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DIRECTIVE PARENTAL COUNSELLING: AN APPRAISAL OF ITS EFFECT OF EXTRA-CONDITIONING VARIABLES.

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AN APPRAISAL OF ITS EFFECT ON

EXTRA-CONDITIONING VARIABLES

by

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FRONTSPIECE

FEAR MADE ME ... be a good child ... be a good student ... be a good businessman ... be a good husband ... be a good father ... to a bunch of ungrateful kids ... who won't learn fear.

Jules Feiffer, July 3, 1969

ABSTRACT

The Directive Parental Counselling (DPC) training program is a treatment system within the behavioural therapy genre which trains parents to be therapists for their children. It is concerned with systematically training parents to observe and modify child behaviour via operant learning principles.

The present study was undertaken as an exploratory first step toward definition of some of the many possible extra-conditioning variables operative in relation to the DPC program. An extra-conditioning variable is any event or process related to treatment which is not a specific target behaviour. Extra-conditioning variables influence, shape, define, and sometimes prevent target-specific behavioural changes, as well as being influenced by the treatment process.

The present research was framed in terms of a what-else-can-it-do approach to the DPC program, besides change specific target behaviours. In finding out, we hoped to define a bit more clearly the potentials and limitations of the DPC delivery.

The DPC program was found to be effective in changing parent-child interaction in positive ways. It was also found to be effective in changing parental attitudes towards their children and toward themselves as parents in positive ways. Positive changes in parental feelings of effectiveness in the parent role were also found. It was also helpful in shifting control of reinforcers for child behaviour from sources outside the family, to within the immediate sphere of parental influence.

In addition, its therapeutic effects appear confined to specific parent-child interactive units, and to the benefit of the specific child who is the focus of the program.

No information was obtained on possible generalization-of-effects to siblings of children in the families studied. Generalization-of-effects from training to the children who were presented as having problems initially were amply demonstrated.

In terms of limitations the DPC program was not found to significantly influence the role perceptions the parents have of their spouses or their attitudes toward the total family unit.

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CHAPTER I

INTRODUCTION

The Darwinian doctrine of natural selection has fallen lately into some disrepute where humans are concerned. People do not fit the model well. While other earthly life forms begin their existence more or less fully programmed with instinctual codes for survival which require little learning, human infants must learn by experience each time around.

If survival-of-the-fittest had much primacy for man, the human species would by now be just an archaeological memory, since human infants are all awkward plasticity, which leaves them quite potential, but deficient in terms of the actual. The initial period of helplessness in the human infant is longer than that of any other creature. During this period of relative uselessness, the infant must do an enormous amount of information processing before he is indeed fit to survive in other than a protected milieu.

The Nature of the Human Family

Through the millenia, humans have developed family bonding systems to aid species survival. These bonding systems have had to endure beyond the random seasonal matings characteristic of most other animals. While family role behaviours may show cultural differences, the basic function of families everywhere is the same, human nurutrance and life support, mainly for progeny, but also for the security and other needs

of the involved adults.

Without the mysterious willingness of fallible, trembling, vulnerable, caring adults to spend years of personal sacrifice nurturing offspring, survival would not happen. This adjustment of family relationships for the protection of childhood has some ethological near-corollaries among primates, whales, porpoises, and elephants, but it is uniquely human in extent, quality, and duration. It demands much in terms of unselfish devotion from the adult caretakers involved. Whether from biological parents, or parent surrogates, the human product depends on a large measure of sustained altruism from those caretakers for the first fifteen to twenty years of life if it is to reach full potential.

While altruism is the glue that holds family bonding systems together, it is costly to the giver in terms of the economy of self. If there is no reasonable balance in families between the needs of the child for nurturance, and those of parents for pleasure, stress-relief, and the meeting of their own needs, parents risk depletion.

Parental Response Cost

Braginsky and Braginsky (1971) talk about the response cost of the parent role. A useful concept which transcends the individual child's personal abilities and deficits, it assumes that even under imaginary ideal conditions, a child's arrival strains the bonds of parental attachment and devotion. Response cost is seen as an aspect of parental attachment and devotion. It is an aspect of parental

caring which can be computed economically in either a monetary or emotional sense. In an emotional sense, it relates to the energy output, attention demands, and frustration which may be caused by each new child arrival in the family.

For those who can afford children financially and emotionally, the reward/cost ratio of the parental role is favorable. In that event, the rewards of having a new child exceed the cost. However, if the reward/cost ratio is reversed, the child may be defined by its parents as a problem, or a liability, with a consequently greater risk of being neglected, abused, rejected, or even discarded.

In all families, a reward/cost ratio exists at any given time. It is based on the balance sheet of their efforts to cope with life prior to the child's arrival. If the costs have been high, and the rewards low, as may be true in families with some chronic disability, or those living in financial poverty, there may be a predisposition to reject the child. The child may also increase the cost side of the equation by having some innate problems of his own.

Viewing the parental role in cost-effectiveness terms is a simplification of what otherwise is usually ennobled with vague crusty platitudes. Platitudes distort reality, however, offer little help in understanding parent-child relationships in terms of what really happens in families, and ignore the stressful complexities of the parental role. Traditionally, the mythology of parenthood has exaggerated its joys, minimized its hardships, and then blamed parents for the failures of joy which usually ensue.

Parental Role Rejection

There is increasing evidence that many parents reject the parent role (Bronfenbrenner, 1974). For a growing number of parents, the reality of child-rearing is at best a painful joy. Assigning blame to either parent or child for this, while ignoring the complexities of family interaction, is grossly misleading.

Of parents, much is expected, but little is given in terms of training prior to parenthood, or substantive support after it. Yet, the genesis and structure of a family is usually a random event, undertaken for a variety of reasons, and rationalized as "love", which then evolves into one of the most complex combinations of variables imaginable. This complex coalescence of events is capable of producing problems so difficult that they may be beyond the coping abilities of the people involved.

While most people were raised in families, none has been fully responsible for one until it happens. Despite the inequities of this situation, most parents muddle through as best they can, in a role which demands endless numbers of monotonous, but essential, inputs into the young child's life. Like Sissiphys rolling the rock up the mountain, many fail to find a consistent sense of closure in the task.

The prevalent social attitude toward parental failures is that everyone "ought to know" how to parent well, though it is never explicitly stated how they ought to. This attitude conveys much blame, and is reflected in most contemporary systems of psychotherapy as well.

This priori assumption of parental role competence seems based on the biological capacity to be a parent. A simple-minded extension of instinct theory from lower animals, it would have validity only if humans were as easy to nurture as baby great horned toads, whose parents come fully programmed with parental role instincts. When the absurdity of this assumption causes it to break down, parents are either punished, or surrounded with a veil of neglect which insists on their right to raise children however they see fit, even if they do not see at all. This isolates parents behind barriers to effective change.

Parents are probably more often blameless than we like to assume. Many make heroic efforts to do the right thing, but they have breaking points beyond which their investment in the parental role is withdrawn.

While we prefer to take for granted the nurturant function of the family, thus avoiding having to do anything about it, this function appears to be becoming unravelled under the stresses of contemporary life. Instead of a universal given, it begins to appear that the ability of the family to nurture may itself need nurturing, and that cultures which fail to nurture family functions may expect many problems.

Nuclear Family Stress

The emergence of that phenomenon known as the nuclear family in the past thirty years, an event which has been much studied, but little understood, probably contributes much to the overall stressfulness of family life (Aries, 1962, 1975; Benedek and Anthony, 1970; Handel, 1967; Spiegel, 1971). After evolving slowly since the Industrial Revolution,

the nuclear family, which is defined as an autonomous unit composed of those immediate members in the biological family, accelerated greatly after World War II, with a generalized breakdown of family involvement with the community.

In the more distant past, the extended family was the rule, including both near and distant (biologically) relatives, and the community, all of whom shared in child nurturing along with parents. The community played a prime role in affection-giving, and in socializing the young child. In turn, the child had a wide choice of emotional attachments, and was freer to both attach to, and avoid, a fairly wide selection of care-givers. Under those conditions, affection among immediate family members was less essential to the formation, endurance, and stability of the family unit than it later became.

In the contemporary nuclear family, which constitutes around eighty per cent of all contemporary families in the North American cultural pool, conditions are much different (Benedek and Anthony, 1970). Deprived of extended family and community supports, the nuclear family is largely on its own, and its members are forced to deal with each other in unique ways.

While pre-modern families were open to society, modern ones tend to be closed. Insulating barriers from both the family and the community prevent effective interaction. The result, noted by Aries (1975), is that it has become less and less possible for family members not to love each other. They have been forced to assume a heavy added emotional

burden of either loving, or pretending they did. This produces unusual stresses, and contributes much to what we sometimes call family pathology.

Combined with the aforementioned demands upon parents for competence despite ignorance, this nuclear family stress can result in a real pressure-cooker effect. In this perspective, child abuse, divorce, neglect, abandonment, and the soaring rate of familial homicide, may become safety valves for maintaining personal balance.

