available and relatively inexpensive, yet very little research has been conducted on the effectiveness of these programs. A systemic evaluation of the effectiveness of these programs would seem valuable given the increasing need for efficient and effective parenting interventions, driven by the disturbing observations that many parents who could benefit from parent-training services never seek services, never follow through in obtaining those services when they are recommended, or terminate training early. This study attempts to evaluate the effectiveness of a commercially produced, self-administered video training program associated with a popular self-help parenting book - "Common Sense Parenting" (CSP) published by Boys Town Press. Thus, some of the same outcome measures used in previous PT efficacy studies are used in this effectiveness trial.

Chapter 2

Literature Review

Conduct problems exhibited by children are currently the greatest social concern faced by parents and caregivers in the United States (McMahon & Wells, 1998). Defiant, oppositional, and aggressive behavior problems comprise the most frequent referrals for clinical and school based services - accounting for one-third to one-half of clinic referrals for children (Kazdin, 1987). Research has shown that aggressive and non-compliant behaviors observed for young children at home predict similar problems at school and tend to remain stable over time (Reid, 1993). Moreover, young children who engage in high levels of aggression across multiple settings have an elevated risk of developing persistent behavioral, academic, emotional, and social problems later in life (Miller & Prinz, 2003). Children who display early-onset conduct problems are at greater risk for long term negative consequences that include substance abuse, unemployment, marital problems, divorce, car accidents, physical problems, and welfare dependence (Kazdin, 1987; Reid, 1993). In addition, unmanageable conduct and related problems are associated with a large and growing population of youth being placed in out-of-home care, the most common of which is group residential care (Friman, 2000). The prolonged exposure of youth displaying pervasive and persistent conduct problems to special assistance from school, mental health, and criminal justice systems results in tremendous societal cost (Kazdin, 1987; 1997).

2.1 Historical Overview

Behavior Modification, the broader discipline that eventually gave rise to Parent Training, developed in the 1920's, flourished for a short time, and then was driven underground by the ascendance of psychoanalysis. The discipline reemerged in the early 1960's due in large part to its notable success in treating what were considered intractable problems (Graziano & Diament, 1992). Parent Training marked a profound shift from the traditional, psychoanalytic one-to-one, therapist-client model of care that dominated psychotherapy at the time. This paradigm shift was driven in large part by the growing need for child treatments that were more successful than traditional psychodynamic approaches.

Psychologists in the late 1960's and early 1970's were alarmed by the large number of children in need of services. It was well understood that in order to change behavior reliably, and maintain that change from day-to-day, interventions frequently had to occur in the natural environment of the subject. Researchers reasoned that only teachers and parents had sufficient numbers and access to deal with the problems of children (O'Dell, 1974). This line of reasoning was further bolstered by the findings of a young researcher by the name of Gerald Patterson and his colleagues (Patterson, Littman, & Hinsey, 1964). After studying children displaying disruptive behaviors, Patterson and colleagues concluded that contingencies in the child's social environment, rather than internal psychological traits, were most responsible for the child's adjustment problems. They suggested that retraining the child's parents may not only be desirable but often absolutely necessary.

Patterson published the first widely used parent training book in 1968 (Patterson & Gullion, 1968). The following decade saw the emergence of a new kind of self-help book focused on the challenges of parenting (e.g., Patterson, 1971; Christophersen, 1982). Since then, a steady stream of parenting books has proliferated the self-help market (Latham, 1994; McIntire, 1996; Forehand & Long, 1996; Gottman & DeClaire, 1998; Christophersen & Mortweet, 2003).

Incorporating the parent as the change agent was intended to provide improved access to the child's natural environment; more reliable and valid information; better generalization, maintenance, and prevention; and improved cost efficiency (see Graziano & Diament, 1992, for review). Once researchers demonstrated that parents could learn behavioral principles and apply them to change the behav-

ior of their children, they began to investigate the effectiveness of PT in ameliorating a variety of child behavior problems and focused on the most effective and efficient means of training parents. PT has been applied to non-compliant children (Forehand & King, 1977), children who are developmentally disabled (Hudson, 1982), hyperactive children (Bor, Sanders, & Markie-Dadds, 2002), children with eating or medical problems (Bigelow & Lutzker, 2000), and children with specific behavioral problems (Forgatch & Toobert, 1979). The following sections, while not an exhaustive review, discuss key findings in the use of PT to treat childhood noncompliance and the use of various training formats to teach parents new skills.

2.2 Parent Training for Non-compliant Children

While there is no universal standard parent training protocol, many of the most effective and empirically supported versions target similar parenting behaviors. Different parent training packages differ primarily in where they place their emphasis. Parenting behaviors frequently emphasized are: giving effective directions, noticing and rewarding good behavior, using non-coercive discipline, monitoring child activities, communicating about emotions, and problem solving. While more recent research has focused on validating the efficacy of different parent training packages, early parent training research focused on evaluating the effectiveness of its various components. Knowledge of key findings in this area is valuable when assessing the relative strengths and liabilities of current parent training packages. The following paragraphs provide an overview of important discoveries in early parent training research.

Most parents seek parent training in order to reduce child disruptive and/or non-compliant behaviors. Early research established that training parents to use time-out (TO) and extinction procedures proved effective in reducing child noncompliance (Day & Roberts, 1983;Hamilton & MacQuiddy, 1984;Hobbs, Walle, & Caldwell, 1984;Roberts, 1988;Walle, Hobbs, & Caldwell, 1984). These findings flew in the face of a pervasive popular belief among parents that physical punishment is more effective than other forms of punishment in decreasing problem behavior. In fact, research demonstrated that the addition of a spanking contingency is no more effective than a simple barrier or a TO room (Day & Roberts, 1983;Roberts, 1988). And while contingent maternal attention to child compliance is commonly

used as a therapeutic tool in parent training packages, it is relatively ineffective (as a stand alone treatment) in decreasing noncompliance (Forehand, 1986;Hobbs et al., 1984;Roberts, 1985;Walle et al., 1984). These findings validate training in TO procedures but cast doubt on the common practice of using differential reinforcement of others (DRO) and physical punishment (e.g., spanking) as the sole means for decreasing non-compliant behavior (Graziano & Diament, 1992). However, social reinforcement (contingent and non-contingent attention) preceding TO has been shown to enhance TO effectiveness (Hobbs et al., 1984;Walle et al., 1984), and may increase the social validity of a parent training package.

2.3 Training Methods

A variety of presentation methods have been used to teach parents new skills including: individual training, group training, didactic instruction, didactic instruction plus modeling, didactic instruction plus modeling and behavioral rehearsal, audiotape instruction, and videotape. Early clinical work with PT utilized didactic instruction, modeling and role playing (Hudson, 1982; Rickert et al., 1988) and usually involved teaching one parent or one set of parents at a time. As technology evolved, clinical researchers experimented with ways to deliver immediate coaching and feedback to parents during practice sessions utilizing new technology such as the "bug in the ear" device (e.g., Eyberg, 1988).

As the need for PT grew, researchers began to explore other means of teaching parents in search of the most efficient and effective method possible. Parent Training groups and classes were formed and they relied heavily on verbal methods utilizing classroom style didactic lectures, written supplementary materials, and group discussion (Webster-Stratton, 1996). Group versus individual training procedures have been compared with no significant difference found in outcomes (Brightman, Baker, Clark, & Ambrose, 1982; Pevsner, 1982; Webster-Stratton, 1984). Keating, Butz, Burke, and Heimberg (1983) found that training parents and children at home, in the office, or parents alone at home resulted in equally effective treatment of children's enuresis. Manuals and written advice packages have been used to successfully teach parents to effectively manage specific problem behaviors. Giebenhain and O'Dell (1984) used a written manual and advice package to teach parents how to reduce children's bedtime fears. Children's troublesome and

inappropriate behaviors in restaurants have been reduced through written "advice packages" for parents, and improvement generalized to a second restaurant (Bauman, Reiss, Rogers, & Bailey, 1983; Green, Hardison, & Greene, 1984). Perhaps as a result of this early research, it is difficult today to find a child or family therapist who provides in home parent training, and almost every therapist regardless of their specialty uses some form of written material for clients.

While didactic methods have been found to be a cost efficient means of disseminating information, they have been shown to be largely ineffective in inducing behavioral changes in non-clinic referred parents (Webster-Stratton, 1981). In addition, these methods may be inappropriate for populations which could benefit the most from PT - parents whose literacy, educational, occupational, or general intellectual levels are deficient. By contrast, more active, performance based methods have proven to be effective in producing behavioral changes in parents and children (O'Dell, 1985). Baker and colleagues (Baker & McCurry, 1984; Prieto-Bayard & Baker, 1986) evaluated a PT program that emphasized active rather than didactic procedures and provided training in the parents' native language with a population of high risk (low SES, ESL) parents. They reported improvement in parental knowledge and mixed improvement in child functioning at post-training. It is interesting to note that in at least one study (O'Dell et al., 1982) demographic characteristics and reading level were related to outcome not only for those parents receiving didactic written instruction but also for those parents receiving live modeling and rehearsal training. Based on the results of the study, O'Dell and colleagues suggested that videotape training appeared to be more consistent in training a wider range of parents. Hypothesizing that parents could enhance their parenting skills by viewing and modeling videotape examples, Carolyn Webster-Stratton initiated a program of research, in 1979, to develop and evaluate a videotape modeling program for parents (Webster-Stratton, 1996).

Videotape modeling, it was believed, would be more conducive to learning for parents less verbally facile, and that this training format would be less expensive than individualized training. If such a program was found to be effective, it would have the added advantage that it could be mass produced and widely disseminated (Webster-Stratton, 1996). Webster-Stratton and colleagues developed their first interactive videotape parent intervention program in 1980. The program was designed for parents of children 3-8 years and consisted of viewing 10 videotapes totaling 26

hours (including 250 parenting vignettes) spread across 13-14 weekly two hour sessions that included group discussions. The program has been shown to: improve parental attitudes and parent-child interactions, reduce parental reliance on violent discipline methods, and reduce child conduct problems (see Webster-Stratton, 1996, for review). A later study (Webster-Stratton, Kolpacoff, & Hollinsworth, 1988) evaluated a totally self-administered condition using the videotape modeling program. Parents had no contact with the therapist and no group support for the entire series of treatment. Parents arrived for the session, were presented with the videotape for that session, and were then asked to view the session in one of the clinic rooms. Results showed that self-administered treatment resulted in significant improvement in parental report of child conduct problems and observed parent-child interactions (Webster-Stratton et al., 1988). While the individually administered treatment was extremely cost effective, it was not as effective as the original program in terms of consumer satisfaction and long-term outcomes (Webster-Stratton, Hollinsworth, & Kolpacoff, 1989).

2.4 The Boys Town Model and CSP

"There are no bad boys. There is only bad environment, bad training, bad example, bad thinking." These are the words of Father Flanagan, the founder of Boys Town, and they embody the spirit found in the various treatment services administered by Girls and Boys Town throughout their continuum of care. Boys Town - and more specifically the Family Home program - is arguably the most famous and effective residential treatment program for troubled youth in the world. The Boys Town Family Home program (BTFH) is a descendant and adaptation of the Teaching Family Model (TFM) created by Mont Wolf and colleagues at the University of Kansas in the late 1960s (Handwerk, Field, & Friman, 2000; Kirigin & Wolf, 1998). Both models rely on married couples to serve as resident Family Teachers. These Family Teachers are trained in basic behavioral principles and interventions, and they are responsible for implementing treatment plans for conduct problem children and adolescents in a family home setting. The TFM consists of 4 principle hallmark components: a behavioral skills curriculum, a motivation system (i.e., token economy), a self-government system, and frequent teaching interactions provided by Family Teachers. The BTFH model adds two additional hallmarks: an emphasis on

moral and spiritual development, and an integration of physical and mental health treatment components (Davis & Daly, 2003).

The CSP curriculum is adopted from the BTFH model and adapted for use by parents in their own homes. The Common Sense Parenting program was created to expose parents to elements of the BTFH model, and thus provide them with tools to parent in a more respectful and effective manner. It stands to reason that such a program might assist youth who have received treatment at Girls and Boys Town in generalizing skills learned there to their natural home environment. In fact, completion of the program by the youth's custodial parent or parental figure is required as part of the youth's treatment. The program is presented in a group format and the class meets for two hours once a week for a total of 6-weeks. For those parents who cannot attend the CSP classes, it is requested that they purchase and view the CSP Learn-at-Home Kit. The CSP program has been shown to result in statistically significant improvements in reported child behavior problems, parental attitude, and overall family satisfaction compared to a wait-list control group (Ruma, Burke, & Thompson, 1996). To the author's knowledge, the effectiveness of the Learn-at-Home Kit has not been evaluated.

Chapter 3

Methods

3.1 Research Design

The first phase of the study involved collecting descriptive, qualitative data regarding the number of referrals per source, number of contacts per source, demographic information of contacts, and rates of attrition at each stage of the process including descriptive data of variables impacting attrition. These attrition variables were assessed using the Ecological Exit Interview (EEI). It was hypothesized that this information would be valued by outside referral agencies, and thus make it more likely that they would allow the author to post recruitment materials in their public areas. Due to the poor response to recruitment efforts at outside agencies, and to the low overall response to the study, specific qualitative data regarding contacts per source, rates of attrition, and variables affecting attrition were not collected. Demographic information for families participating in the study was collected, however, and those data are presented in the results.

The second phase of the study utilized a multiple baseline across subjects design. Initial parent meeting times were coordinated across parents in order to establish overlapping baseline phases and treatment start dates were staggered for comparison purposes. Ideally, in such a design phase changes for individual parents would be based on stability of the primary dependent variable (in this study, the Parent Daily Report (PDR) data). However, due to the outpatient applied nature of this research, demands on the parent's schedule determined when they'd be able to start the treatment phase of the study. A more complete description of the study

and the dependent measures follows.

3.2 Subjects and Setting

Subjects were parents of children age 3-7 years who reported that their child displayed difficult or disruptive behaviors and compliance problems. While neither the recruitment materials nor the author specified which parent would participate in the study, each parent-child dyad participating in the study consisted of a mother and her child. Eight mothers and their children (6 boys, 2 girls) completed the study.

Pre-treatment and post-treatment assessment took place at the Girls and Boys Town Outpatient Clinic in a standard therapy room. The room was equipped with a desk and chairs for the parent to complete the written assessment measures. A small video camera was set-up on a shelf in a corner of the room, and a variety of toys were placed in the opposite corner. During videotaped parent-child interactions, parents were asked to confine their play with their child to the front half of the room in order to ensure interactions would be captured by the video camera. Daily data collection occurred over the phone by calling the mother at home or at work during a time that was convenient for her. During the treatment phase, the mothers viewed the CSP videotape sessions in their own home.