With increasing numbers of parents dysfunctioning in the parent role in some way, the need has become imperative to find effective ways of supporting family functioning. This support is essential while, hopefully, cultural alternatives to the nuclear family are established.

Systems of Family Therapy

In recent years, it has become increasingly clear that traditional approaches to family therapy have not been very effective in helping with contemporary family problems, (Sage, 1975). Their overall competence is questioned, and increasing resistance to their application on a still larger scale has occurred. At times, traditional family therapy has been accused of ignoring the existence of intrinsic stressors in the family situation per se, while focussing a bit myopically on psychopathology. It has also been accused of operating from a sort of idyllic assumption base with a nineteenth century view of an intact, stable family unit which no longer characterizes life for millions of families.

Problems in family living have been recognized as a legitimate concern of social institutions since the late nineteenth century, (Acker-

man, 1954). Prior to that time, such problems were the concern of smaller community groups, such as neighbors, friends, and relatives.

With the advent of social agencies late in the nineteenth century, and before the advent of anything called family therapy, attempts to correct family problems were made primarily by social workers, using a variety of social intervention modes. These included things like friendly visiting, re-education, religious indoctrination, occupational guidance, and other methods which dealt with the conscious, situational aspects of family life.

The study of the family as a significant social sub-system dates for the most part, with the exception of some early work by Burgess (1926), to the 1950's. Despite over two decades of effort, studies of the family and attempts to systematically treat presumed disturbances in it, have not developed a coherent set of generally accepted concepts, or established findings. The field, like psychotherapy in general, has been characterized by assorted fads and scholasticisms. These divergent views can be categorized into four main approaches to family therapy.

1. The child and family guidance approach.
2. The psychopathological or mental illness approach.
3. The communications theory approach.
4. The behavioral approach.

In the present study we shall be most concerned with the behavioral approach to family therapy. The other approaches will be reviewed briefly for historical purposes, and to put the behavioral approach in context.

I. Child and Family Guidance

With the advent of psychoanalysis, the general ineffectiveness of purely social intervention modes was recognized, and there was a frantic rush by social agencies into working with the unconscious and psychodynamic relationships (Ackerman, 1951, 1954 a and b; Ackerman and Sobel, 1950; Deutsch, 1937; Mittleman, 1948; Waller and Reuben, 1951). Earlier social intervention modes were rejected as being too superficial.

The adoption of psychoanalytic ideas resulted in the formation of the child guidance movement, which gained momentum after the second world war, and died some fifteen years later, after producing a large number of clinics. During this phase in the development of family therapy, conscious conflicts and situational stresses were put aside, and the realistic life situations of families were ignored. Concern with the tensions produced by interpersonal relations were minimized, in favor of a preoccupation with individual psyches, unconscious conflicts, and irrational motivations. Families as families became virtually lost as objects of study, (Ackerman, 1954).

In the child guidance approach, the main focus was upon the child, secondarily upon mothers, and rarely were fathers ever involved in treatment. This produced many failures, plus a tendency to blame all problems upon parents, via much arcane surmising about oedipal conflicts, anal fixations, and so forth. Rarely were parents and children treated together.

2. Psychopathological Approaches

After the futility of the child guidance approach became generally recognized, the focus shifted to the family unit. Still borrowing heavily from psychoanalysis, as well as group and child therapy, this view was nonetheless a slight progression beyond the child guidance approach, in that it at least dealt with the family totality as producing problems, (Ackerman, 1954; Bell, 1961, 1963; Bott, 1957; Lidz, 1963; Leik, 1963; Satir, 1967, 1972).

In this approach, the treatment focus was on the relationships between members of the family group, and their emotional functioning. The behaviour of any one family member was interpreted as being a symptom of psychopathology of the family unit, which happened to be reflected in the one member of that unit who had recognizable problems. The focus of treatment thus had to be expanded to include the sources of pathogenicity in the family members, as well as to the individual himself.

While this approach saw families as perhaps pushing forward one of their members who they labelled as being sick, its main concern was with the emotional contagion occurring in family relationships, and with the ways in which pathogenic conflict was transmitted across generations, (Caplan, 1961). Treatment dealt with the total cluster of illness processes, by entering the mainstream of family interaction in favor of health. It penetrated the family facade, and dealt with deeper levels of fear and conflict (Ackerman, 1954). The aim was to undermine pathogenic coping and defense patterns, by calling attention to the inefficiency, inappropriateness, and danger of sickness-induced behaviour, and

then substituting healthier modes of coping (Ackerman, 1954). The successful outcome of all this was supposedly healthier family bonds.

This approach to family therapy was not only more appropriate in its inclusion of the family unit, but it was also at least concerned with who did what to whom within that unit. Its main fault lay in its concern with illness and pathology, which were hangovers from medicine, and which have never proven able to produce much light in the area of human behaviour, (Laufer, 1969; Szasz, 1961; Ullman and Krasner, 1969).

3. The Communication Theory Approach

This approach to family therapy is also concerned with interaction, but it is based on relationship rules, exchanges of information, and the ways in which family members communicate overtly and covertly, rather than upon individual dynamics, (Haley, 1958, 1959; Haley and Jackson, 1967; Jackson, 1957, 1965; Bateson, 1958; Weakland, 1973). It is an approach which still has some currency.

In this approach, it is assumed that actual differences between family members are far less important than the difficulties they may have in communicating and collaborating as they go about the daily business of living and problem solving.

The family is seen as one kind of situation calling for collaborative human interaction. There are many such situations in life. Individual differences between the participants are less important than the ways in which they collaborate and work out rules for interacting, based on differences and similarities.

Whenever people are in a collaborative relationship, they must exchange information concerning how they define the relationship, who they are, what they expect from it, and what they do not want. This occurs via specifiable interaction rituals which serve to establish the rules of the relationship. Sometimes words are used in this process, but much of it is communicated non-verbally via a mutual testing process.

The above role definition process is open to much mis-understanding if people fail to communicate clearly, or accept that which is communicated. The result is interpersonal conflict. Family members engage in repetitive exchanges of information as relationships are defined and re-defined. Sometimes re-defining the relationship fails, and conflict is perpetuated. This is especially true if family members do not insist on clear definitions to begin with.

Treatment in this approach consists of intervening in the family communication process, helping family members communicate more clearly. This enhances understanding and resolves conflict.

4. The Behavioural Approach

The behavioral approach to the family rests on a basic set of assumptions which have traditionally been described as having been derived from learning theory, (Eysenck, 1964; Lazarus, 1971; Yates, 1970, 1975). Operant learning theory has been most favored in explaining much of what behaviour therapy is and does, though as Yates (1975) points out, clinical behaviour therapists have made little use

of formal psychological theories in devising treatment approaches in clinical practice.

To the extent that treatment techniques have been derived from formal psychological learning theory, they generally make the common assumption that behaviour is controlled by its consequences. A further assumption is that behaviour can be modified if sufficient control over its reinforcing consequences can be achieved. Where child problems are concerned, the behavioural approach assumes that difficulties arise in part because parents use faulty reinforcement modes, unwittingly reinforcing unwanted behaviours, or failing to reinforce wanted ones.

Behaviour therapy has been criticized by psychoanalysts, humanistic psychologists, sociologists, and others of what Eisen (1973) calls the sensitive-humanistic-interpretive-therapy persuasion. They are inclined to object, among other things, to its attempts to systematically control and change behaviour.

While behaviour therapy is not without fault, much of the criticism is undeserved, and sometimes represents over-reaction by its opponents, who would like to associate it with psychosurgery, electro-shock therapy, and other procedures which do violence to the individual. As Yates (1975) makes clear, behaviour therapy is by no means as potent as its opponents say it is, nor as ineffective as some other forms of psychotherapy.

Virtually all psychotherapy attempts to change behaviour. It can be made to serve humane goals in terms of individual autonomy and freedom from neurotic coercion, or alien ones in terms of imposing alien

value systems on the individual. There are two compelling advantages to behaviour therapy. The first is that it is consistently more effective in a briefer period of time than other forms of therapy. The second is that it is more honest, admits its manipulations, tells people what it is doing, and actively engages them in the change process.

Some other forms of therapy proceed less honestly. They utilize rules known only to the therapist, hidden from the client, and intended to influence behaviour change subtly.

The humanistic encounter group leader, for example, denies manipulating people, then criticizes their "uptightness" if they reject his definition of the appropriate attitude toward group intimacy, while praising them for "opening-up" if they bare all their secrets for the group. He is, in effect, using operant reinforcement, though in this case it tends to leave clients somewhat soggy and confused about what really went on.