3.3 Recruitment

Advertisement for the study initially consisted of stacks of numbered brochures distributed around the community to various child-oriented agencies and public locations (e.g., pediatric dentist offices, public libraries, day care centers). Many of these agencies refused to place the brochures in their public areas. In total, 6 different agencies agreed to place 20 numbered brochures in each of their public areas. This initial recruitment strategy resulted in zero phone calls from interested parents in the three weeks following the distribution of brochures. The second recruitment strategy involved placing a classified ad within the Girls and Boys Town (GBT) weekly electronic newsletter distributed to employees of GBT working in various capacities at affiliate child oriented facilities spanning Girls and Boys Town's continuum of care (e.g., National Research hospital, pediatric clinic, residential treatment center). In the week following the placement of the ad, researchers received calls

from 20 families interested in participating in the study.

3.4 General Procedure

3.4.1 Phase 1

When interested parents called to find out more information about the study, the author provided a brief overview of the purpose of the study, collected contact information from the parent, and obtained verbal consent to proceed with phase 1 data collection. Once verbal consent was obtained, the author completed a brief demographic/family data interview with the parent over the phone. At the conclusion of this initial interview, the author scheduled an initial meeting with the parent. The entire telephone call took less than 10 minutes.

3.4.2 Phase 2

The initial meeting served as the "kick-off session" for phase 2 of data collection. During the initial meeting, the parent along with their child, met the author at the Girls and Boys Town Outpatient Clinic. The author presented the rationale for the study, explained the general time line and procedures involved, reviewed the informed consent document, and obtained the first set of baseline measures. These measures included: the Eyberg Child Behavior Inventory (ECBI; Eyberg & Ross, 1978), the Parent Daily Report (PDR; Chamberlain & Reid, 1987), and the Parenting Stress Index (PSI; Abidin, 1995). After these measures were complete, the author instructed the parent on the procedure of the videotaped parent-child interactions (V-PCI; using DPICS-R, Webster-Stratton, 1984). The videotaped interactions included three separate 5-minute conditions (child game, parent game, and clean-up). This first session lasted approximately 60 minutes. At the end of this session, the author established a specific time to call the following day to complete the PDR. Each subsequent PDR call ended with the author establishing a specific call time for the following day.

The parent returned with their child approximately 3-7 days later to obtain their CSP-Learn at Home Kit. This return date was initially to be based on the stability of the PDR data. Due to the nature of conducting research in an applied setting, however, the date was determined primarily by demands on the mother's

schedule. During this second meeting, the parent completed the ECBI, PDR, and the V-PCI. Following the completion of these measures the parent was given a copy of the CSP-Learn at Home Kit from the author. The parent was instructed to view at least two 30-minute video segments a week and no more than two per day. A time for the next day's PDR call was scheduled at the end of the session. The author attempted to schedule a last treatment session if: the parent had viewed all videotape sessions, the parent decided they no longer wanted to view the videotape sessions, a period of two weeks passed with no videotape sessions being viewed, or a total of three weeks had passed since the parent had received the CSP Learn at Home Kit.

The parent and child attended the third and final treatment session together, and the structure of this session was very similar to the first. The parent completed the ECBI, PDR, and PSI. In addition, the parent completed a Consumer Satisfaction Survey (CSS) and along with their child completed the final V-PCI. The author then informed the parent that they would be receiving their gift card and consultation certificate in the mail within the week. In addition, the parent was told they would receive a follow-up phone call one month after the last treatment session, during which the author would collect PDR data over the phone.

3.5 Independent Variable

The independent variable for this study was the Common Sense Parenting (CSP) Learn at Home Kit. The CSP Learn at Home Kit consists of two videotapes (each containing three 30 minute lessons) and a workbook to use in conjunction with the lessons. The workbook is 172 pages long and consists of an introduction, six chapters (each corresponding with a videotape lesson), two appendices, and an index. Each chapter concludes with a section of frequently asked questions (and answers), exercises to test knowledge acquisition, and homework assignments to put the skills into practice. Subjects were considered to be "in treatment" the day following their second meeting when they received the CSP kit. During daily PDR calls in the treatment phase, the author noted when video segments were viewed by the mother. Table B.1 provides a brief content description for each video lesson.

3.6 Measures/Dependent Variables

The primary dependent variable for this study was the PDR. More specifically, the Total Behavior score of the PDR. The primary target of the intervention was to reduce the amount of disruptive behavior exhibited by the child. Measures of parental perception of the problem behavior, perception of life stress, and satisfaction with the intervention were also administered.

3.6.1 Parent Daily Report (PDR)

The PDR consists of 33-items describing negative or disruptive behaviors commonly exhibited by children. The PDR is administered in person or over the phone, with the author asking "In the last 24 hours has (child's name) been" inserting the specific problem behavior following the statement. For example, parents would be asked, "In the last 24 hours has Johnny been aggressive? In the last 24 hours has he argued?" and so on. The parent gives a "yes" or "no" response. Total affirmative answers are summed to yield a Total Behavior score. Items previously identified by the parent as particularly troublesome are then summed to yield a Target Behavior score. The PDR was administered daily by the author via phone calls made to each family. Previous studies have reported the test-retest reliability of the PDR to range from .62 to .82 (Chamberlain & Reid, 1987).

3.6.2 Eyberg Child Behavior Inventory (ECBI)

The ECBI is a 36-item inventory applicable for children 2-16 years, which measures parental perceptions of their children's behavior problems. Each of the 36-items is assessed on two dimensions: the frequency of problem behavior occurrence and identification of the behavior as a problem for the parent. Frequency ratings range from (1) "never occurs" to (7) "always occurs". Frequency ratings are summed to yield an overall disruptive behavior Intensity Score. The problem identification dimension asks the parent to rate whether each item is a problem for them by circling "yes" or "no". Affirmative answers are summed to yield a total Problem Score. Previous research has obtained reliability coefficients for the ECBI scales of .86 (test-retest) and .98 (internal consistency). The measure has also been shown to differentiate non-clinic from clinic referred populations and to correlate well with

independent observations of children's behaviors (Eyberg & Ross, 1978; Robinson, Eyberg, & Ross, 1980).

3.6.3 Consumer Satisfaction Survey (CSS)

The CSS used in this study is a 6-item qualitative open response survey developed by the author. Questions were based on common questions used to evaluate customer perceptions of various products and services. The CSS asks parents to list the tips and suggestions from the "CSP-Learn at Home Kit" they found most helpful, least helpful, their overall experience with the project, and tips and suggestions for improvement. Parental responses are presented in the Appendix.

3.6.4 Family Data Questionnaire (FDQ)

The FDQ was developed by the author to serve as an initial screening instrument and to gather information on the family home environment. This 12-item qualitative measure provides information on: whether the target child meets inclusion criteria for the study, the number of individuals living in the household (including their age, occupation, and relation to the target child), the marital status of the parents, estimated annual household income, education level of the parents in the household, and a brief description of the problem behaviors exhibited by the target child.

3.6.5 Parenting Stress Index - Third Edition (PSI)

The PSI is a 120-item parent self-report measure designed to identify potentially dysfunctional parent-child relationships. The PSI is designed for the early identification of parenting and family characteristics that fail to promote normal development and functioning in children, of children with behavioral and emotional problems, and of parents who are at-risk for dysfunctional parenting. Developed on the theory that the total stress a parent experiences is a function of certain salient child characteristics, parent characteristics, and situations that are directly related to the role of being a parent the PSI yields a global Total Stress score, Child Domain score, Parental Domain score, and Life Stress score. Past research has linked PSI scores to observed parent and child behaviors and to child's attachment style and social skills (Abidin, 1995).

Chapter 4

Results

Subjects were run in matched cohorts based upon their first date of data collection. Cohort 1 consisted of Subjects 03, 05, and 02. Cohort 2 included Subjects 01 and 06. Subjects 08, 11, and 10 comprised Cohort 3. In order to facilitate comparison of data between subjects and reflect the multiple baseline nature of the design, all figures are grouped according to cohort. Table B.2 includes mean scores for PDR Total and Target behaviors for both baseline and treatment phases. Results for ECBI and PSI pre- and post-intervention are presented in Table B.3, B.4 and B.5 respectively. An overview of the specific results obtained for each subject is presented below, a more detailed discussion follows in the next section. Subjects are presented by cohort and thus fall out of numerical order in terms of their assigned subject number.

4.1 Subject 03

Subject 03 is a 37-year-old married mother of three who works as a nurse. Her husband is also 37-years-old and works as an architect. Their annual household income is approximately $90,000. The highest level of education achieved by Mom was a bachelor's degree and Dad obtained his Master's degree. Their children include a 6-year-old son (the identified patient (IP)), a 4-year-old son, and an 18-month-old daughter.

PDR data showed a sharp decelerating trend before intervention and a slight decelerating trend post intervention. There was a noticeable decrease in the mean number of total problem behaviors endorsed on the PDR during baseline and treat-

ment conditions, though the sharp decreasing trend during baseline coupled with the wide variability in scores during intervention make it difficult to interpret this difference. There is no clear change in level between the two phases. The frequency of target behaviors remained relatively stable across both phases (Figure A.1). The ECBI Intensity score at post-treatment (T3) was unchanged from baseline (T1) level while the Problem score declined over the course of the study (Figure A.2). Examination of the PSI data reveal that the subject's level of Life Stress remained unchanged after treatment. There was a slight decrease in child related stress while there was a noticeable increase in total stress experienced due largely to the sharp increase in parent and spouse related stress (Figure A.3).

Based on visual inspection of the data, one could conclude that the intervention had a paradoxical effect slowing the rate of change in daily disruptive behavior that was already occurring. Parental perception of disruptive behavior intensity increased from treatment inception (T2) to treatment completion (T3). Perception of intensity at the end of treatment was the same as the initial intensity perception at the beginning of the study. The number of disruptive behaviors considered to be problematic decreased steadily over time - providing little evidence of a positive treatment effect functioning independent of time. Parental ratings of disruptive behavior intensity and problems fell within the normal range at study entry (T1), treatment onset (T2), and treatment completion (T3). Following intervention, the level of reported parental stress increased substantially leading to a similar increase in total stress. However, all scores still fell within the normal range. Treatment thus does not appear to have been helpful, but it does not appear to have made matters worse.

4.2 Subject 05

Subject 05 is a 35-year-old married mother of four who works as a medical assistant. Her husband is a 41-year-old general laborer. Their annual household income is $25,000-30,000. Mom has earned her associates degree and Dad earned his GED. Their children include a 13-year-old son, a 10-year-old son, a 9-year-old son, and a 4-year-old daughter (the IP).

PDR data show a prominent downward trend before intervention and a slight accelerating trend post intervention. There is a slight decrease in the mean number

of total problem behaviors endorsed on the PDR between baseline and treatment conditions, though the degree of variability is about the same within both conditions. There is no clear change in level between the two phases. The target behavior scores were noticeably lower during the intervention phase, although equally low scores were present during the last two days of baseline (Figure A.1). The ECBI Intensity and Problem scores were highest immediately before treatment, but post-treatment scores were almost equivalent to initial scores (Figure A.2). PSI domain score analysis reveals a noticeable decrease in current Life Stressors, Total Stress, and a significant decrease in the Child Domain scores. Parental Domain scores remained about the same (Figure A.3).

Based on visual inspection of the data, one could conclude that treatment was ineffective in changing daily disruptive behaviors exhibited by the youth. Parental perception of disruptive behavior intensity stayed relatively constant from entry into the study through treatment completion. The number of behaviors viewed as a problem by the parent was relatively unchanged from study entry to treatment completion. The parents total reported stress fell to within normal limits after treatment, with a significant decrease in stress related to child characteristics. However, this change coincided with a decrease in life stressors making it difficult to determine if positive changes in stress level were due to treatment specific variables or other ecological variables. Based on the convergence of data, treatment would appear to have been ineffective for this subject.

4.3 Subject 02

Subject 02 is a 26-year-old single mother of one who works as an office assistant. Her annual household income is approximately $17,000. She has earned her high school diploma and is taking night classes at a local college. Her son is 3-years-old.

PDR data show a wide range a variability within both baseline and treatment conditions. There is no clear difference in the mean number of total problem behaviors endorsed between baseline and treatment conditions. There is a very slight accelerating trend during baseline and a slightly more noticeable downward trend during treatment. There is no clear change in level between phases, and target behavior scores remained consistent across both conditions (Figure A.1). The ECBI Intensity and Problem scores were highest immediately prior to treatment and re-

mained above the clinical cut-off level at post-treatment (Figure A.2). PSI data analysis suggests that the subject's level of stress - already extremely high during baseline - increased across all four domains between T1 and T3 (Figure A.3).

Based on visual inspection of the data, treatment appears to have been ineffective in decreasing the number of daily disruptive behaviors exhibited by the youth. Parental perception of the intensity of disruptive behaviors and of the number of disruptive behaviors judged to be a problem was identical at study entry and the beginning of treatment. Very slight improvement can be seen at treatment termination, although both the intensity and problem score remained in the clinically distressed range. Parental stress increased and remained in the clinically distressed range following treatment. Convergence of the data suggests that treatment was ineffective and may have had iatrogenic effects.

4.4 Subject 01

Subject 01 is a 22-year-old married mother of two who works as an office assistant. Her husband is 24-years-old and works as a general laborer. Their annual household income is approximately $22,000. Mom has earned her high school diploma and Dad has completed some college courses. Their children include a 5-year-old son (the IP) and a 2-year-old son.

PDR data show an accelerating trend during baseline and a slight decelerating trend during treatment. There is no clear difference in the mean number of total problem behaviors endorsed between baseline and treatment conditions. There is a high degree of variability for total behaviors endorsed within both the baseline and treatment conditions with no clear difference in level between the phases. There is a slight decelerating trend for target behaviors during baseline and that trend continued during treatment (Figure A.4). The ECBI problem score was highest just prior to treatment, and both the Intensity and Problem score remained above the critical cut-off level at post-treatment (Figure A.5). PSI data analysis reveal that the subject's current Life Stressors increased between pre- and post-treatment while Total Stress decreased largely due to a significant decrease in the Parent Domain score. The Child Domain score remained about the same between pre- and post-treatment (Figure A.6).

Based on visual inspection of the data, one could conclude that the inter-

vention had very little to no effect in reducing the amount of disruptive behavior exhibited by the IP on a daily basis. There was little to no change in parental perception of the intensity and problematic nature of the child's behavior from study entry to termination. Parental ratings of the child's disruptive behavior still fell within the clinically distressed range following treatment. Following intervention, the level of reported parental stress fell from clinically distressed levels to well within the normal range helping to lower the parent's total stress level to just below critically distressed levels. While treatment does not seem to have effectively lowered daily disruptive behavior, it may have helped lower parental stress in spite of the fact the subject reported additional life stressors at treatment termination. Convergence of the data would suggest that treatment was minimally effective.

4.5 Subject 06

Subject 06 is a 40-year-old married mother of three who works as a department manager. Her husband is also 40-years-old and works as a construction manager. Their annual household income is $80,000. Both parents have earned their bachelor's degree. Their children include a 7-year-old son, a 4-year-old son (the IP), and an 11-month-old daughter.

PDR data inspection reveals a decelerating trend during baseline that continues during the treatment condition. There is a noticeable difference in the mean number of total problem behaviors endorsed during baseline and treatment conditions. There is a high degree of variability during both baseline and treatment conditions, with no clear change in level between the two conditions. There is a noticeable difference in target behavior means between baseline and treatment conditions (Figure A.4). ECBI Intensity and problem scores were highest during baseline assessment and lowest at post-treatment. However, a downward trend in Problem scores is evident prior to treatment (Figure A.5). PSI data inspection shows all four domains below the clinical range at pre-test and a noticeable decrease in three of the four domains at post-test (current Life Stressors remained about the same) (Figure A.6).

Based on visual inspection of the data, one could conclude that the intervention had a slight effect in reducing the amount of disruptive behavior exhibited by the IP on a daily basis. Or, at least the intervention did not hamper positive changes

that were already taking place. Parent perception of the intensity and problematic nature of the child's behavior decreased from study entry to treatment termination, with parental ratings of the child's behavior moving further into the normative range following treatment. Following intervention, the level of reported parental stress fell further within the normal range with the concomitant effect of lowering the parent's total stress level to well within the normal range. Convergence of the data suggests that treatment was slightly effective - helping to reduce daily disruptive behaviors displayed by the youth as well as reducing parental stress.

4.6 Subject 08

Subject 08 is a 36-year-old married mother of two who works as a research analyst. Her husband is also 36-years-old and works as a credit analyst. Their annual household income is $70,000. Both parents have earned master's degree. Their children include a 9-year-old daughter and a 4.5-year-old son (the IP).

PDR data inspection reveals a very slight decelerating trend during baseline, while a slight accelerating trend is evident during the treatment phase. The mean for total problem behaviors during treatment is slightly greater than the mean during baseline. Variability in total problem behaviors is consistent across phases and there is no clear change in level from baseline to treatment conditions (Figure A.7). ECBI Intensity scores were identical at T1 and T3. ECBI Problem scores were identical across all three time periods (Figure A.8). PSI data inspection shows all four domains below the clinical range at pre-test and post-test, with no change observed in the Life Stress and Child Domains. There was a slight increase in the Parent Domain score leading to a slight increase in the overall Total Stress score (Figure A.9).

Based on visual inspection of the data, one could conclude that the intervention was ineffective in reducing the amount of daily disruptive behavior exhibited by the youth. Parental perception of the intensity of disruptive behaviors and of the number of problematic behaviors were unchanged and within normal limits at study entry, treatment onset, and treatment termination. Parental stress was very low and well within normal limits before and after treatment. Convergence of the data suggests that treatment was ineffective across all dependent measures.

4.7 Subject 11

Subject 11 is a 36-year-old married mother of three who works as an auditor. Her husband is a 33-year-old independent business owner. Their annual household income is $65,000. Both parents are college educated with Mom holding an MBA and Dad earning a Bachelor's degree. Their children include a 6-year-old daughter, a 3-year-old son (the IP), and a 5-month old daughter.

PDR data inspection reveals a clear decelerating trend during baseline, and a very slight decelerating trend is evident during the treatment phase. The baseline mean for total problem behaviors is slightly greater than the treatment mean. Greater variability in total problem behaviors is evident during the treatment phase compared to baseline. There is a slight increase in level from baseline to treatment conditions (Figure A.7). ECBI Intensity score increased between T1 and T2 and fell to its lowest level at T3. ECBI Problem score increased from T1 to T2 then fell at T3 with the T1 score being the lowest overall (Figure A.8). PSI data inspection shows all four domains below the clinical range at pre-test and post-test, with no change observed in Life Stress at treatment termination (Figure A.9).

Based on visual inspection of the data, one could conclude that the intervention was ineffective in reducing the amount of daily disruptive behavior exhibited by the youth. Parental perception of the intensity of disruptive behaviors and of the number of problematic behaviors increased from study entry to treatment onset with both scores falling in the clinically distressed range at treatment onset. Both scores fell to just below the clinically distressed range at treatment completion, although scores at treatment completion were very similar to scores at study entry. Total parental stress increased after treatment, with a substantial increase in stress related to child traits and characteristics. Stress specific to spousal and parental roles decreased slightly after treatment. Convergence of the data suggests that treatment was ineffective but not harmful.

4.8 Subject 10

Subject 10 is a 27-year-old married mother of three who works as a patient representative. Her husband is a 28-year-old truck driver. Their annual household income is $35,000-40,000. Both parents have completed some college class work. Their chil-

dren include a 7-year-old daughter (the IP), a 4-year-old daughter, and a 2-year-old daughter.

PDR data inspection reveals a clear accelerating trend during baseline, and a clear decelerating trend during the treatment phase. The baseline mean for total problem behaviors is clearly greater than the treatment mean. Greater variability in total problem behaviors is evident during the treatment phase compared to baseline. There is a clear change in level from baseline to treatment conditions (Figure A.7). ECBI Intensity scores decreased steadily over T1, T2, and T3. ECBI Problem score also fell steadily from T1 to T3 (Figure A.8). PSI data inspection shows all four domains well above the clinical range at pre-test and post-test, with very little change (Figure A.9).

Based on visual inspection of the data, one could conclude that the intervention was effective in reducing the amount of daily disruptive behavior exhibited by the youth. Parental perception of the intensity of disruptive behaviors and of the number of problematic behaviors decreased steadily from study entry through treatment onset and treatment termination, though scores continued to fall within the clinically distressed range after treatment completion. Total parental stress and stress related specifically to parental responsibilities and roles remained about the same from study entry to treatment completion. Convergence of the data suggests that treatment was effective in reducing the amount of disruptive behavior displayed by the youth, slightly effective in altering parent perception of the problem behavior, and ineffective in reducing parental stress.

4.9 Visual Inspection Summary

Seven out of eight subjects showed a decrease in mean PDR Total Behavior scores from baseline to treatment. Only one subject (Subject 10) showed a clear change in terms of mean, level, and trend. Subject 6 showed a change in level and mean, but the trend stayed the same across phases. Subject 3 showed a change in mean, but not level or trend. Subject 1 showed a clear change in trend, but not level or mean. Thus, via visual inspection one could conclude that Subject 10 clearly improved. The intervention did not hamper the improvements already underway for Subjects 6 and 3 - although it is questionable whether treatment provided any additional benefit. A weak case could be made that intervention kept Subject 1 from getting

worse, but for most subjects the intervention had no noticeable effect on the daily occurrence of child behavior problems.

It is possible, however, that clinically relevant changes occurred across the group that were not captured by the PDR ratings. Perhaps the intervention proved effective in alleviating concerns in other domains. If the intervention was unsuccessful in altering the "doing" (i.e., child behaviors) of the problem, then perhaps it was effective in altering the "viewing" (i.e., parental perception) of the problem. Or, perhaps the intervention was successful in addressing a set of more macro level, ecological variables such as those falling under the conceptual umbrella of "parental stress".

Quick visual inspection of the ECBI intensity score data shows no substantial improvement (in terms of degree of change) for subjects 03, 05, 02, 01, and 08. A slight improvement is noticeable for subject 10 and clear improvements are evident for subjects 06 and 11. In terms of categorical improvement, three subjects that began the study in the clinically distressed range on this scale also ended the study in the clinically distressed range. Four subjects began in the normal range and finished in the normal range. One subject began the study in the distressed range and ended in the normal range, and none of the subjects began in the normal range only to wind up in the distressed range at the conclusion of the study.

Visual inspection of the PSI Total Stress and Parental Domain scores reveal no substantial improvement (in terms of degree of change) for subjects 03, 02, or 11. Subject 5 had a noticeable reduction of stress at treatment termination. Slight improvements in stress level were visible for subjects 01 and 06, while increased levels of stress were noted for subjects 03, 02, and 11. There was no change in parental stress for subjects 8 and 10. Categorically, two subjects began the study in the clinically distressed range of the Total Stress scale and fell to within normal limits at termination. Two subjects began the study in the clinically distressed range and still fell within that range after treatment. Four subjects began the study in the normal range and remained there at treatment termination.

4.10 Clinical Significance

While it is interesting to investigate whether an intervention produces any change in behavior, it is much more relevant and powerful clinically to ask whether any

observed change is actually helpful to the client. Clinicians should concern themselves not only with answering the question "Was change produced?" but also with answering "Was the change produced important or clinically significant?" Clinical significance refers to a level of change following treatment that is both meaningful and reliable. Change is meaningful if a once troubled and clinically distressed individual is, after treatment, indistinguishable (along the dimension of interest) from representative others who are not distressed (Kendall & Grove, 1988). In other words, the individual is returned to a state of functioning that is within the normal range. Change following treatment is reliable if the level of change is unlikely explained by measurement error alone (Jacobson & Truax, 1991; Ogles, Lambert, & Masters, 1996). That is, the change is of sufficient magnitude that it cannot be accounted for merely by the variability inherent in the psychological measure used to evaluate treatment outcome.

Visual inspection of data is adequate for identifying powerful treatment strategies with strong treatment effects - the type of interventions highly valued by all. Visual inspection is also valuable in making categorical judgments regarding treatment effectiveness (i.e., moving from above a clinical cut-off score to below that score). Visual inspection is also less likely to lead to what statisticians refer to as Type I errors - that is, concluding the intervention had an effect when in reality it did not. Unfortunately, visual inspection may not be sensitive enough to detect subtle (but none the less real) treatment effects increasing the chance of making more Type II errors - concluding the intervention had no effect when in fact it did. Thus a clinician relying solely on visual inspection may prematurely abandon an intervention that holds some potential promise. Fortunately, psychotherapy researchers have developed a variety of tools to assist in measuring clinical significance. The following section illustrates the clinical utility of one of these tools - the Reliable Change Index.

4.10.1 Reliable Change Index

The Reliable Change Index (RCI) is defined as the difference between a post-test score and a pretest score divided by the standard error of measurement (SEmeas). The standard error of measurement accounts for the variation or spread of change scores that could be expected if no actual change had occurred. The standard

error of measurement for the following analyses was calculated using the following formula: $SEmeas = SD \times \sqrt{1 - r}$ where SD is the standard deviation from the normative sample for the measure and r is the reliability coefficient for the measure. Traditionally, Cronbach's alpha is used for the r value although alternatively one could use the test-retest reliability coefficient. By convention, an RCI of 1.96 ($p < .05$) would be considered to be reliable. An RCI greater than 1.96 indicates the difference is reliable. In other words, a change of that magnitude on this particular instrument is not likely due to measurement error alone. Conversely, RCI scores of 1.96 or less would not be indicative of reliable change as changes of this magnitude could be due solely to the unreliability of the measure. The 1.96 value reflects a general consensus that "normal" can be defined as scores falling within one standard deviation (SD) of the mean of the non-distressed or normative reference group for that measure. By multiplying 1.96 by the SD of an outcome measure, we can define a 95% confidence interval which may serve as an aid when interpreting results.

RCI scores for the Total Behavior scale of the PDR were calculated based on descriptive statistics of the normal sample ($\overline{x} = 5.33$, $SD = 3.10$, $r = 0.82$, $SEmeas = 1.32$). The SEmeas for the PDR Total Behavior scale was calculated using the test-retest reliability coefficient as the author was most interested in the normative changes that could be expected to occur over time. Based on the findings of Chamberlain and Reid (1987) (1987) suggesting that PDR Total Behavior scores are inflated on Day 1 but highly stable after that, two RCI scores were calculated for each subject. The first (RCI) was calculated using the unadjusted baseline mean. The second (RCIa) was calculated after dropping the first baseline data point for Total Behavior score. RCI scores ranged from 1.29 to -3.56, and RCIa scores ranged from 2.11 to -3.42 (Table B.6). RCI scores suggest that two subjects showed reliable improvement following treatment. RCIa scores reveal two subjects reliably improved while one reliably deteriorated following treatment.

The same information is presented in a slightly different way in Figure A.10. Here every dot corresponds with an actual subject. Dotted lines represent a 95% confidence interval (calculated by multiplying 1.96 by the SD) surrounding a solid diagonal line of no change. The solid horizontal line represents 1 SD above the mean score for the normative sample. Thus, dots falling to the left of the upper dotted line represent subjects who got reliably worse following treatment. Those falling to the right of the lower dotted line but above the horizontal line represent

subjects that showed reliable improvement following treatment but did not return to within normal limits. Those to the right of the lower dotted line and below the horizontal line showed reliable improvement that returned them to a normal level of functioning. Those dots falling between the dotted lines represent unreliable or uncertain change. This type of graphical display of the data may be more clinically useful than the RCI values themselves in that a quick glance allows one to see whether reliable change was also clinically relevant in terms of moving the subject from a distressed level of functioning to a non-distressed, normal level of functioning. Looking at Figure A.10 one can clearly see that of the two subjects who showed reliable improvement based on RCI scores, one returned to a level of functioning within the normal range. A quick glance at the RCIa figure shows the previously mentioned improved subjects and also reveals the subject who deteriorated following treatment.

RCI scores for the Intensity scale ($\overline{x} = 96.6$, $SD = 35.2$, $r = 0.86$, $SEmeas = 13.17$) and Problem scale ($\overline{x} = 7.1$, $SD = 7.7$, $r = 0.88$, $SEmeas = 2.67$) of the ECBI as well as the Total Stress ($\overline{x} = 222.8$, $SD = 36.6$, $r = 0.95$, $SEmeas = 8.184$) and Parental Domain ($\overline{x} = 123.10$, $SD = 24.4$, $r = 0.93$, $SEmeas = 6.456$) scale scores for the PSI were also calculated. The SEmeas for the ECBI was calculated using test-retest reliability coefficients as once again the author was mostly concerned with normative change over time. The SEmeas for the PSI on the other hand was calculated using Cronbach's alpha, as the measure of internal consistency seems to be most apropos when evaluating normative change over time for a heterogeneous construct such as parental "stress". RCI scores for the ECBI Intensity scale range from -3.95 to 2.658 and -3.37 to 2.247 for the Problem scale. The range in RCI scores for the PSI Total Stress domain is -2.69 to 5.25 and the range for the Parent Domain is -3.10 to 4.49. RCI results for the ECBI and PSI are presented in Table B.7 and Table B.8 respectively. Figure A.11 presents data on ECBI changes from T1 to T2, Figure A.12 presents changes from T2 to T3, and Figure A.13 presents changes from T1 to T3. PSI changes are visible in Figure A.14.