Similarly, early in therapy the psychoanalyst acts out his role of contrived stimulus ambiguity for the purpose of bludgeoning his patients into babbling autistically about the "unconscious" in the service of "therapeutic regression" and "getting worse to get better", after which he rewards them by talking, if they have developed an appropriate degree of dependency on him. This also is operant conditioning, but in this case it tends to leave clients in a confused condition for the long years needed to produce "therapeutic progression," to a mythical endpoint called being "completely analyzed", which no one

has ever seen.

Unlike some other forms of therapy, the behavioural approach does no violence to the client's ability to cope with daily reality while "therapy process" is ongoing. It is more concerned with the specifics of that process, clearly states its rules, and tells people what changes can be expected to happen if the rules are followed.

In its openness, behaviour therapy is relatively free of the need to engage in sophisticated control and punishment in line with hidden value systems. Because its clients always know what is going to happen, they are usually much freer to exercise mature evaluation of the process, and consciously refuse to cooperate if they wish. In this way they are actually allowed more freedom than in some other forms of treatment, since freedom is defined not by the number of options available, but by the perception of those options, and the ability to use them.

Still other criticisms have been aimed by behaviour therapists at traditional, psychodynamically-oriented psychotherapy. Where children are concerned, such traditional therapy has been seen as essentially artificial, devoid of contact with the child's real environment, and dealing with only a small part of his life (Graziano, 1969).

The data of traditional therapy are often limited to those obtained in brief one-hour visits each week, and often from unreliable reports of parents not trained in behavioural observation (Russo, 1964). The traditional therapist has also been accused of not making practical suggestions for dealing with life stresses in the family, since these

are seen as less important than psychodynamic material (Russo, 1964). This often results in his suggestions not translating into specific behavioural correlates for parents and children. Such unusable suggestions do nothing to relieve the frustration, helplessness, and rage of parents who are trying to cope with child behaviour problems (Holland, 1969; Patterson, et. al, 1967).

To date, there has been little concern with how such parental feelings and associated stresses work in relation to negative attitudes which may be a cause of, and a response to problem child behaviour. Such negative parental feelings and attitudes may produce further family disorganization (Patterson, et. al, 1967).

There have been a number of attempts to use behavioural approaches to family and child therapy. Those of interest in the present study have been mainly concerned with teaching parents to modify problematical behaviours in their children (Becker, 1971; Bernal, 1968, 1969; Gardner, et. al, 1968; Guerney, 1964; Guerney, et. al, 1966, 1967; Hawkins, et. al, 1966, 1969; Hirsch and Walder, 1969; Holland, 1969; Hyde, 1975; Krapfl, et. al, 1969; Labadie, 1969; Lindsley, 1966; O'Leary, et. al, 1967; Patterson, 1971, 1973; Patterson and Gullion, 1968; Patterson, et. al, 1968; Risley, 1968; Ross, 1964; Russo, 1964; Stabler, et. al, 1973; Stover and Guerney, 1967; Tharp and Wetzel, 1969; Wagner, 1968; Walder, et. al, 1966, 1967, 1969; Wahler, et. al, 1965; Zeilberger, et. al, 1968).

The above attempts at family therapy have certain assumptions in

common (Peine, 1969). These can be stated as follows:

1. Most of a child's behaviour is acquired in, and maintained by its effects upon the natural environment.
2. If the natural environment of the child is not modified, new adaptive behaviour learned in the clinic may be extinguished, and maladaptive behaviour which has been extinguished in the clinic may be reinforced at home.
3. Changing the reinforcing contingencies in the home can best be done by those social agents who live with the child.
4. Parents are the most important social agents in the child's life, and have the ability to control most of the reinforcing events affecting the child, hence direct modification of child behaviour by parents is an effective way to proceed.
5. The role of the therapist should be that of a consultant or coach to the parents, who will bear the main responsibility for behaviour change.

This represents a departure from traditional modes of family therapy, in that the professional person shares his knowledge openly with non-professional parents, who then carry out detailed and direct therapeutic measures. The professional person is thus one step removed from the actual treatment arena, but in being so removed he moves the focus of treatment several steps closer to a prevention model of service delivery according to Graziano (1971).

The behavioural approach to problematical child behaviour has been used with virtually all diagnostic categories, ranging from mild conduct

disorders, to psychotic disturbances and mental retardation (Brown, 1970). Much, but not all, of the work has been limited to single-subject case studies which have dealt with clearly defined, single-problem behaviours.

The general approach in behaviour therapy with families has been to select specific target behaviours occurring in the child, then teach one or both parents to modify those behaviours, using careful observation and training techniques. With the exception of a few treatment programs aimed at eliminating enuresis (DeLeon and Mandell, 1966; Martin and Kubly, 1955; Lovibond, 1964) which used respondent conditioning procedures, the aforementioned work has relied on operant approaches to contingency management.

A variety of training methods have been used. Parents have been trained individually and in groups, via lectures, assigned readings, programmed materials, group discussions, modeling, role rehearsal, and direct coaching. Some training procedures have used the telephone, audio and video tapes, movie films, and assorted kinds of signalling or cue-producing systems.

Several criticisms have been made of the work done in this area thus far. The major effort has been limited to dyadic relationships. For the most part these have been between the mother and the child, with mothers being expected to carry out the major portion of behaviour modification (Berkowitz and Graziano, 1972). Rarely have treatment efforts involved both parents, other family members, and the child. In this regard, behaviour therapy with families has suffered from the same

limitations found in the old child guidance approach. There are no convincing reasons why at least fathers cannot be involved, and their involvement usually enhances the potency of treatment efforts (Graziano, 1971).

Until fairly recently, the behavioural approach has generally ignored the interactive complexities of the family unit (Brown, 1969). Even now, attempts to bring client-family relationships into the treatment process are meager (O'Brien and Azrin, 1974; Hunt and Azrin, 1975). In this regard, family behaviour therapy has been overly-concerned with specific target behaviours, important as they may be, at the expense of those familial contextual events which are also very important.

This disregard of some important aspects of the child's natural environment leaves the impression that child behaviour occurs in a vaccum, or just appears out of nowhere. As Tharp and Wetzel (1969) note, techniques for monitoring the treatment environment with all of its complexities, proclivities, and prohibitions have not developed in pace with our ability to study specific behaviours, such as enuretic episodes, temper tantrums, and so forth. The result has been that much more is known about specific behaviour changes than is known about events in the natural environment which shape, control, enhance, or prevent change.

Other areas of need where the behavioural approach is concerned have been outlined by Graziano (1968, 1971). They can be summarized as follows:

1. The development of predictive measures of the extent of parental

success.

2. Further development and validation of a "family systems" framework for behavioural therapeutic intervention.
3. Development of precise and meaningful measures of parental and child behavioural change in the broader sense of attitudinal and interactional variables which go beyond specific target behaviours.
4. Investigation of the preventive value of behavioural intervention, i.e., do disturbed children whose parents were trained in behaviour modification have significantly fewer problems in the future than those whose parents were not so trained.
5. Comparative studies of the preventive value of behavioural intervention in the above terms, with the post-treatment problems experienced by children treated via conventional psychodynamic therapy to determine the relative preventive value of the two models.

The Directive Parental Counselling Program

We will now turn to a consideration of one particular treatment program within the behavioural framework. Known as the Directive Parental Counselling (DPC) program, it is concerned with training parents to be therapists for their children (Holland, 1969, 1970; Daly and Holland, 1970; Holland and Daly, 1974).

The DPC program is based on a thirty-step delivery system, which

specifies the operations to be followed by counsellors and parents in a sequential manner. Unlike many other systems of family therapy, including those of the behaviour therapy genre, the DPC program relies on a specific and detailed description of the operations performed at each step.

The DPC program was devised in response to the need for a simplified, organized, and comprehensive treatment (Holland and Daly, 1974). The organization of the thirty-step process used in the DPC program was made to reflect clinical reality as much as possible, and the steps were derived from clinical practice over an eight year period in which learning theory principles were applied to a variety of clinical problems.

As stated by Holland and Daly (1974), the goals of the DPC system are:

1. To be relevant to the interactions which commonly occur in the treatment relationship, and blend naturally with the processes involved there.
2. To provide an overview of the client's natural environment as a means of deciding where, when, and what interventions to make.
3. To categorize problems presented by children and families in relevant behavioural terms, and then train parents to be good observers of behaviour. This is done via steps 1 through 9 of the program.
4. To use the information generated via steps 1 through 9 to

formulate appropriate intervention strategies for changing behaviour. This is done via steps 10 through 30.

The entire thrust of the thirty-step process used in the DPC program is toward the complete involvement of parents in successfully modifying one behavioural problem. The DPC program emphasizes learning-by-doing as the most effective and reinforcing form of learning experience. It assumes that if parents can solve one major problem successfully, they can then develop reasonable skills in solving other problems which may occur in the family.

The typical mode of presentation used with the DPC program is heavily didactic. Training sessions, which usually occur weekly for about twelve weeks, follow the general format:

Presentation of Step ⟶ Planning Application of Step to Daily Life ⟶ In Vivo Application and Practice of Step ⟶ Discussion of any Difficulties Encountered.