The RCI results for the ECBI Intensity Scale reveal that one subject was functioning reliably worse prior to intervention when compared to the same subject's level of functioning at study entry. Changes for all other subjects from study entry to treatment onset fell within the unreliable range. A similar pattern is seen with the ECBI Problem Scale data for study entry to treatment onset. One subject

demonstrated significant clinical improvement on the ECBI Intensity scale from treatment onset to treatment completion, while the change for other subjects remained within the unreliable band. For the same time period (treatment onset to treatment completion), three subjects showed borderline improvement on the ECBI Problem Scale although the change was still unreliable. Only one subject showed reliable (though not clinically significant) improvement on the ECBI Intensity scale from study entry to treatment completion. Two subjects showed reliable change of clinical importance on the ECBI Problem scale from study entry to treatment completion. Three subjects showed reliable improvement in Total Stress scores of the PSI from study entry to treatment completion, with two of those subjects falling within the normal range at treatment completion while the other still fell within the clinically distressed range. Three subjects showed reliable deterioration in Total Stress from study entry to treatment completion with one of the three falling within the clinically distressed range. Only one subject demonstrated reliable improvement in Parental Domain stress levels, while three subjects demonstrated reliable deterioration in Parental Domain stress levels (with one of those falling in the clinically distressed range).

4.11 Social Validity

Finally, clinicians and therapists - especially those in private practice - must concern themselves with an additional outcome variable. Not only should they evaluate an intervention based on the behavioral and performance outcome desired, but they must also evaluate the intervention based on its social validity. Clinicians must concern themselves with whether or not the client felt comfortable with the intervention prescribed. In a competitive market, the therapist must win the hearts and minds of his clients. It may not be enough to produce results. It is likely that the results would need to occur in a context where the client understands why certain actions are being prescribed, accepts the level of effort required by the intervention, and views the results as satisfactory given the time, energy, and effort invested in achieving those results.

Consumer satisfaction surveys (CSS) are a quick and dirty means of assessing the social validity of services rendered. The CSS used in this study consisted of the following six questions. What suggestions were implemented in the home? What

suggestions were most helpful? What suggestions were least helpful? What changes or suggestions for improvement would you have based on your experience with the intervention? Would you recommend the intervention to family and friends who were facing similar challenges? On a scale of 1 (very unsatisfied) to 10 (very satisfied), how would you rate your experience in this study? Overall, social validity for the CSP Learn-at-Home Kit was very high. Every mother reported she would recommend the program to family and friends, and 6 of 8 mothers rated their satisfaction as an 8 or higher.

Chapter 5

Discussion

This study, a simple multiple baseline across subjects investigation, was designed to evaluate the effectiveness of the Common Sense Parenting (CSP) Learn-at-Home Kit as a clinical intervention. The CSP Learn-at-Home Kit was chosen as an example of the many types of self-help parenting videos available for those parents whose children display disruptive and non-compliant behaviors (e.g., Webster-Stratton, 1992; Sanders, 1996; Clark, 1991; Phelan, 2001). The results of the study indicate that the CSP Learn-at-Home Kit was largely ineffective in changing child disruptive behaviors. Furthermore, the intervention was ineffective in altering parental perceptions of the problem behavior, and had indeterminate effects on parental stress levels. Some possible explanations for the ineffectiveness of the CSP Learn-at-Home Kit are presented in the following sections.

5.1 More Than Common Sense

Pat Friman is fond of saying that all children (and indeed all humans) learn through an active process of repetition with experiential contrast. We emit behaviors, and we are exposed to events, that have an effect on the world around us. The larger the experienced effect the greater the contrast and the fewer repetitions required to learn (i.e., fewer trials are needed to associate the behavior or event with the corresponding effect). Using these broad categories as our vantage point, we can take a closer look at some potential reasons why the CSP Learn-at-Home Kit might be ineffective in teaching parents how to alter their children's behavior.

First, let's consider the issue of repetition. The Webster-Stratton videotape modeling program consists of 26 hours of footage (including 250 parenting vignettes) demonstrating the proper and improper use of various parenting techniques. The CSP Learn-at-Home Kit on the other hand consists of a mere 3 hours of footage with less than 30 parenting vignettes demonstrating skills traditionally covered in the CSP training class. The difference between the sheer number of vignettes illustrating examples and non-examples is staggering. Thirty trials may be all the repetition that is necessary to establish a rather simple and novel behavioral response for a healthy individual under ideal training conditions; however, it is likely to be far too few to teach new complicated behaviors intended to compete with well established functional (albeit maladaptive) behaviors to an individual who is psychologically distraught and trying to learn in less than ideal conditions. In addition, a large body of research exists that demonstrates the way teaching examples are presented affects the quality of learning that occurs (see Engelmann & Carnine, 1991). Learning is more likely to take place when examples are given at a high rate, juxtaposing examples and non-examples so that examples span the wide range of possible correct responses and non-examples differ minimally from examples to fine tune discrimination based on critical controlling variables. The CSP Learn-at-Home Kit likely provides too few examples at too slow a rate for reliable fine discrimination training to occur.

Repetition (frequency and rate) is important in discrimination training, but this training has relatively little value unless the new discriminative stimuli are likely to evoke new adaptive responses. Here again, repetition plays a critical factor. The Learn-at-Home Kit may not provide enough opportunities for parents to practice the skills being taught. More correctly stated, the Learn-at-Home Kit may not (indeed cannot) produce the social contingencies that would make parent rehearsal of new adaptive responses more likely. The tapes cannot provide immediate reinforcement for emitting the desired behaviors, nor can they systematically shape closer approximations to the desired parental behaviors. The Common Sense Parenting class may provide these necessary social contingencies, but these social contingencies cannot be packaged with the videotapes. Even when necessary social contingencies are constructed (as in the CSP class), new adaptive responses may not replace maladaptive parenting behaviors unless the adaptive behaviors are trained to a fluent level and/or they are practiced repeatedly under the same internal and external

conditions in which they are likely to be needed in the future.

Let's now turn our attention to the idea of contrast. Let's assume that the parents watching the tape are really invested in becoming better parents. They watch the tape with great interest and encounter tips and techniques that they have never in their whole life considered using, and they encounter slight variations on techniques they have attempted in the past with little success. The ideas that are likely to seem powerful are those with the greatest contrast (i.e., those that the parent has never tried before), and by extension those ideas with little contrast (i.e., those the parent has tried before) will seem less powerful. The parent is likely to invest a substantial amount of time, energy, and effort in applying those new techniques felt to be most powerful. In essence, a selection bias of sorts may be operating affecting the skills a parent chooses to practice and apply. This bias may contribute to poor outcomes.

Many parents have heard a chorus of benevolent concerned others tell them to pay more attention to their children, spend more time with their children, and use time out with their children. These suggestions then are unlikely to show up as new or powerful for the parent. On the other hand, few of these same people have discussed the importance of "preventive teaching" or "corrective teaching" let alone provided parents with a script for these teaching interactions. Given this stark contrast, it is likely that many parents will see the problem as not providing enough verbal teaching interactions during discipline encounters. So, they adjust to do more talking and provide more reasons and rationales during discipline situations. Unfortunately, the strategy of talking more during discipline interactions may strengthen attention maintained or escape maintained disruptive behaviors. There is nothing wrong, per se, with providing these scripts, it is just unlikely that parents will learn to apply them prescriptively with so few teaching examples to help the parent discern when it is appropriate to use the script and when it is not given the function of their child's behavior. In fact, relatively little attention is paid to the function of child disruptive behavior at all within the CSP program. The prevailing theme is not that children do what works for them, but rather that children do what they do because they don't know any better. The emphasis on teaching may lead to more talk and less action (in terms of applying consequences) from the parents, which may contribute to poor outcomes.

There is one final way in which this idea of contrast can help us understand

the relative ineffectiveness of the CSP Learn-at-Home Kit in modifying child behaviors in this study. The contrast created by juxtaposing a rich time-in condition and a stark time-out condition is perhaps the single most powerful tool in addressing child disruptive and non-compliant behavior, yet coverage of time-out procedures in the CSP Learn-at-Home Kit is limited to 1 page in the workbook, and 1 minute of videotape time. The Learn-at-Home Kit devotes a lot of time and space to the discussion of natural consequences for disruptive behaviors (e.g., withholding privileges and adding extra chores); however, it does not appear to stress the contingent nature between behavior and the immediate response from the environment. In addition, it does not spend a lot of time discussing the setting events and establishing operations that may influence the power of consequences. Failing to account for these variables may contribute to poor outcomes.

It appears that the Common Sense Parenting Learn-at-Home Kit focuses primarily on those variables that may enhance treatment acceptability and increase social validity. In doing so, however, it may not provide enough education for parents in the areas of behavioral contingencies and the relationship between contextual variables, child behaviors, and the environment's response to be an effective clinical intervention. But that's not to say the CSP Learn-at-Home Kit is not valuable. The value of the Learn-at-Home Kit may be heavily influenced by the broader systemic context of its use. For parents with children receiving services within the Girls and Boys Town continuum of care, the CSP Learn-at-Home Kit may be effective as a universal or selected (to borrow terms from the prevention literature) intervention. Outside of that system, outside of that specific social context, the therapeutic value of the CSP kit may be questionable.

Understanding the role of context is essential in understanding and appreciating effective parent training. Therapists often address six broad areas when providing parent training in real-world clinic settings. These areas are: parental monitoring of child activities, catching kids being good, giving effective commands, using non-coercive discipline strategies, increasing emotional intelligence, and developing effective problem solving strategies. However, therapists who are very successful in working with parents do not address all of these areas in a predetermined sequence with each client that walks through their door. They tailor their interventions to the unique circumstances of each family situation. For example, one set of parents may have unrealistic expectations of their child and their complaints

of child noncompliance may in fact reflect child behavior that is developmentally appropriate. In this case, redirecting the parents to observe the child closely and focus on catching the child being good combined with subtle psychoeducation about child development may be all that is necessary to bring about important clinical change. On the other hand, a single parent whose primary form of discipline for his 6-year old strong willed son consists of a pattern of reasoning, raising the voice, and raising his hand (for light swats on the bottom) may need an intervention addressing increasing the son's frustration tolerance through non-coercive discipline combined with emotional coaching provided by Dad. In this way, Dad is encouraged to change his behavior towards his son not because he is a bad parent but because his son needs help developing important life skills. These type of subtle but powerful therapeutic maneuvers are necessarily prescriptive and cannot be mass produced or disseminated.

There are a number of limitations with this study. One major limitation of this study is that - due to the nature of the design - conclusions regarding the efficacy of the intervention cannot be generalized outside the study. Second, there was a restricted range of subjects in this study (i.e., mothers of primarily young male children). Third, the author cannot be certain that parents watched the complete videotape segments when they reported that they watched them, nor can he know for sure whether or not the related pages of the workbook were completed while viewing the tapes. Finally, it is possible that subtle changes in parent child interactions occurred during the course of the study, but went unnoticed due to difficulties with the coding system. Future analysis of videotaped interactions are planned to determine the level of relationship change displayed by the mother-child dyad.

While there are significant limitations to the current study, it can serve as a catalyst for future research and discussion. Small scale effectiveness studies could be conducted to evaluate changes in the videotape presentation based on the variables discussed previously (e.g., frequency, rate, diversity of clinical vignettes). In addition, larger group studies could compare families involved with GBT services to families distressed but not involved in GBT services to explore whether larger systemic variables influence the efficacy of the CSP Learn-at-Home Kit. If we acknowledge the influence of broader contextual variables on the effectiveness of an intervention, then we must also acknowledge the influence of broader systemic variables on our own behavior as scientists and practitioners. The systemic influences

lurking in the background of this study, and thus deserving of some comment, include: distinguishing between efficacy and effectiveness research, understanding the gap between psychotherapy research and psychotherapy practice, and exploring the role of trained Scientist-Practitioners in advancing clinical science and practice. The remainder of this paper is devoted to the discussion of these distinctions.

5.2 Efficacy vs. Effectiveness

During the last decade of the 20th century, psychotherapy researchers began to distinguish between two different approaches to psychotherapy research - the efficacy model and the effectiveness model (Nathan & Gorman, 2002). Largely, this distinction resulted from an attempt to understand the low value most psychotherapists and other mental health practitioners placed on psychotherapy research. Historically, practitioners were hesitant to utilize psychotherapy research outcomes to inform their practice because of inadequate research methods and relatively small treatment effects. Research methods continued to improve and treatment effects continued to grow more robust. By the late 1980s and early 1990s, the prevailing concern shifted to a lack of correspondence between the interventions and subjects chosen for empirical study, and the treatments and clients seen in a real world clinical practice. Said differently, while practicing clinicians acknowledged the efficacy of the treatments they questioned the effectiveness of those same treatments.

Outcomes of efficacy studies have been characterized by Barlow (1996) as "the results of a systematic evaluation of the intervention in a controlled clinical research context. Considerations relevant to the internal validity of these conclusions are usually highlighted" (p. 1051). Efficacy studies emphasize internal validity and replicability, and in so doing - many clinicians feel they have little external validity. In contrast, Barlow described effectiveness studies as primarily concerned with "the applicability and feasibility of the intervention in the local setting where the treatment is delivered" and designed to "determine the generalizability of an intervention with established efficacy" (p. 1055). In effectiveness studies, clinical considerations rather than the strict demands of the research design generally dictate the choice of treatment, as well as the frequency, duration, and means of assessing outcome. For this reason, researchers argue that they lack acceptable controls to preserve internal validity. Neither effectiveness studies in isolation, nor efficacy studies alone provide

the clinician with all the information necessary to adequately inform clinical judgment at every stage of the treatment process for a particular client. However, the two processes are theoretically complimentary and new approaches are being developed that will take advantage of the strengths of both to provide more clinically relevant information to psychotherapists.

The efficacy-effectiveness distinction was introduced (at least in part) as an explanation for the gap that exists between clinical practice and clinical research. And while the distinction may be useful in understanding the world views that contribute to the divide, the author invites the reader to consider that there is nothing inherently wrong with the gap. There is nothing in need of fixing. Indeed, the gap may function systemically not as a barrier to progress but as the engine of change driving the evolution of both domains. Perhaps what is needed is not more vigorous attempts to converge but an acknowledgment and acceptance of the gap "as is" and an appreciation for the value of work pursued by psychologist living and working on either side.