A complete copy of the DPC program parents manual appears in Appendix B of this dissertation. The parents manual includes the thirty steps which form the basis of the program, and explains the ways in which they are used by parents.

In terms of their purpose, the thirty steps can be divided into four logical phases which follow sequentially.

I. Training Parents to Observe Behaviour, Steps 1 through 4.

1. List the problems presented by the child.
2. Select one problem to work on. For every behaviour that occurs too often, some other more acceptable behaviour is

not occurring often enough.

3. Estimate strength (frequency of occurrence) of the problem behaviour.

4. Set reasonable goals for changing the problem behaviour.

II. Teaching Operant Learning Principles to Parents, Steps 5 through 9.

5. A-B-C principles of antecedent-behaviour-consequence.

6. Know the positive reinforcers in the child's life.

7. Know the negative reinforcers in the child's life.

8. Making words matter by attaching consequences to them.

9. Making rules for the child which are reasonable, enforceable, and within his response capacity.

III. Teaching Strategies to Decrease Unwanted Behaviour, Steps 10 through 18.

10. Where or when the unwanted behaviour occurs.

11. Exploring present consequences for the child of the unwanted behaviour.

12. Decreasing unwanted behaviour via punishment, loss, or withholding reinforcement.

13. Punishment as a decreaser of behaviour.

14. Loss as a decreaser of behaviour.

15. Withholding as a decreaser of behaviour.

16. Withholding when people outside the family control the positives and negatives.

17. Withholding sometimes vs. never, with the goal of never

giving positive reinforcement in a withholding situation.

18. Rehearse decreasing strategies.

IV. Teaching Strategies to Increase Wanted Behaviour, Steps 19 through 30.

19. Where or when the wanted behaviour occurs.

20. Exploring present consequences for the child of the wanted behaviour.

21. Increasing wanted behaviour via relief or reward.

22. Knowing what the child is doing right with regard to the problem.

23. Immediacy of reward is important.

24. Step-by-step progress toward the goal of changing the problem behaviour, not all-or-none change.

25. Bringing behaviour out which does not occur often enough via encouragement and imitation.

26. Vary the type of reward, having several available for use with any wanted behaviour.

27. Vary the amount of the reward from more to less in order to strengthen wanted behaviour.

28. Using an intermittent schedule of rewards which does not reward behaviour every time it occurs, to begin weaning the child away from physical reinforcers, and onto social ones.

29. Depriving the over-indulged child in order to make rewards more important.

30. Rehearse increasing strategies.

Presentation of each of the steps is accomplished via the lecture format. This is followed by discussion of the step presented to insure parent understanding, planning how it will be applied to the real life family situation, and rehearsal of that application. The step is then applied at home by the parents. Following this application, time is devoted to a detailed discussion of any difficulties parents may have encountered in using the training material.

The DPC program has been used in training parents of children with a wide variety of behavioural problems. It has been employed with both individual and group treatment delivery modes. When delivered individually, less time is typically required to complete the program.

While the group mode is more time consuming it has certain other benefits. The DPC program is particularly adaptable to the group format, which seems in some ways to amplify training effects. It has been observed by those experienced with the program that group members often benefit from exposure to other peoples problems, problem solutions, and general life experiences in the group situation.

Purpose of Present Research

Eight years of heuristic experience in a variety of clinical situations have suggested the efficacy of the DPC program on an it-seems-to-work basis. There remains a need to know more rigorously how it works, why it works, and when it works. The presently proposed study is part of a series of validity and outcome studies with the DPC program

(Hyde, 1975; Labadie, 1969).

Those clinicians who have had experience in training parents via the DPC program, report many empirically derived hunches concerning its efficacy. It does not seem as effective, for example, when parents are unable to give rewards and must rely excessively on punishment to control child behaviour, as it is when they are able to reward freely. Some report that is also less effective with severely disturbed children, who might in some settings be diagnosed psychotic, autistic, or mentally retarded.

The role of social class in determining treatment outcome via the DPC system has been hinted at by some. Still others have speculated about the importance of the overall coping ability which parents bring to the treatment process. These, and many other questions, have thus far remained in the province of speculation, and no attempt to systematically assess them has been made.

As with most of the aforementioned programs for training parents to be therapists for their children, the DPC program has thus far concentrated mainly on the modification of specific target behaviours. While such target behaviours are important in the sense of serving as a means of delivering treatment, they are probably only a small part of the treatment process.

Specific target behaviours can be seen as those events which bring people together for treatment, and around which treatment occurs. They have a motivating function in causing parents to seek help, and a catalytic function in terms of maintaining the therapeutic process once it

is ongoing, at least up to a certain point. Target behaviours constitute those conditioning variables toward which training is aimed, and serve as the framework within which it occurs.

It is necessary to begin looking beyond target behaviours in assessing the effectiveness of behavioural treatment programs in general, and the DPC program in particular. In line with the research needs expressed by others, it is time to extend our concern to the broader range of events in the natural environment of the child and his family which relate to, and have important consequences for, the treatment process (Graziano, 1971; Tharp and Wetzel, 1969).

The primary concern of the currently proposed research will thus be with those events which exist within the realm of extra-conditioning variables. We shall direct ourselves to points two and three of Graziano's (1968, 1971) analysis, which are concerned with:

1. The validation of a family systems framework for behavioural intervention.
2. The development of meaningful measures of parental and child behavioural change in the broader sense of attitudinal, perceptual, and interactional variables which go beyond specific target behaviours.

A more complete discussion of the role of extra-conditioning variables in the treatment process follows in the next chapter.

Most broadly defined, the term extra-conditioning variable refers to everything related to the treatment process which is <u>not</u> a specific target behaviour. It refers to any and all of those variables in the

child's natural environment which influence treatment outcome. Extra-conditioning variables not only relate to changes in target behaviours, but may actually determine whether or not such changes occur. They are capable of encouraging, shaping, modifying, or preventing changes in target behaviour.

In practice, while the existence of such extra-conditioning events has been inferred clinically from experience based on treatment processes and outcomes, it has never been confirmed. This state of affairs has left clinical experience with the DPC program somewhat in the dark.

The purpose of the present research will be to:

1. Define a set of extra-conditioning variables related to the DPC program.
2. Determine whether or not such extra-conditioning variables can be measured meaningfully.
3. Determine whether changes in those extra-conditioning variables studied occur following exposure of parents to the DPC program.

It is not possible at this point in time to study, or even clearly define, all of the extra-conditioning variables which may be operative in the treatment process. It is assumed that the universe of possible variables which may be included under the extra-conditioning variable rubric is very large indeed. If only some of those variables can be defined and studied in relation to the DPC program, it will be a beginning. The present study is thus seen as an exploratory start in the quest for understanding extra-conditioning variables, as they relate to the DPC program treatment process.

CHAPTER II

METHODOLOGY AND PROCEDURE

Selection of Sample

Twenty-one families were referred initially from various mental health and educational facilities for the proposed study. They were seen on an order-of-appearance basis, with no attempt at pre-selection by the agencies involved. Formal pre-selection criteria were avoided in the interest of approximating the real-life clinical situation. Nonetheless, due to the subsequent inappropriateness of some of the referrals, some natural attrition of the original sample occurred as families dropped out. As a result, 12 of the 21 original families actually started treatment, and of that 12, seven completed the entire DPC program. Additional reasons for this attrition rate of the treatment group will be discussed later. The original families are referred to as the total group while the seven families completing treatment are referred to as the treatment group.

Description of Sample

All of the families in the study were from the Windsor, Ontario area. They were referred for DPC treatment by one of two local agencies, a hospital childrens psychiatric service, or a day nursery school. In each case they sought help from the primary referring agency because of behaviour problems with their children which they felt unable to cope with.

The mean age of parents in the total group was 32.65 years,

with a range of 22.75 to 53.50 years. The mean age of those in the treatment group was 30.71 years, with a range of 23.16 to 48.41 years. In each family, the problem child behaviour had first appeared, or been identified as a problem, more than nine months prior to referral.

Five of the seven families in the treatment sample were intact, with both parents living together. The remaining two families were non-intact, involving divorced mothers who were independent heads of household. In two of the intact families, both parents were employed outside the home, while in the remaining three, the mothers pursued the homemaker role. In the two non-intact single-parent families, one mother was employed as a secretary, and the other received welfare assistance from the Province of Ontario.

General Procedure

The parents in each family were seen initially for an individual clinical interview aimed at assessing presenting problems and the overall relevance of the referral, to see if the problems were appropriate to the general orientation of the DPC program. In addition, a basic assessment battery was given during this first session, which consisted of the following instruments.

1. The Family System Survey, (FSS). This instrument was constructed for this study, and was used as a structured interview guide with each family. The Family System Survey consists of 37 items which are designed to systematically measure a number of extra-conditioning variables that might influence treatment outcome.