5.3 Clinical Research versus Clinical Practice

As previously mentioned, much has been made about the perceived divide between clinical research and clinical practice. Clinical researchers have lamented the the low value therapist in general continue to place on psychotherapy research. Psychotherapist routinely complain that there is little value in much clinical research because it lacks external validity and real world application. Both groups are convinced that they are right in their perception, and perhaps they are. Perhaps the problem is that both groups speak of psychology and mistakenly think they are speaking about the same thing. To illustrate this example lets imagine a similar impassioned divide among another group of professionals - say fishermen.

Now for our purposes we will grossly simplify things and recognize that all of the world's professional fishermen can be roughly divided into two camps - fishing boat anglers and independent fishing guides. Captains of large fishing vessels and their crew attempt to snare many fish in big waters. They cast nets of various size in order to collect some fish while allowing others to swim free. They study macro-level variables like weather patterns, ocean currents, depth and temperature readings, feeding and migration patterns of various species of fish, and what kind of

environmental variables influence large schools of fish. Their bottom line is impacted by producing significant results, and they use sophisticated equipment to gain whatever advantage is available to bring in a significant haul. They are contracted by larger agencies interested in the weight and volume of their catch, and the value of their catch must be greater than the expense of pursuing it lest they lose their jobs. Their livelihood, the health and well being of their family, and indeed the health and well being of their community rides on their success. Their behavior is thus governed largely by these macro-level contingencies. They have acquired specialized knowledge based on collective data from other large fishing ventures, and they use this knowledge to secure large contracts and to reduce as much as possible the level of chance (and accompanying mistakes) in their new venture. They are fishermen. They know they are fishermen. They are good at what they do, and they have evidence to support this belief.

Let's now contrast this with the solitary angler working as a paid guide along a river or stream in some highly prized piece of trout heaven - for example, Southwest Montana. Many individuals seek out the guide in hopes of catching their dream fish. The guide must discern what kind of fish and fishing experience they are looking for, assess the level of skill they currently posses, and then develop a strategic plan that will increase the individual's chance of obtaining her goal based on this information. The guide is being paid to shoulder the responsibility of matching this particular angler with her particular skill level and equipment with complimentary zones of the local river system to obtain the desired outcome of catching the customer's prized fish. The guide is paid to be the expert on these waters and these fish. Those who pay for his service may at times come in with preconceived ideas of where to go, what equipment to use, and when to use it and the guide must respectfully and gently guide him or her to redirect that energy in a way that will be most productive in terms of helping the client achieve their stated goal. The angler's livelihood, the health and well being of his family and indeed the health and well being for a larger community may depend on his success as a guide. His behavior is governed largely by more micro-level contingencies. He has acquired specialized knowledge based on the detailed study of variation among individual people, rivers, time of day, and idiosyncratic ecological events such as insect hatchings in order to best take advantage of inherent chance and mistakes. He is a fisherman. He knows he is a fisherman. He is good at what he does, and he has evidence to support his

belief.

Strange . . . we never lament the gap between commercial fishing fleets and individual fishing guides. Perhaps it is because they intuitively recognize that although they both "fish" their behavior is different. Though the verbiage used to describe their actions is the same, they pursue different means to different ends. Vikki Lee (1988) argues convincingly that the proper focus of psychology is not only on action but also on the fruit of that action. Behavior is defined not by actions (or means) alone but also by the results (the ends) of those actions. Thus the proper subject matter of psychology as a scientific discipline is, according to Lee, the analysis of means-ends units. Behavior is defined not by action alone but by its means-and-ends.

Researchers are interested in "fishing" for the variable or variables that produce the biggest effects in isolation from other variables. Like the fishboat captains they select their target population and nets of various size to screen out all other variables in an effort to increase the odds of catching what they seek. These selection measures are a means by which researchers weed out variability in an effort to discover which variable or predefined combination of variables - occurring in isolation of the random noise generated by life - produces the largest reliable effect (end). Researchers are interested in minimizing life's influence to find "real" (i.e., reliable, replicable) effects. Though these "real" effects may be small for any one individual entity within a population, there is great value in the cumulative effect across individuals and across time for the entire population.

Therapist are interested in "fishing" for the variable or variables that produce a socially defined important effect for the client sitting across from them at this moment. Like the fishing guide, they clarify the client's interest, appraise the skill level and motivation of the client, take stock of larger ecological variables, and actively select in all pertinent variables in an effort to increase the odds of the client catching what they seek. This data gathering is the means by which therapist increase variability in an effort to discover a combination of variables supported by the environment and accepted by the client that will produce a previously negotiated important change (end). Therapist are interested in maximizing life's influence now to find "workable" (i.e., effective, efficient) solutions to address the current crisis.

Striking a healthy balance between processes that minimize variation in some domains and maximize variation in others is a defining feature of complex adaptive

systems (Axelrod & Cohen, 2000). As a complex adaptive system, psychotherapy continues to change and move forward not merely in spite of but rather as a result of the creative tension that exists between researchers and therapists. The dynamic interplay between variation minimizing means-end units (traditionally the domain of psychological researchers) and variation maximizing means-end units (traditionally the domain of therapists) functioning within the same system allows the system to evolve over time. Variation maximizing units prevent stagnation and premature convergence, while variation minimizing units prevent chaos and eternal boiling.

The field of psychotherapy often errs in believing that services provided by psychotherapy research and those provided by psychotherapist naturally compete against one another, and indeed must compete against one another, when in reality this is not so. As discussed earlier, psychotherapy researchers and psychotherapists differ in their means-end units. Said differently, they have different customer and client relationships, and provide distinctly different services. Clients are those that pay for services. Customers are those who receive services. Like charter fishing boat captains, psychotherapy researchers are paid by larger entities for accumulated results. Their customers are often also larger entities interested in accumulated results (e.g., universities, HMOs, pharmaceutical companies, large groups of psychotherapists). Individuals are secondary or tertiary customers. Like private fishing guides, psychotherapists are paid by individuals for individual results. Their customers are primarily those individuals who come into their office. Larger entities are secondary or tertiary customers. The work of one enterprise can and should influence the other, the output of each provides grist for the other's mill. These service lines can be complimentary and work together synergistically, but they likely will not do so naturally. They will need liaisons who recognize the nature and value of the different subsystems and can accept the influence of both. Scientist-practitioners are ideally suited to be these liaisons, and by their training have the opportunity to add unique value to the system as a whole.

Chapter 6

Conclusion

In 1986, Morrow-Bradley and Elliott (1986) conducted a survey of clinical practitioners who were members of the American Psychological Association concerning the use of psychotherapy research by practicing psychologists. They found that most practicing psychologists felt: questions addressed in research often are not clinically relevant, variables studied are often not representative of typical clinical practice, and forms in which the results are reported (e.g., mean differences, and F ratios) do not represent clinically important changes or differences. In addition, the researchers noted that single case research methodology was used infrequently and practical or relevant measures of psychological change were seldom used. This study attempted to address some of these concerns.

Reviewing contemporary psychotherapy research in the 1999 Annual Review of Psychology Kopta, Lueger, Saunders, and Howard (1999) suggested that much of the clinical research and clinical practice gap might be due to the field's preference for randomized clinical trials (RCTs). They proposed that "this approach should be replaced by naturalistic designs, which can provide results more applicable to real clinical practice, therefore strengthening external validity" (p. 449). Essentially, the authors endorsed effectiveness studies as the best means of understanding psychotherapy's impact in real-world clinical settings. However, arguing that naturalistic designs should replace RCTs misses the critical issue. There is understanding psychotherapy's impact in real-world clinical settings, and there is understanding psychotherapy's impact on the real world. From a public health stand point, small, cumulative effects over time are extremely valuable. From an

individual's perspective, relief now (or at least as soon as possible) is highly prized. The field of psychotherapy is comprised of two different enterprises providing different services to different clientele. As such, one does not need to dominate or replace the other. In fact, the greater system would suffer if one enterprise were to ever dominate the other. Outcomes of one enterprise can, and often do, serve as fuel - as generating factors - for the other. This dynamic process of creative tension between psychotherapy research and psychotherapy practice drives the forward progress of both enterprises.

Effective psychotherapy is a complex adaptive system. Efficacy studies can serve to provide guidance on what variables may be important for the therapist to consider, where the therapist should begin, and how the therapist should proceed in order to increase the likelihood that a successful outcome will be obtained. Without this guidance, too much variability would exist within the therapy system making a positive outcome unlikely (a condition referred to by some theorist as eternal boiling). However, use of empirically supported and empirically validated treatments are not the same as providing effective treatment. Use of empirically supported treatment without an appreciation of the unique nuances inherit within each therapeutic relationships, and without tailoring the intervention to fit the context of the individual client would result in too little variability in the therapy system (a condition often referred to as premature convergence). The intervention would feel canned, and a positive outcome would be unlikely.

What is efficacious is not always effective. That is, what is statistically significant on a large N basis is not always clinically significant on an individual basis. What is effective is not always efficacious. A novel, paradoxical intervention may yield clinically significant change for one client, but may not yield statistically significant change for a population of subjects. Efficacy and effectiveness research are necessary but not sufficient components of evidence based psychotherapy (EBT). Ideally, the practice of evidenced based psychotherapy results in a whole that is greater than the some of its parts. Scientist-practitioners have the training and expertise to distinguish between the two service enterprises within the broader domain of psychotherapy, and are thus in the unique position to provide valuable feedback to both. We should focus not on debating which approach is better, but on communicating the advantages and necessity of each enterprise to those that reside on the other side of the gap. We should focus not on closing the gap, but on being the

vehicles of trade that transport valuable discoveries from one side to the other. It is the author's hope that this journey has provided something of value to both sides of the divide.

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Appendix A

Figures

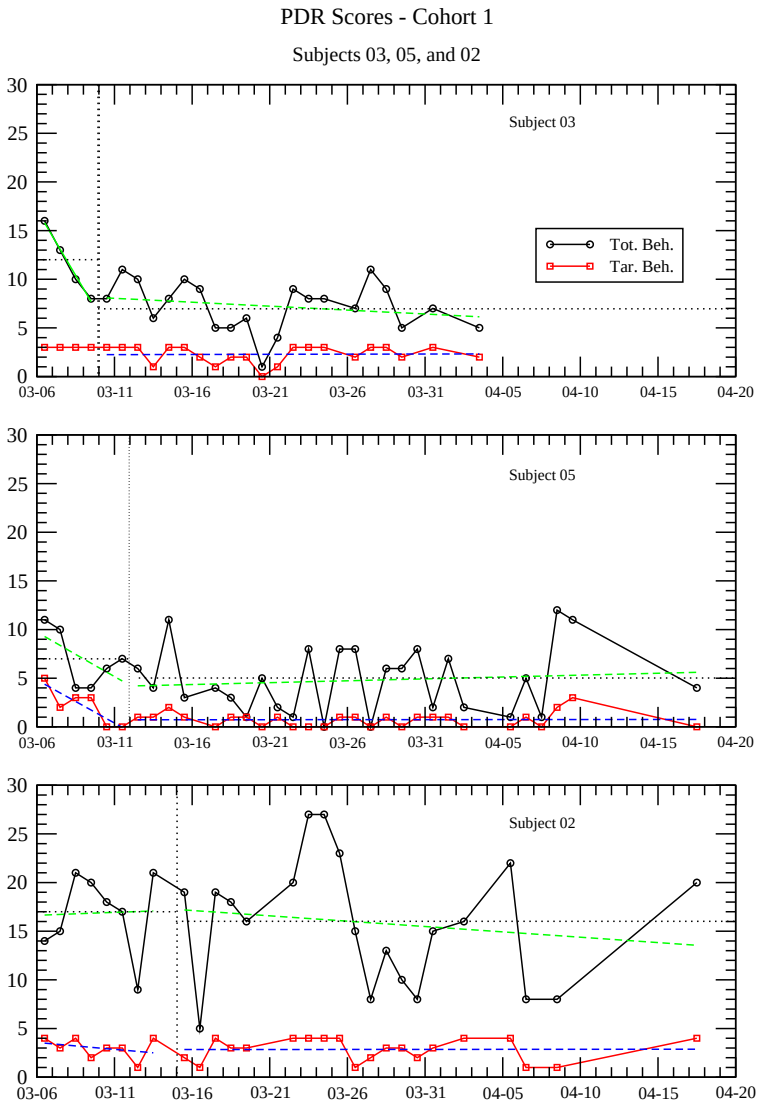
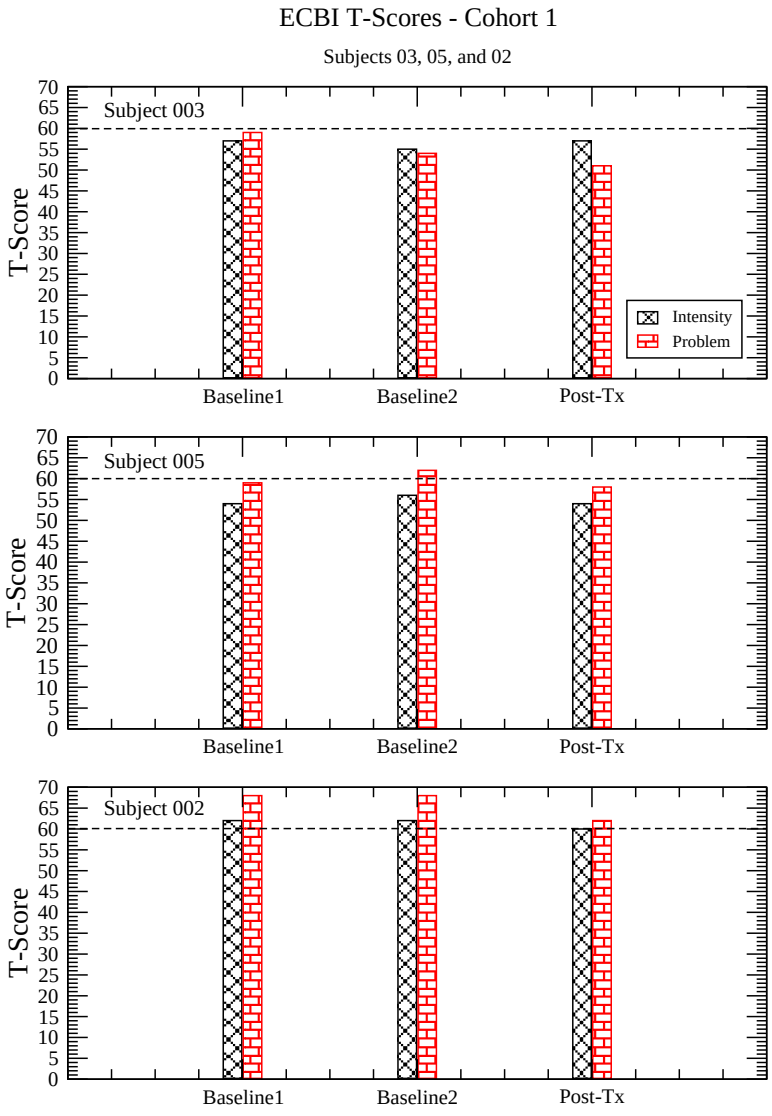


Figure A.1: PDR Data Cohort 1



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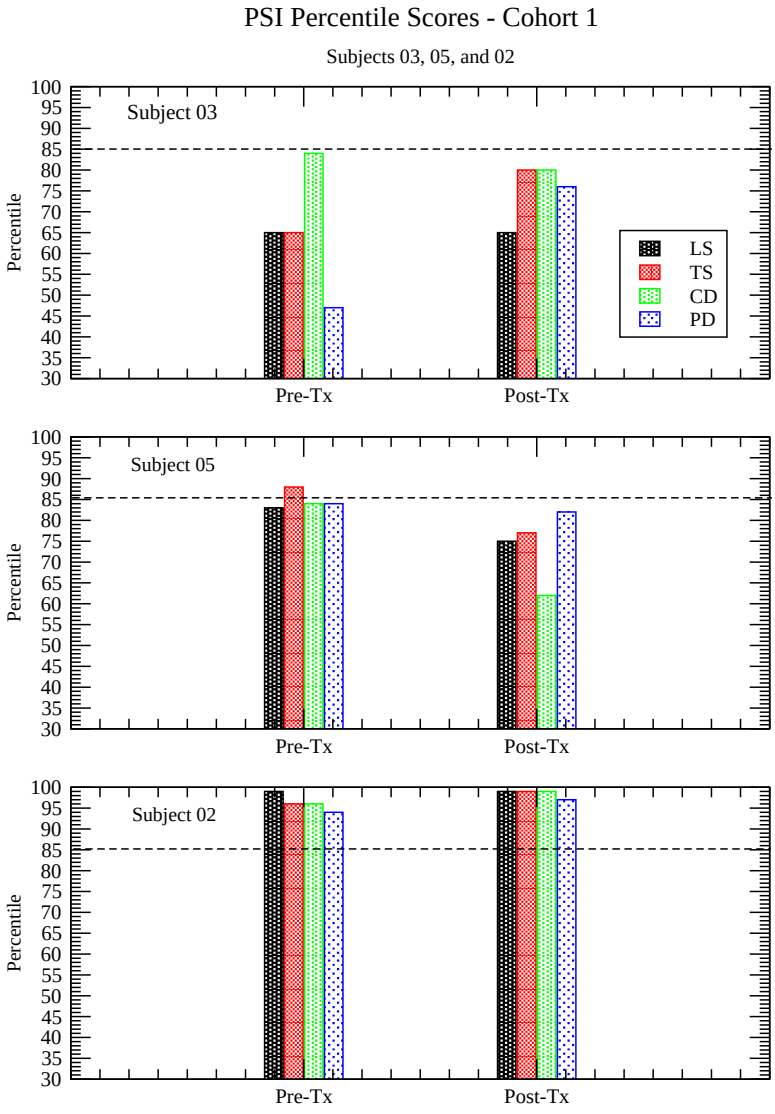

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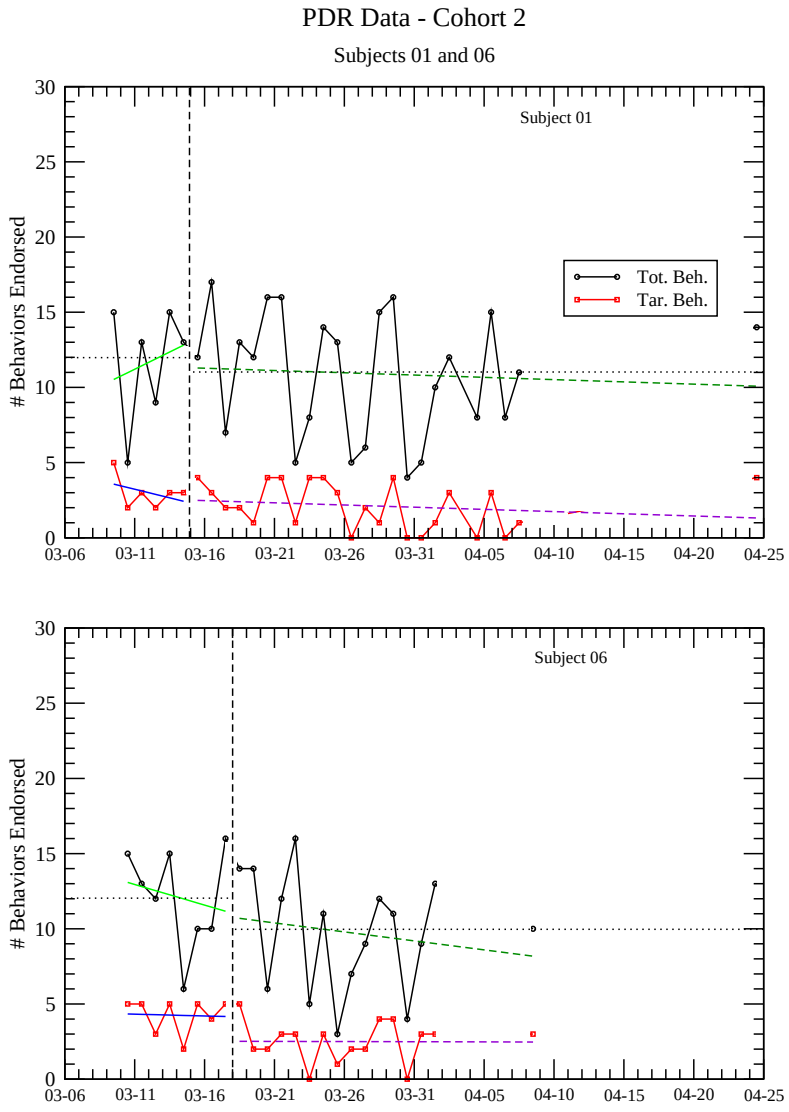

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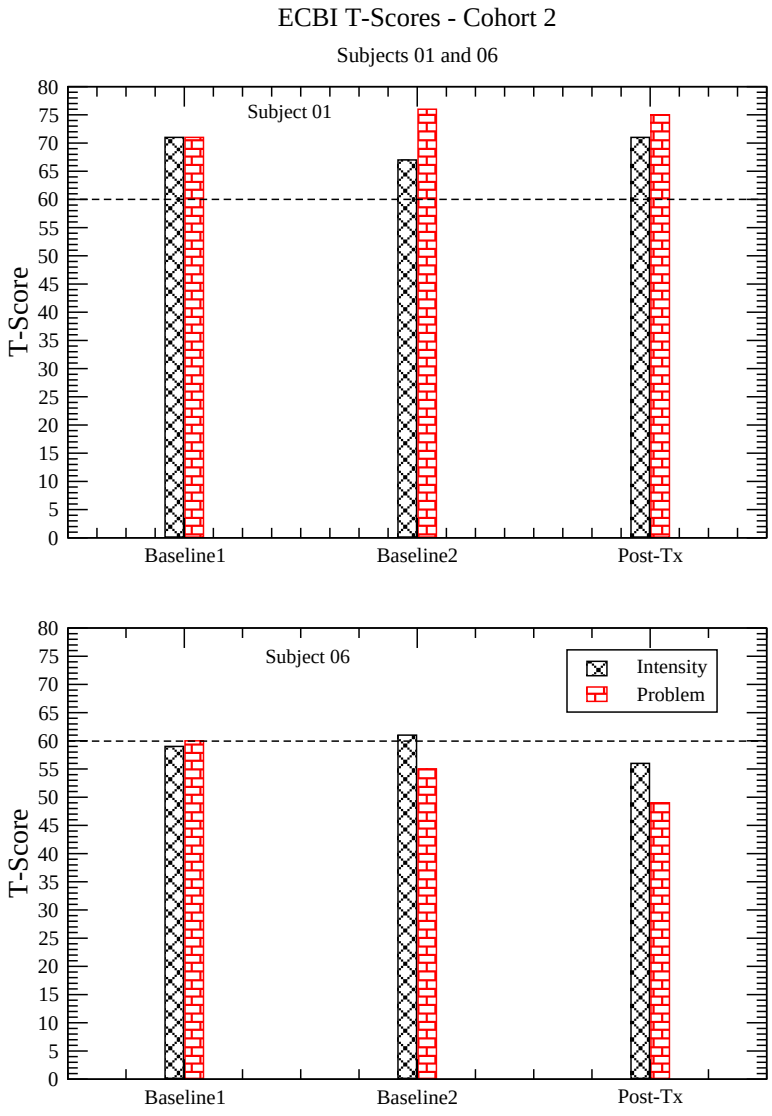

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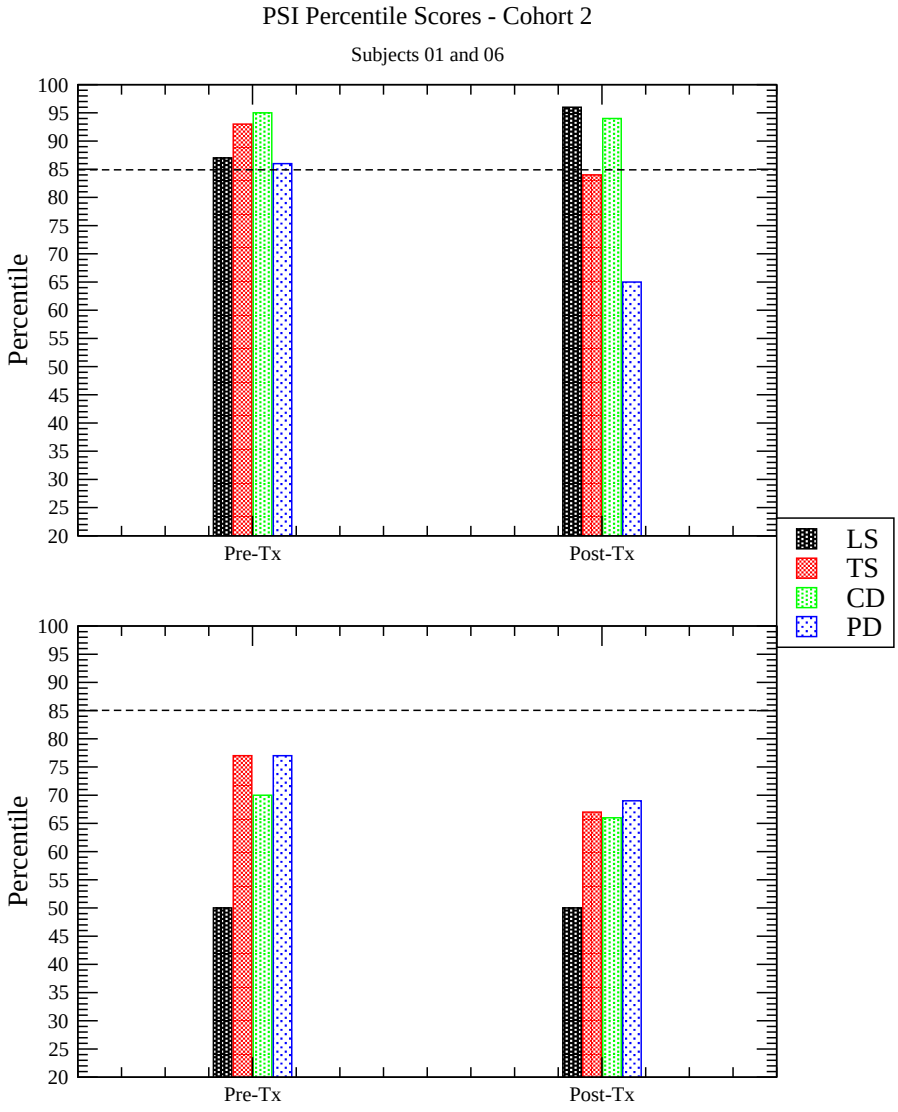

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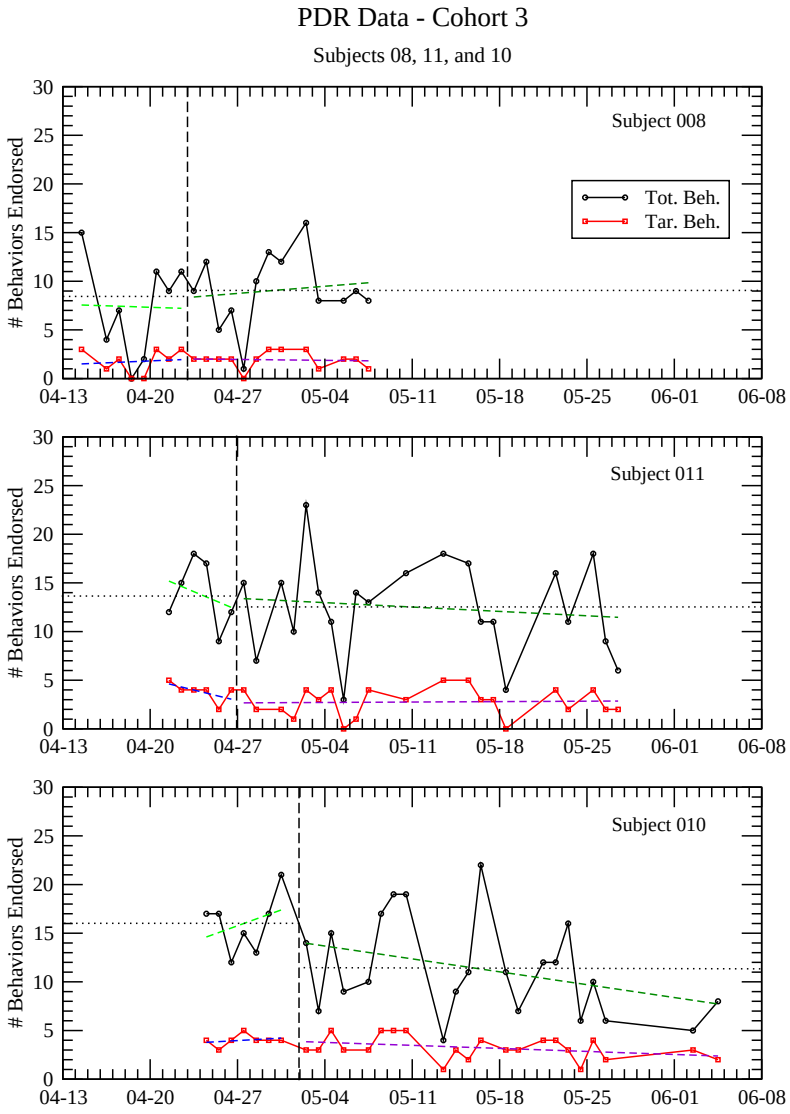