Information was sought via this instrument on socio-economic factors through the Hollingshead Two-Factor Index of Social Position (Hollingshead, 1957) which was incorporated in the survey, as well as other variables, such as family income, physical environmental factors, physical mobility of the child in the home, effectiveness of parent communication, parental feelings of adequacy in the parent role, parental role stress, subjective tension level in the home, effectiveness of parent-child communication, outside influences on problem behaviour, the conjugal role relationship between parents, and other factors. A copy of this instrument can be seen in Appendix A.

One descriptive measure referred to often in this study is the Subjective Unit of Discomfort, or SUD. First used by Wolpe (1966) in his work on systematic desensitization, the term SUD scale refers to a 100 point scale of subjective distress upon which people can rate the amount of anxiety or discomfort caused them by any given event. A state of absolute calm would be rated as 0 at one end of the scale, while a state of extreme, spastic anxiety would be rated 100 at the other end. Most people can assign a number to their subjective anxiety level with little difficulty, and with a bit of practice, they become increasingly confident in using the SUD description in ways that are much more informative than foggy verbal statements about how they feel.

2. The Social Readjustment Rating Scale, (SRRS). This in-

strument was designed by Holmes and his associates (Holmes and Masuda, 1967, 1972; Masuda and Holmes, 1967; Komaroff et. al., 1968). The SRRS was re-named the Personal Experience Rating Scale for this study in order to clarify some ambiguity which people experienced with the original title. However, the original stimulus items were unchanged. A copy of this instrument can be seen in Appendix A.

The SRRS consists of 43 life-events, the occurrence of which evokes, or is associated with, some adaptive coping behaviour on the part of the individuals who experience them. Each event requires a significant change in the person's ongoing life pattern which may be stressful, and which further influences the amount of adaptive energy available to him within a given span of time, usually 12 months.

Cross-cultural and sub-cultural normative data for this instrument are extensive. Consistently high similarities have been found in perceptions of the amount of social stress caused by different life-change events. These in turn have been related to the relative costs and benefits of different coping strategies, as well as to factors underlying interpersonal competence in any given situation. It has been shown that competence at any point in time is partly a function of adaptive reserves brought to the current situation, and that depletion effects occur which can have a profound influence on psycho-social adaptibility and somatic disease (Caplan, 1964; Coelho et. al., 1974; Lindemann, 1944).

Comparisons between expected life stress, based on the normative

data for this instrument, and actually observed life stress in an idioverse specific sense can be made by asking subjects to not only check-off life events experienced, but rate them in terms of subjective units of discomfort, or SUDs. That was done in this study and represents a slight modification of the original SRRS technique.

3. The Semantic Differential Technique, (SD). This technique, which is not a formal test per se, was devised by Osgood (1957, 1969) to measure word meaning in an objective way. Given any word concept, such as "problem child", subjects are required in a forced-choice manner to judge the concept in terms of several pairs of polar opposites, such as good/bad, strong/weak, fast/slow, on a seven point scale. A copy of this instrument is in Appendix A.

The semantic differential technique measures the emotional, or shared-affective, meaning which people attach to words, as well as changes in that meaning over time if assessed by repeated measures. Osgood has found that most of the emotional meaning associated with words falls into one of three categories which have been derived factorially. These categories of meaning are, Evaluation (A), or the good/bad dimension, Potency (P), or the strong/weak dimension, and Activity (A), or the active/passive dimension.

Osgood (1973) refers to the principles of congruity in cognitive processes which underly this psycho-logic process. Words are conservative, and associated with a relatively stable bundle of semantic features over time, even though their effects may be radical when arranged in sentences. Repeated exposure to certain words under altered

conditions over time can, however, change their semantic properties, with related changes in the emotional, cognitive, and perceptual meanings of the word, or its connotation. The semantic differential technique has been found to be an effective tool in psychotherapy research because it detects personality and attitude changes during the course of treatment (Endler, 1961).

In the present study, seven word concepts were measured along nine polarities, three loading most heavily on each of the three meaning factors, E, P, and A. The seven concepts studied were: MY FAMILY (MF), THE IDEAL CHILD (IC), A PROBLEM CHILD (PC), MY CHILD (MC), THE IDEAL PARENT (IP), ME AS PARENT (MAP), and MY SPOUSE AS PARENT (MSP).

The nine polarities along which the seven concepts were rated by the subjects, and their respective factor loadings on E, P, and A, were:

Evaluation:	bad/good	.91
	sad/happy	.91
	beautiful/ugly	.90
Potency:	strong/weak	.67
	difficult/easy	.60
	broad/narrow	.41
Activity:	fast/slow	.70
	active/passive	.59
	interesting/dull	.52

In the extensive literature existing for this technique, it consistently loads most heavily on the Evaluation factor in validational studies of it.

4. The Walker Problem Behavior Identification Checklist (WPBIC).

Constructed by Walker (1970), the WPBIC is a fifty-item checklist composed of observable, operational statements about child behaviour. It identifies children with behaviour problems on five clinical scales, each of the points 1 through 5 having weighted values for each item in terms of how much it is judged to handicap a given child's current adjustment.

The five clinical scales on this instrument are: ACTING-OUT, WITHDRAWAL, DISTRACTABILITY, DISTURBED PEER RELATIONS, and IMMATURITY, plus a TOTAL SCORE. These scales are aimed at identifying negative, or pathological, behaviours and are sensitive to changes in child behaviour over time as a repeated measure. A copy of this instrument appears in Appendix A.

Adequate reliability and four kinds of validity data are reported for the WPBIC. The Kuder-Richardson split-half reliability coefficient reported for the WPBIC is .98, while an inter-judge reliability value of .83 was obtained, (Walker, 1970). Validity measures for the WPBIC included contrasted groups, criterion, factorial, and item validity studies. In the contrasted groups study, the difference between the means of experimental and control groups was significant beyond the .001 level of confidence. In the criterion validity study, a biserial correlation of .68 between checklist scores and the criterion, was found with an index of predictive efficiency of .33, which gives a measure of the predictive value of the WPBIC, indicating that it has utility in predicting behaviour disturbance in children. Factorial validity of the WPBIC was studied using a Varimax Orthogonal rotation, which yielded

the five factors making up the clinical scales. The results indicated that very little overlap existed among the five scales, with the exception of a .67 correlation between ACTING-OUT and DISTRACTABILITY, suggesting that these two scales represent some common elements.

The item validity studies on the WPBIC included item variance and validity indices, as well as intercorrelations for all fifty items. The range of item variances for the WPBIC is from .09 to .16 for the separation of disturbed children from non-disturbed ones, which is considered within the optimal range of discrimination. Intercorrelations among the fifty WPBIC items yielded coefficients ranging from .00 to .83, and it was concluded that, with the exception of six items, the WPBIC is measuring separate functions of the same behavioural domains, hence not prone to excessive duplication. In addition, a biserial correlation between scale items and the total score was computed, yielding a discrimination index as a measure of internal consistency between the individual items and test scores. The item validity indices varied from .03 to .67, indicating that the individual items discriminate between subjects in the upper and lower twenty-seven percent of the sample in terms of checklist scores, and also correlate highly with the total score criterion, (Walker, H. M., 1970).

5. The Child Behavior Rating Scale, (CBRS). Constructed by Cassel (1962), the CBRS consists of 78 observer-checked items related to child behaviour. It is scored on a six-point scale related to the presence of problem behaviours which might influence a child's adjustment in different areas, with a score of 1 given for the presence of the indicated

behaviour, and a score of 6 given for its complete absence. The higher the score, the better the child's adjustment is assumed to be. The CBRS yields adjustment scores in five areas, SELF-ADJUSTMENT, HOME-ADJUSTMENT, SOCIAL-ADJUSTMENT, SCHOOL-ADJUSTMENT, and, PHYSICAL-ADJUSTMENT, plus a PERSONALITY TOTAL ADJUSTMENT score. The CBRS offers a frame of reference for evaluating changes in child adjustment and personality over time, according to the author (Cassel, R. N., 1962). A copy of this instrument can be seen in Appendix A.

Reliability data for the CBRS indicate a coefficient of .83 for a sample of 800 assumed normal children, and .58 for maladjusted children, using the Spearman-Brown formula for odd-items (Cassel, R. N., 1962). In two other reliability studies, raters completed the CBRS on two separate occasions, and their scores were correlated, using the Pearson coefficient, which showed an r of .91 and .73 respectively. In the first study, parents did the rating, while teachers served as raters in the second study.

Validity data for the CBRS include correlations of ratings done by mothers, fathers, and teachers of child behaviour. Pearson coefficients between mothers and fathers were .65, high enough for significance, suggesting that both parents are not needed in evaluating child behaviour. The correlations between parents and teachers ratings were lower, with a coefficient of .33 between teachers and fathers, and .28 with mothers, which might pose some difficulties if the CBRS were given in the school setting, or by raters less familiar with the individual child.