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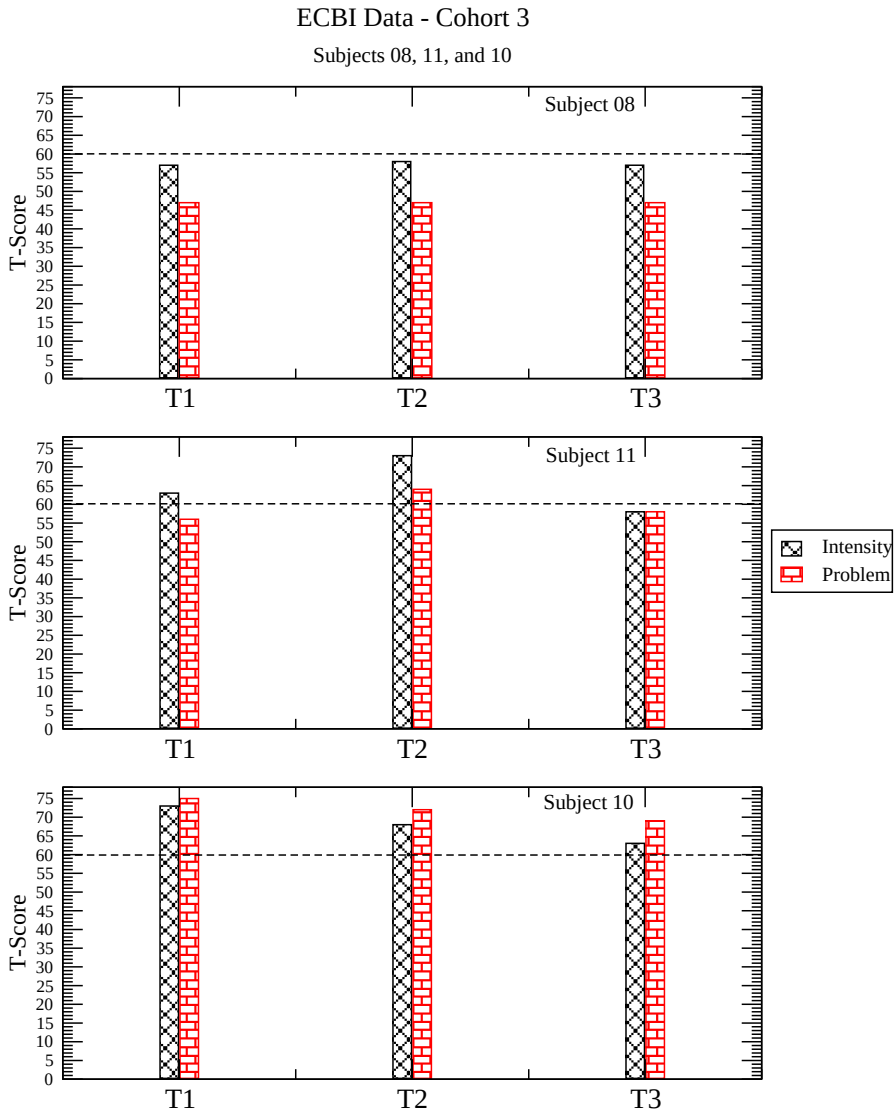

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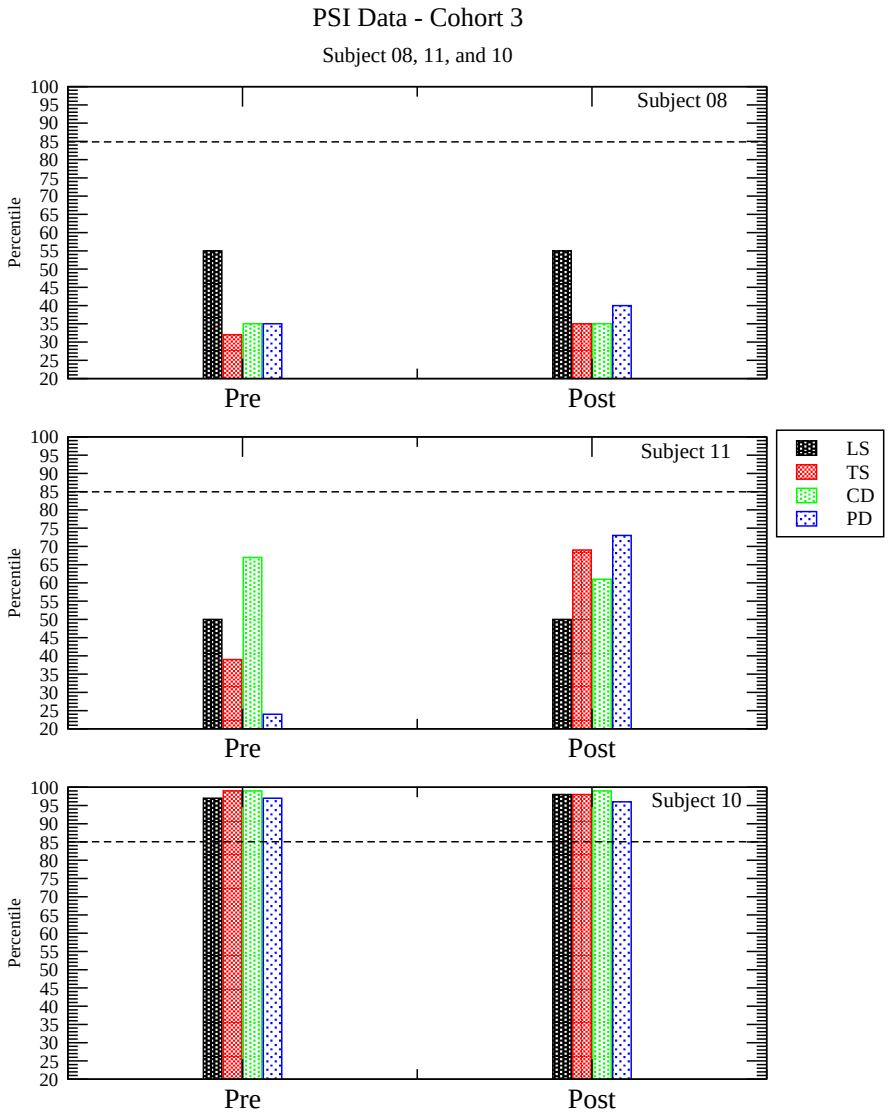

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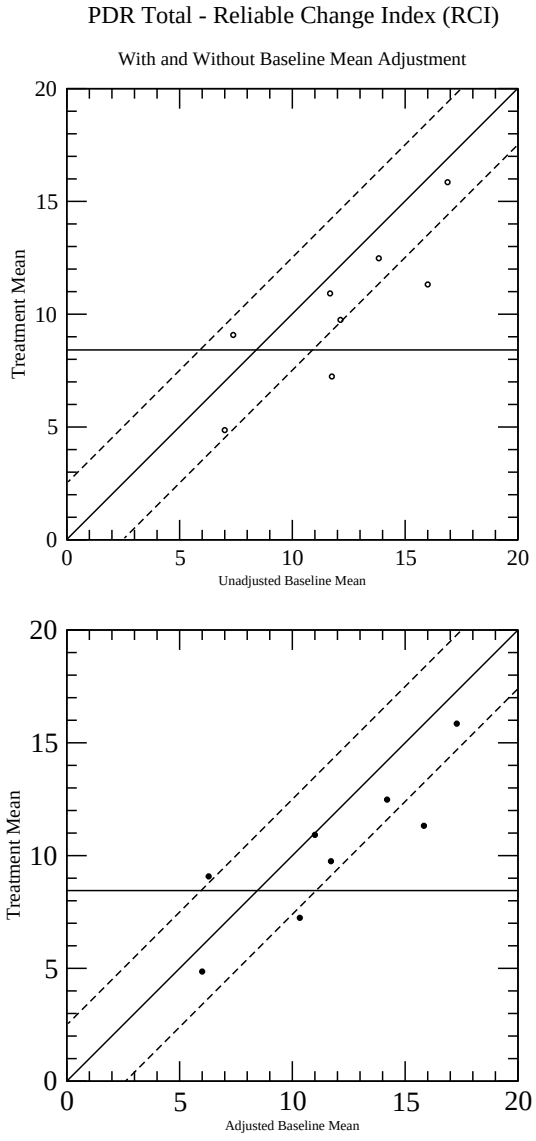

Figure A.10: PDR Total Behavior Score RCI

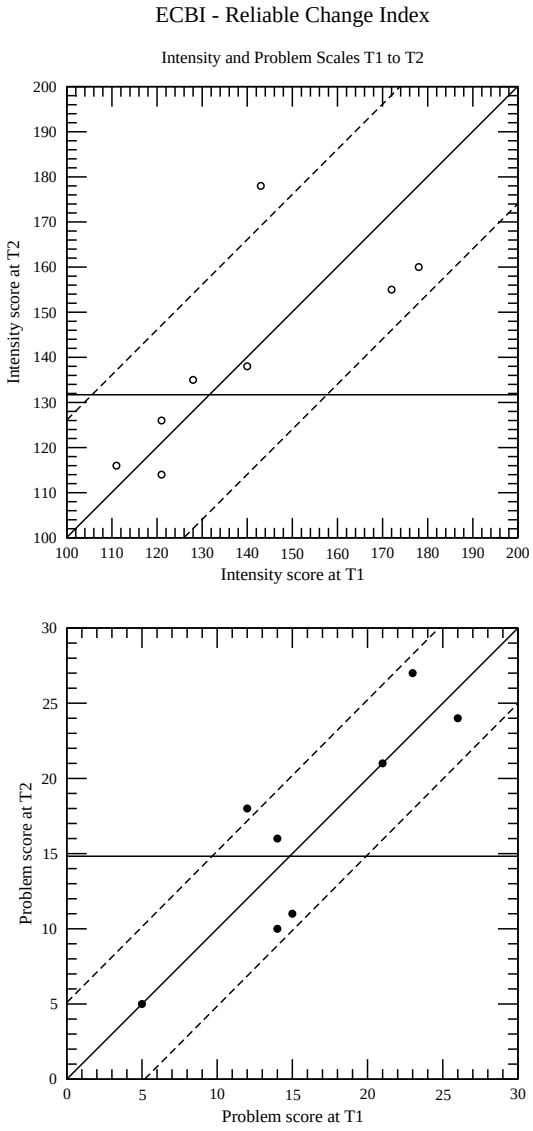

Figure A.11: ECBI: RCI T1 to T2

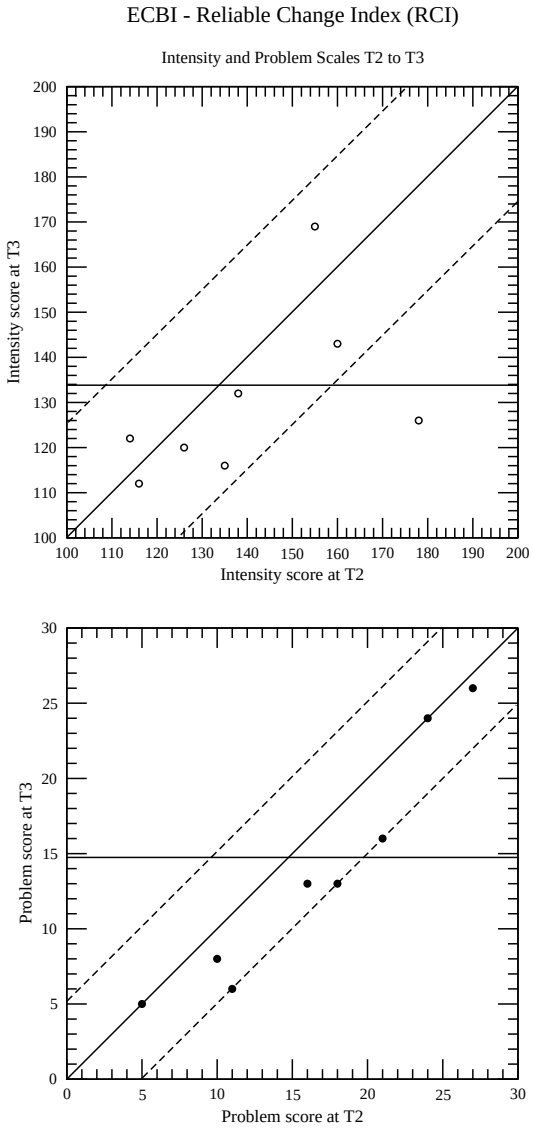

Figure A.12: ECBI: RCI T2 to T3

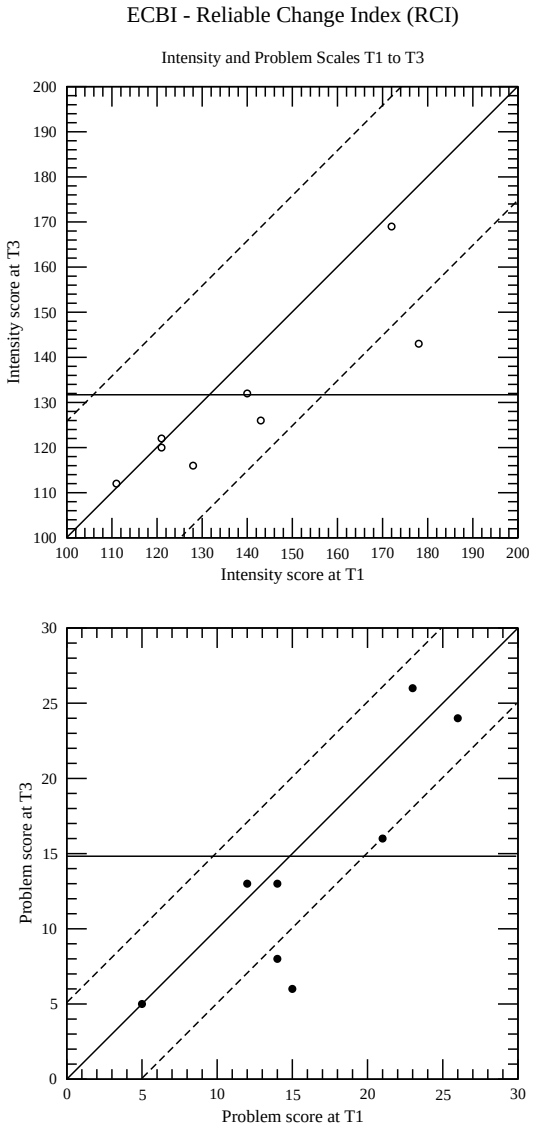

Figure A.13: ECBI: RCI T1 to T3

PSI Reliable Change Index (RCI)