Cassel (1962) claims face validity for the CBRS since all of its

items were obtained directly from case reports made by trained people in different disciplines dealing with child behaviour. He also claims construct validity in that scores on the CBRS correlate highly with other tests measuring school achievement, intelligence, and general social development. However, the highest correlations were found with school achievement, specifically grade point average in reading and language skills, which showed coefficients of .72 and .66 respectively.

6. The Mother-Child Relationship Evalutation, (MCRE). Devised by Roth (1961), the MCRE is a 48-item test which measures certain attitudes by which mothers relate to their children. It offers an objective estimate of a mother's relationship to her child based on a five-attitude profile: ACCEPTANCE, which is seen as a positive attitude, and OVERPROTECTION, OVERINDULGENCE, REJECTION, and CONFUSION-DOMINANCE, which are negative ones. A copy of this instrument appears in Appendix A.

The MCRE items consist of statements about child behaviour, and child-rearing practices, with which subjects are asked to rate their agreement on a five-point scale, ranging from "Strongly Agree", with a score of 5, to "Strongly Disagree" which would receive a score of 1. Most of the items are stated to reflect negative attitudes, hence the lower the score, the better. The direction of scoring is reversed for the ACCEPTANCE scale.

In the present study, the CONFUSION-DOMINANCE scale was not used, since it proved confusing and yielded no meaningful results. Attitude

as used in the MCRE is described as an intervening variable which mediates the mother's behaviour toward her child, who in turn serves as a stimulus for the mother's behaviour (Roth, R. M., 1961). While attitudes are fairly stable over time, they are subject to change as the stimulus value of the child alters, and these changes can be seen with repeated measures.

Reliability data for the MCRE are rather meager, consisting of Pearson product-moment correlation coefficients for split-half reliability. Coefficients reported for three of the scales, ACCEPTANCE, OVERPROTECTION, and OVERINDULGENCE, are .57, .53, and .41, respectively, (Roth, R. M., 1961). Validity data consist of scale intercorrelations, which show that the ACCEPTANCE scale correlates negatively with the others, coefficients of -.68 for OVERPROTECTION, -.47 for OVERINDULGENCE, and -.45 for REJECTION being reported. The ACCEPTANCE scale also showed an overall negative correlation of -.55 with the other, NONACCEPTANCE scales. It was found that OVERPROTECTION and OVERINDULGENCE are most closely related to non-accepting parental attitudes.

The Treatment Phase

The initial interview required about three hours to complete, including testing time. Following it, parents were assigned randomly to one of three small groups for DPC treatment.

These treatment groups met weekly for 90 minutes for a 12 week period, two groups at a local hospital, and one at the university psychological center. The groups were conducted by four experienced

co-therapists, including the author, with a mean of 14.3 years of clinical experience beyond their internships. In the first two groups a third professional person from social work also participated as an observer for the purpose of learning the DPC system.

Standard delivery of the DPC program was done during the treatment phase of the study. Schematically, the procedure followed this format:

Week 1: Initial interview, parents seen individually.

Week 2: Group Session 1.

Introduction to the DPC program; parents given the training manual; Points 1 (make a list), 2 (select one behaviour), and 3 (estimate strength); observing behaviour at the what-do-you-see-and-hear level; homework assignment for the above; group interaction and discussion.

Week 3: Group Session 2.

Review Points 1, 2, and 3 with discussion of problems with the material; Points 4 (setting goals), and 5 (A-B-C charts); making A-B-C chart for selecting and observing behaviour; introduce Child Cooperation Index (CCI) and explain verbal control of behaviour; group interaction and discussion.

Week 4: Group Session 3.

Work more on Point 5; practice thinking in DPC terms; review material from CCI; Points 6 (know the positives), and 7 (know the negatives); define reinforcers in each child's life; group interaction and discussion.

Week 5: Group Session 4.

Review Points 6 and 7; discuss problems with the material; present Points 8 (making words matter), and 9 (making rules); examples of common problems parents have with these points; five ways to reinforce behaviour via consequences, or C's: C+ (reward), C- (punish), -C- (relief), -C+ (loss), and C° (withhold), and their effects on frequency of behaviour; group interaction and discussion; collect CCI data.

Week 6: Group Session 5.

Review Points 8 and 9; discuss problems with material; present Points 10, 11, 12, 13, 14, 15, 16, 17, and 18 which relate to decreasing the frequency of unwanted behaviours; group interaction, discussion and practice.

Week 7: Group Session 6.

Review Points 10 through 18; discuss problems with material; practice decreasing strategies; expand individual lists of negative reinforcers; collect CCI data; group interaction and discussion.

Week 8: Group Session 7.

Present Points 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, and 29 which relate to increasing the frequence of desired behaviour; principles of positive reinforcement; group interaction and discussion.

Week 9: Group Session 8.

Review Points 19 through 29; discuss problems with material; Point 30 (rehearse (A-B-C); collect CCI data; group interaction and discussion.

Week 10: Group Session 9.

DPC practice; discuss problems with material; rehearse application of DPC principles to home situation.

Week 11: Group Session 10.

As in Session 9; collect CCI data..

Week 12: Group Session 11.

As in Session 9.

Week 13: Group Session 12.

As in Session 9; parents advised that this would be the end of the formal training program; we will meet again in one month for a follow-up session to handle any problems that may emerge; therapists are available in the meantime on a stand-by basis; collect CCI data.

At this point the main treatment program was completed. Parents were asked to go home and practice what they had learned.

The Child Cooperation Index (CCI) mentioned above was devised for this study. It was used as an ongoing measure of in-treatment progress. A copy of this instrument appears in Appendix A. The CCI was administered every two weeks throughout the treatment phase of the study to assess the amount of verbal control parents might achieve over time for certain specified behaviours of their child.

The rationale for the CCI was that the amount of verbal control acquired over a child's behaviour by his parents would be reflected in some aspects of the child's cooperation with parental requests. Parents were thus asked to make a list of five routine daily behavioural tasks which they expected their children to complete. These consisted of such things as brushing teeth, eating meals, picking up toys, and so forth. A complete list of the behaviours appears in Appendix D.

After making a list of five daily behaviours, parents were asked to score them for a seven day period on three dimensions: (a) the number of times the behaviour was requested before the child began complying, (b) the number of minutes needed by the child to complete the task, and (c) the amount of the task finally completed, rated on a nine point scale. Ultimately, only the first measure, time to task completion was used, since the other two measures proved ambiguous and difficult for parents to assess accurately. However, each parent seemed acutely aware of how many times they had to ask their children to do things.

One Month Follow-up

When the parents in the treatment group returned one month later, the follow-up session was devoted to discussing any difficulties they may have had with implementing the DPC program. There were few problems. During this session, the parents were also asked to complete some of the same tests used in the initial interview, as part of the repeated measures strategy. Tests used at this time were: The Semantic Differential (SD), Family System Survey (FSS), Walker Problem Behaviour Identification Checklist (WPBIC), Child-Behavior Rating Scale (CBRS), and Mother-

Child Relationship Evaluation (MCRE):

In addition, one other measure, the Improvement Rating Scale (Patterson, 1973) was used. The Patterson Improvement Rating Scale (PIRS) is a six-item questionnaire designed to measure consumer satisfaction with treatment outcomes. It measures feelings about changes in parent, child, and family, as a result of treatment, in a better-same-worse manner. An additional item was added to the PIRS for this study, asking parents to rate the tension level of their homes on a 100 point SUDS scale. At this point, treatment was concluded. Parents were advised that we would be available if needed, and that we might also want to contact them at some future point to see how they are doing then.

One Year Follow-up

During the following 12-month period, no further contact with us ensued from any of the parents. At the end of this one year period following conclusion of treatment, an attempt was made to contact each of the families in the treatment sample. This was successful with five cases.

A one-year follow-up interview was done with the five cases, during which an informal discussion of "how things are now" was completed. In addition, the fate of the original presenting problem behaviours was probed. Parents were asked specifically about the current occurrence of the problem behaviours which had brought them to therapy a year before. A complete list of those behaviours appears in Appendix C.

These behaviours constituted the specific foci of treatment for each parent, that is, the behaviours which they set out to modify via the DPC program. The problem behaviours were tabulated in advance, and parents were asked if they now fit one of four categories: (a) worse; (b) the same; (c) much better, or; (d) non-existent.

In addition, each parent was again given the Patterson Improvement Rating Scale, plus selected items from the Family System Survey which had shown significant changes one year earlier in the pre and post-treatment conditions.

Summary of Measures Used

The following is a schematic outline of the measures used in this study under pre-treatment, in-treatment, one month post-treatment, and one-year post-treatment conditions.

1. Pre-treatment measures.

   Semantic Differential (SD).

   Walker Problem Behaviour Identification Checklist (WPBIC).

   Social Readjustment Rating Scale (SRRS).

   Family System Survey (FSS).

   Child Behavior Rating Scale (CBRS).

   Mother-Child Relationship Evaluation (MCRE).

2. In-treatment measures.

   Child Cooperation Index (CCI).

3. One-month post-treatment measures.

   Semantic Differential (SD).

Walker Problem Behavior Identification Checklist (WPBIC).

Family System Survey (FSS).

Child Behavior Rating Scale (CBRS).

Mother-Child Relationship Evaluation (MCRE).

Patterson Improvement Rating Scale (PIRS).

4. Twelve-month post-treatment measures.

Family System Survey (FSS), 14 items.

Patterson Improvement Rating Scale (PIRS).

Survey on fate of presenting problems.

Treatment Time

One measure of therapeutic efficiency is how long it takes any form of treatment to produce effects. If the time needed is extreme, as in psychoanalysis, for example, the treatment cannot be said to be very efficient. This of course is not inseparable from clarity and specificity of treatment goals.

In this study, group and individual clinical contact time totalled 14 sessions at 1.5 hours per session, or 21.0 hours in all. This includes the initial interview and one-month follow-up session, but excludes test-taking time, which added another 5.0 hours to the total. Test-taking would probably not be part of the usual clinical situation with the DPC program. Excluding the initial interview, treatment time amounted to 19.5 hours.

Added to the above is the amount of time parents spent in home practice. Six of the seven parents in the treatment group reported

spending about one hour a day on DPC practice during the active 12-week treatment phase. This amounted to around 84.0 hours of practice time over 12 weeks. The total time investment for each parent thus amounted to around 95.0 hours.

The DPC program is seen as being fairly economical in its demands for clinical time, especially when compared to more traditional forms of family therapy. Ways must constantly be sought to further streamline the program and enhance its impact however.

Statement of Purpose

The major purpose of this research is to investigate the effect of the Directive Parental Counselling program on those events which are called extra-conditioning variables in parents who have been trained as therapists for their children. It is the first organized attempt to assess those extra-conditioning events.

The study is vitally concerned with being relevant to the realities of clinical practice. Noting that clinical practice and research have not been convergent endeavors, Tharp and Wetzel (1969) urgently argue for more concern with the development of techniques for monitoring the treatment environment and its many human complexities. Most clinical research to date has had little relevance to the treatment process itself. Tharp and Wetzel argue for looking beyond behavioural frequencies and statistical probability statements about age, sex, number of clinic visits, long term job stability, and so forth, to variables more intimately related to the environment in which the treatment process occurs,

that is, to extra-conditioning variables.

The term extra-conditioning variable is used to describe those events in the lives of parents and children which are not target behaviours, but which relate to, or are associated with, changes in target behaviours. In past clinical research, the DPC program has been shown to be an effective method for altering the behavioural repertoire of children who have been labelled as problem children by their parents, or others in their environments (Holland, 1970; Hyde, 1975; Labadie, 1969).

Therapists experienced with the DPC program often comment that changes in successful cases are frequently initiated by, or associated with, observable changes in the parents and family situations. Such changes are in addition to those occurring in the target behavioural events toward which the DPC program directs itself, thus constituting extra-conditioning variables.

Extra-conditioning variables include such things as changes in the overall appreciation of the problem child by his parents, changes in discipline, less reliance on punishment, various attitudinal changes, changes in the feelings parents have about their effectiveness in the parental role, altered perceptions of themselves and their spouses in relation to the problem child, changes in their modes of observing and valuing behaviour, changes in family communication patterns, decreased sensitivity to the behaviour of siblings, increased positive spontaneous interaction among family members, changes in the problem child's interaction with peers, siblings, and parents, and so forth. In most instances

these assumed changes were seen as necessary adjunctive events if therapy was to be successful, and if changes in target behaviour were to endure over time.

The actual existence of these extra-conditioning events remained in limbo however. Like the hunt for the elusive, mythical Snark, their existence was based heuristically on inferences derived from statements made by parents during clinical interviews, which led to the belief that such events "must exist." While the parents probably were being truthful, having no motivation to lie, they could have been imagining things, since no attempt had been made to systematically search for such changes until the present study was undertaken.

If such extra-conditioning variables indeed existed, their measurement would obviously be much more difficult and elusive than simply measuring changes in target behaviour. Target behaviour changes can be easily handled via simple frequency counts and grapholinear curves. Extra-conditioning events probably could not be. For these and other reasons, the present study was undertaken with much trepidation as an exploratory shot-in-the-dark, without confident expectations of significant results. The feeling was that if it got any results at all, it would be a minor miracle, in view of the essential untidiness of its subject matter.

In this study, target behaviours are dealt with only indirectly. Target behaviours are obviously necessary as a means of delivering the DPC program, and are seen as anchoring points for treatment. The main concern is with changes in other events and with global effects which

go beyond target behaviours. To study such extra-conditioning variables at all, measuring instruments had to be chosen or constructed which would cover a fairly large number of possibilities, most of which could only be guessed at in advance.

Research Design

The design used in the present study follows the A-B paradigm (Barlow and Hersen, 1973), or quasi-experimental design (Campbell, 1966). The study uses a single group outcome, or multiple systematic case study design.

Barlow and Hersen (1973) note that there are serious problems in evaluating clinical treatment via traditional research methodology using large group comparisons. The A-B design is often more appropriate to the study of complex behavioural situations, as well as being firmly founded in the scientific method.

In the A-B paradigm, systematic measurement of pre-treatment baseline (or A) conditions is done, with repeated measures during and after treatment (or B) conditions. This design yields interpretable results if baseline data are adequate, and if there is a change in behaviours coincident with the introduction of treatment. Finding similar changes in target variables in several subjects at the same point in time in relation to treatment is seen as fairly strong evidence for the efficacy of treatment (Barlow and Hersen, 1973).

The A-B design lacks the scientific rigor of a design using pre-treatment baseline, treatment, and return to baseline conditions, or

the A-B-A paradigm. It also lacks the rigor of the A-B-A-B paradigm which requires a second test of the efficacy of B as the agent responsible for change. It is also less rigorous than a design using an untreated control group, or even more powerfully, one using treatment, attention-placebo, and no-treatment controls. There are difficulties in applying more rigorous methodology to the clinical situation, however, which tend to offset its value.

Levine (1974) argues that demands for scientific rigor in clinical research tend to involve a simple-minded extrapolation of laboratory conditions to real-life situations, which seldom permit adequate controls. There also are obvious ethical issues related to the use of untreated control groups when one deals with the demands of human pain and despair alleviation. In genuine clinical situations, it is not possible to ask people to get better, then get worse again, to test the efficacy of clinical procedures. The thrust of clinical work is entirely toward getting better and staying that way.

Problems also exist with adding control groups. What has become known as Lord's Paradox states that there is simply no logical or statistical procedure to rule out uncontrolled pre-existing differences in groups of people, hence control groups are never truly comparable (Lord, 1967). Werts and Linn (1969) also point to the difficulties encountered with scientifically rigorous procedures which are not a reasonable approximation of the events studied. This is often not a safe assumption in clinical research.

Difficulties also arise with adding an attention-placebo control

group, to compensate for changes due to "attention" paid to people, which may operate therapeutically via expectancy or hope effects. For the most part, these problems relate to defining attention so that it is not de facto therapeutic, hence confounding of real treatment effects. Since placebo effects can be genuinely therapeutic, it is hard to deliver attention non-therapeutically in ways which do no violence to the human condition, and normal social reality. Doing violence to the human condition assures that attention will be harmful, hence countertherapeutic, which offers yet another distortion of results gained in this way.

After reviewing the above difficulties, the less rigorous but more realistic A-B design seemed most desirable. It was assumed that if we found any changes in the treatment group on the variables studied between pre-treatment baseline and post-treatment conditions, those changes would qualify as being coincident with the introduction of treatment, hence probably due to the effects of treatment. Further, if any of the observed changes were found to hold over time, it would be further confirmation of treatment effect.

Statistical Analysis

The following presentation discusses the rationale for choosing the measuring instruments used in this study, and the ways in which they were analyzed.

1. The Family System Survey, (FSS). A major problem in psychotherapy research has been defining and equating for future comparative

research those client characteristics which may have a significant influence on the outcome of the treatment process. In behaviour therapy, many paradigmatic studies have been done, the results of which when applied to the clinical situation, fall short of expectations. One major problem in this regard seems to be that the populations studied have often been selected from university students, or university counselling centers. As such, they have differed radically along many dimensions from those individuals seeking professional help from diverse hospitals and clinics. College students or laboratory groups are probably not representative of the typical clinical population, itself an admitted abstraction, hence generalization from them to the typical population of clinical help-seekers is limited.

For this reason, the Family System Survey was devised to assess those specific environmental and personal, as well as interpersonal, characteristics which can influence treatment outcomes. This instrument was used in two ways in the present study.

The first application of the FSS was to derive a set of sample descriptors based on the pre-treatment baseline data, in order to describe the sample and see if it came from the same population. For this purpose, mean scores on each of the 37 items of the FSS were computed. From that, descriptive statements of such variables as socio-economic level, physical characteristics of the home, quality of interaction between family members, and so forth, could be made.