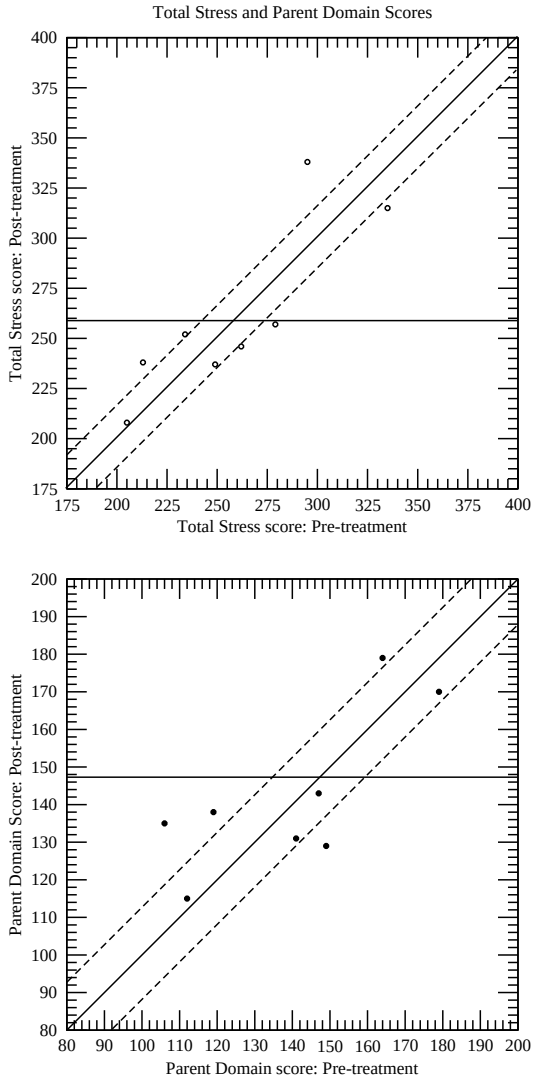

Figure A.14: PSI: RCI Total Stress and Parent Domain

Appendix B

Tables

[1]Webster-Stratton (1982), GDVM = Group Discussion plus Video Modeling
[2]Webster-Stratton (1988), IVM = Individually Administered Video Modeling
[3]Webster-Stratton (1988), Cont= Control group
[4]Data for Subjects 8-11 are presented in Table 5
[5]Webster-Stratton (1988), IVM = Individually Administered Video Modeling
[6]Webster-Stratton (1988), Cont= Control group
[7]Based on Adjusted Baseline Mean

Table B.1: CSP Learn At Home Video Sessions

Videotape	Lesson	Content
Video 1	1	Parents Are Teachers
		Discipline
		Clear communication
		Using consequences
	2	Encouraging Positive Behavior
		General praise and affection
		Giving specific praise
		Using charts and contracts
	3	Preventing Misbehavior
		Using preventive teaching
		Teaching social skills
Video 2	4	Correcting Problem Behaviors
		Using corrective teaching
		Teaching positive alternative skills
	5	Handling Emotionally Intense Interactions
		Staying calm when children push buttons
		Teaching emotional expression
		Teaching self-control
	6	Helping Children Succeed in School
		Establishing homework time
		Teaching social skills for school
		Getting involved with school
		Communicating with school staff

Table B.2: PDR Means by Subject for Baseline and Treatment Conditions

	Mean Behaviors Endorsed					
	$\bar{x}$ Total			$\bar{x}$ Target		
Subject	Baseline	Treatment	Change	Baseline	Treatment	Change
S001	11.67	10.91	-0.76	3.00	2.13	-0.87
S002	16.88	15.85	-1.03	3.00	2.85	-0.15
S003	11.75	7.24	-4.51	3.00	2.29	-0.71
S005	7.00	4.78	-2.22	2.17	0.74	-1.43
S006	12.13	9.75	-2.38	4.25	2.50	-1.75
S008	8.43	9.08	+0.65	2.33	2.08	-0.25
S010	16.00	11.32	-4.68	4.00	3.23	-0.77
S011	13.83	12.47	-1.36	3.83	2.76	-1.07

Table B.3: ECBI Raw Scores Pre- and Post-Treatment

Subject	Scale	Time 1	Time 2	Time 3	T1-T2	T2-T3
S001	Intensity	172	155	169	-17	+14
	Problem	23	27	26	+4	-1
S002	Intensity	140	138	132	-2	-6
	Problem	21	21	16	0	-5
S003	Intensity	121	114	122	-7	+8
	Problem	14	10	8	-4	-2
S005	Intensity	111	116	112	+5	-4
	Problem	14	16	13	+2	-3
S006	Intensity	128	135	116	+7	-19
	Problem	15	11	6	-4	-5
S008	Intensity	121	126	120	+5	-6
	Problem	5	5	5	0	0
S010	Intensity	178	160	143	-18	-17
	Problem	26	24	24	2	0
S011	Intensity	143	178	126	+35	-52
	Problem	12	18	13	+6	-5
WS1982	Intensity		118.5	106.68		-11.82
(GDVM)[1]	Problem		7.9	4.2		-3.70
WS1988	Intensity		156.07	126.15		-29.92
(IVM)[2]	Problem		20.11	11.70		-8.41
WS1988	Intensity		157.25	147.59		-9.66
(Cont)[3]	Problem		22.55	19.14		-3.41

Table B.4: PSI Raw Domain Scores Pre- and Post-Treatment (Subjects 1-6)

	Subjects 01 - 06 [4]			
Subject	Domain	Pre	Post	Change
S001	Life Stress	16	21	+5
	Total Stress	279	257	-22
	Child Domain	130	128	-2
	Parent Domain	149	129	-20
S002	Life Stress	53	42	-11
	Total Stress	295	338	+43
	Child Domain	131	159	+28
	Parent Domain	164	179	+15
S003	Life Stress	9	9	0
	Total Stress	234	252	+18
	Child Domain	115	114	-1
	Parent Domain	119	138	+19
S005	Life Stress	13	11	-2
	Total Stress	262	246	-16
	Child Domain	115	103	-12
	Parent Domain	147	143	-4
S006	Life Stress	6	6	0
	Total Stress	249	237	-12
	Child Domain	108	106	-2
	Parent Domain	141	131	-10

Table B.5: PSI Raw Domain Scores Pre- and Post-Treatment (Subjects 8-11)

	Subjects 08 - 11			
Subject	Domain	Pre	Post	Change
S008	Life Stress	7	7	0
	Total Stress	205	208	+3
	Child Domain	93	93	0
	Parent Domain	112	115	+3
S010	Life Stress	23	25	+2
	Total Stress	335	315	-20
	Child Domain	156	145	-11
	Parent Domain	179	170	-9
S011	Life Stress	6	6	0
	Total Stress	213	238	+25
	Child Domain	107	103	-4
	Parent Domain	106	135	+29
IVM[5]	Parent Domain	151.44	139.48	-11.96
Cont[6]	Parent Domain	141.66	138.03	-3.63

Table B.6: PDR Reliable Change Index (RCI)

Subject	RCI	RCIa[7]
S001	-0.57	-0.06
S002	-0.78	-1.09
S003	-3.43	-2.34
S005	-1.63	-0.87
S006	-1.81	-1.49
S008	1.29	2.11
S010	-3.56	-3.42
S011	-1.03	-1.31

Table B.7: ECBI Reliable Change Index (RCI)

		RCI scores from:		
Subject	Scale	T2 to T1	T3 to T2	T3 to T1
S001	Int	-1.29	1.06	-0.23
	Prob	1.50	-0.37	1.12
S002	Int	-0.15	-0.46	-0.61
	Prob	0	-1.87	-1.87
S003	Int	-0.53	0.61	0.08
	Prob	-1.50	-0.75	-2.25
S005	Int	0.38	-0.30	0.08
	Prob	0.75	-1.12	-0.37
S006	Int	0.53	-1.44	-0.91
	Prob	-1.50	-1.87	-3.37
S008	Int	0.38	-0.46	-0.08
	Prob	0	0	0
S010	Int	-1.37	-1.29	-2.66
	Prob	-0.75	0	-0.75
S011	Int	2.66	-3.95	-1.29
	Prob	2.247	-1.87	0.38

Table B.8: PSI Reliable Change Index (RCI)

Subject	Scale	RCI
S001	Total Stress	-2.69
	Parent Domain	-3.10
S002	Total Stress	5.25
	Parent Domain	2.32
S003	Total Stress	2.20
	Parent Domain	2.94
S005	Total Stress	-1.96
	Parent Domain	-0.62
S006	Total Stress	-1.47
	Parent Domain	-1.55
S008	Total Stress	0.37
	Parent Domain	0.46
S010	Total Stress	-2.44
	Parent Domain	-1.39
S011	Total Stress	3.05
	Parent Domain	4.49

Appendix C

Consumer Satisfaction Survey - Comments

C.1 What tips and suggestions from the videotapes did you attempt to use in your home?

- Tell how I want the child to act instead of yelling at him
- Get a chart and mark when child has done what he was supposed to do, after a week if child has one or two or whatever then he can pick a treat accordingly
- Preventive teaching, proactive teaching along with consequences. Getting more involved with his teachers and his learning.
- Using more positive praise, using specifics when telling children to stop unwanted behaviors, using the 4-step process in highly emotional situations
- Staying calm, consequences, siblings taking breaks from one another when fighting with each other
- Identify what my child was doing wrong. Consequences - positive and negative.
- Preventive teaching
- Correcting problem behaviors using time-out and then tell him what is wrong and what is right thing to do and practice.

- Separate siblings when they are arguing.
- Talking positively
- Describe behavior, use age appropriate reason, have child practice the right thing
- Have the child say "OK" and reward good behavior

C.2 What tips and suggestions did you find most helpful?

- Tell child how I want him to act
- Use charts to show what needs to be done
- Have a chore jar and joy jar
- Give praise for good behavior
- Staying calm and identifying what he is doing wrong, rather than just yelling. Preventive teaching. Using a school note with his teachers.
- Staying calm, being specific about unwanted behaviors, giving clear instructions
- Giving consequences when you and your child are calm, otherwise nothing gets solved
- Following through with consequences when able
- Corrective teaching, joy jar/job jar, positive and negative consequences, time-outs
- Calming the child down and then talking with him about the problem behavior
- All tips are helpful, but some are used more than others.
- Provided more options/choices for what to do to change behavior other than time-out, spanking, or slapping.

C.3 What tips and suggestions did you find least helpful?

- Suggestions dealing with teens. My children are still young.
- Job and joy jars because these are for older children.
- The school section, only because it hasn't been an issue or wasn't new material
- Trying to teach to children before a situation occurs
- Parts of segment 5
- All are helpful
- None
- None

C.4 What suggestions would you have to improve the videotape training system?

- Not sure, I thought this was very good. I liked the book and reading, (better) than watching video.
- Using a more realistic approach to handling out of control children.
- None
- I think the video segment about staying calm should be 1st or 2nd not 5th. I think that is one of the hardest things to do as a parent when dealing with misbehaviors in children. After that, you can teach.
- None
- More situations need to be considered, such as dealing with conflict between friends or classmates, setting up a sleeping and eating schedule, etc.
- None.
- More suggestions on teaching social skills.

C.5 Would you recommend the "Common Sense Parenting Learn-at-Home Kit" to a friend or family member who was having difficulty managing their child's behavior? Why or why not?

- Yes, because some of the things you don't normally think of unless you've had a dozen kids. First time parents need all the help they can get. And this is a good, helpful way of learning.
- Yes, because everyone can learn something from these tapes on how to handle your child's behaviors and use them in their own way to create their own style.
- Yes, it is easy to watch in the short segments and the examples are helpful
- Yes, it had a lot of helpful items in it. It at least gives a parent something to trying in dealing with problems.
- Yes, it's easy to follow. You are able to do it at your own pace. It is a great reference to have on hand.
- Yes, I would (definitely) because there are so many tips that we can learn from there. Those suggestions make our life a lot easier and give us a new view about children's behavior problems. That is, they need to learn and we need to teach.
- Sure, everyone needs a little help perfecting their parenting skills.
- Yes, it gives you a starting point, and some tools to use.

C.6 On a scale of 1 (very unsatisfied) to 10 (very satisfied) how would you rate your experience as a participant in this study?

- 10
- 6, because I think my child has deeper issues than these steps can help with.

- 8
- 10
- 10
- 1 (Author's note: Due to extremely positive comments about the CSP Learn-at-Home Kit on the other items, I suspect this subject meant to rate their experience as a "10" not a "1".)
- 8
- 8

Appendix D

Parent Daily Report (PDR) Items

In the last 24-hours has (child's name) . . .

1. been aggressive?
2. argued?
3. wet the bed?
4. been overly competitive?
5. complained?
6. cried?
7. been defiant?
8. been destructive?
9. been overly fearful?
10. fought with siblings?
11. set things on fire?
12. hit others?

13. been hyperactive?
14. been irritable?
15. told a fib or lied?
16. been negative?
17. been noisy?
18. been non-compliant?
19. refused to eat meals?
20. wet his/her pants?
21. pouted?
22. run around like a wild child?
23. run away from you?
24. been overly sad?
25. soiled his/her pants?
26. stolen something?
27. talked back to an adult?
28. teased someone?
29. thrown a temper tantrum?
30. whined?
31. yelled?
32. had contact with the police?
33. had behavior problems at school or daycare?

Vita

Sean Smitham was born in San Antonio, TX in 1973 and he spent most of his early life in Western Montana. Always interested in positively impacting the lives of young people, Sean served as a mentor and peer counselor in high school graduating from Butte High School in 1992. He further indulged his passion for helping others by working as a Resident Advisor (RA) and Resident Director (RD) at Montana State University — Bozeman where he graduated with honors in 1996 earning his Bachelor of Science degree in Psychology.

Sean was accepted into the Clinical Psychology program at Western Michigan University (WMU) in the fall of 1998 and earned his Master's degree in 2002. His practicum experiences at WMU included time spent providing individual and family therapy services to youth through Borgess Hospital's Adolescent Inpatient and Partial Hospitalization programs. In addition, Sean served as the Student Coordinator of WMU's Clinical Psychology Training Clinic from 2001 to 2003. He completed an American Psychological Association (APA) approved predoctoral internship with the Nebraska Internship Consortium in Professional Psychology (NICPP) in July 2004. During his internship year, Sean worked under the auspices of the Specialized Clinical Services and Research department providing psychological services for the Family Home program at Girls and Boys Town in Boys Town, NE.

Sean is currently receiving advanced training in behavioral pediatrics as a postdoctoral fellow for the Girls and Boys Town Behavioral Pediatrics and Family

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