The second application of the FSS involved comparisons of some of the 37 items in pre-treatment baseline and post-treatment conditions.

Not all of the FSS items could be expected to show changes during treatment; for example, number of rooms in the home, income, and so forth. Still others, such as the child's mobility in the home, amount of punishment received, and so forth, could show changes. To assess these possible changes, the F-test analysis of variance for main effects was again used, plus the t-test to evaluate significance of differences between the means for each of the items.

The FSS was thus used mainly as an instrument which might give information helpful as a survey of environmental factors supportive of treatment outcome. It represented a sort of omnibus measure with a variety of item content. Its use constituted a pilot attempt to define environmental characteristics relevant to treatment in a rational, heuristic manner.

2. The Social-Readjustment Rating Scale (SRRS). The SRRS was used in the pre-treatment baseline condition only, and served as a general measure of yet another extra-conditioning variable, personal life stress. It was also an indirect measure of a person's adaptation to their environment, as discussed earlier. The greater the number of life changes scored on this scale, the more varied the life circumstances of the person have been in the preceeding 12 months, and the greater the adaptive cost of living. The higher the score on the SRRS, the greater the amount of stress experienced in the personal life situation, hence the more difficult will be adaptations to new demands. This could have an indirect effect on treatment outcome, since higher scoring persons would be expected to be less open to change, due to

depletion effects.

The scoring unit used in the SRRS is the Life Change Unit (LCU), derived normatively from the amount of stress associated with various adaptive changes (Masuda and Holmes, 1967; Komaroff, et. al, 1968). It is scored on a 100 point scale and is nearly identical to that other stress unit, the Subjective Unit of Discomfort (SUD) used by others (Wolpe, 1966).

Prior work with the SRRS has shown that higher scores relate to organic and non-organic dysfunction in the following way:

150	- 199 LCU's	=	Mild Stress	=	37%	illness
200	- 299 LCU's	=	Moderate Stress	=	51%	illness
300+	LCU's	=	Severe Stress	=	79%	illness

We assumed that people who seek help clinically might experience a greater amount of stress than the average population. Our treatment group could thus differ significantly from the standard population in terms of subjective stress, which might be reflected in their LCU scores related to live adaptations made in the year prior to treatment.

Comparisons were made between expected LCU values, based on the norms for the SRRS, and observed LCU values reported by the parents in the treatment group for the idioverse specific effects of their adaptive stress in the 12 months prior to treatment. Mean LCU values were used for this purpose, and a t-test was done for significance of mean LCU differences.

3. The Semantic Differential. A major set of extra-conditioning

variables often noted by those familiar with the DPC program relates to changes along attitudinal dimensions in parents with regard to: (a) their individual child; (b) their entire family constellation; (c) themselves as parents; (d) their spouses as parents; (e) how they define problematical child behaviour, and; (f) how they perceive their own children along problem lines. It was assumed that if these changes are real, they could be measured by a test of conceptual meaning constructed with a view to the above dimensions, and that changes in meaning might be seen as a result of treatment.

The Semantic Differential was chosen as a means of measuring certain perceptual and conceptual meaning changes occurring during the treatment process. In this context, meaning is defined as an intervening variable, explicitly defined as a representational mediation process, or a learned state, which is elicited by certain stimuli and constitutes their significance, and which also initiates overt responses, both linguistic and nonlinguistic (Osgood, et. al, 1957).

It was assumed that parents overt responses to the Semantic Differential would serve as an operational index of that representational mediating process called meaning. In prior applications of the semantic differential technique to psychotherapy, it was found to reliably reflect changes in meaning significance which various persons, events, and situations have for the patient, as well as the inter-relationships between these changes in meaning (Osgood, et. al, 1957; Endler, 1961).

In the present study we were concerned with making comparisons of

the seven relevant concept meaning dimensions in the pre-treatment and post-treatment conditions. The major concepts used were compared in terms of parent ratings, that is, MY FAMILY (MF); MY CHILD (MC); THE IDEAL CHILD (IC); A PROBLEM CHILD (PC); THE IDEAL PARENT (IP); ME AS PARENT (MAP); and MY SPOUSE AS PARENT (MSP), under pre and post-treatment administrations of the Semantic Differential.

Comparisons were then made of changes in the seven concepts, using the F-test analysis of variance for overall main effects. In addition, the t-test was used for assessing the significance of differences between means for each concept on each of the three factors, E, P, and A.

Hypothesis I of the study was that there would be significant changes in the meanings assigned to the seven concepts in the post-treatment condition. It was not possible to specify the direction of change in an a priori way.

In addition to the above analysis of the seven semantic differential concepts, six difference comparisons were made of concepts with each other in the pre and post-DPC treatment conditions. The six concepts compared were: MY CHILD vs. IDEAL CHILD (or MC/IC), MY CHILD vs. PROBLEM CHILD (or MC/PC), IDEAL CHILD vs. PROBLEM CHILD (or IC/PC), MY SPOUSE AS PARENT vs. ME AS PARENT (or MSP/MAP), MY SPOUSE AS PARENT vs. IDEAL PARENT (or MSP/IP), and, ME AS PARENT vs. IDEAL PARENT (or MAP/IP). For this second analysis of the semantic differential technique, the F-test was also used.

Hypothesis 2 of the study was that there would be significant changes

between pre and post-DPC treatment conditions in the mean differences shown for the six concept comparisons. It was further hypothesized that changes in the meaning discriminations assigned by parents to the concepts involved would change following DPC treatment. It was not possible to specify the direction of change in advance.

4. The Walker Problem Behavior Identification Checklist, (WPBIC). Apart from those target behaviours presented by parents for change via DPC treatment, it appeared desirable to have information about the degree of disturbance in the children of those parents in the treatment sample. Degree of disturbance, as defined by the Mean values of the five clinical scales of the WPBIC, plus its total score, might have an effect treatment outcome, as yet another extra-conditioning variable. Changes in degree of disturbance of the children involved would also be of great importance, since the children were not treated directly, and if such changes did occur, it would lend support to the efficacy of the DPC program as a vehicle for changing child behaviour via parent interventions.

The WPBIC scales all measure negative behaviours, such as might be defined as psychopathology in many clinical settings. In the present study, this instrument was used to asses changes in disturbed behaviour in children as a result of treatment of their parents. To assess these changes, the F-test analysis of variance for main effects was used, plus the t-test for significance of mean differences on each of the WPBIC scales in pre and post-DPC treatment conditions.

Hypothesis 3 of the study was that each of the five clinical scales

of the WPBIC, which are: ACTING-OUT, WITHDRAWAL, DISTURBED PEER RELATIONS, IMMATURITY, and DISTRACTABILITY, as well as the TOTAL SCORE, would show a significant decrease following DPC treatment of the parents of the children showing these behaviours.

5. The Child Behavior Rating Scale, (CBRS). The CBRS was used as a further measure of the impact of the DPC program on child behaviours. As with the WPBIC, we were concerned with changes in the child's behaviour mediated by the parents. Changes in the CBRS would serve as another indication of the efficacy of the DPC program.

As a measure of the child's adjustment in several critical areas: HOME-ADJUSTMENT, SELF-ADJUSTMENT, SOCIAL-ADJUSTMENT, SCHOOL-ADJUSTMENT, PHYSICAL-ADJUSTMENT, and PERSONALITY TOTAL ADJUSTMENT, the CBRS is also negatively biased, measuring behaviours which show disturbed or faulty adjustment of the child. The concept of adjustment goes somewhat beyond specific behaviours, however, and relates to more global effects in the child's life. In the present study, it was seen as possibly related to the spread of effects from treatment beyond target behaviours to broader aspects of the child's life. To assess these possible effects, the F-test for overall main effects was used for administrations of the CBRS in pre and post-DPC treatment conditions, plus the t-test for significance of differences in the mean scores for adjustment on the various CBRS scales.

Hypothesis 4 of the study was that children of parents in the treatment sample would show changes in the direction of significantly better adjustment, as measured by the CBRS, following treatment by the DPC

program.

6. The Mother-Child Relationship Evaluation, (MCRE). As a measure of maternal attitudes toward children, the MCRE was used in this study to assess changes in the pre and post-DPC treatment conditions in the four attitudes measured by this instrument: ACCEPTANCE, OVER-PROTECTION, OVERINDULGENCE, and REJECTION. These four attitudes on the part of mothers in the treatment sample were seen as critical determinants of the ways in which they related to their children. If changes in these attitude scales could be found following treatment, it would lend further support to the efficacy of the DPC program in changing not just child behaviours, but maternal attitudes as well.

To assess these possible changes in the MCRE, the F-test analysis of variance for main effects was again used. The t-test for significance of differences in the mean values for each of the MCRE scales was also utilized.

Hypothesis 5 of the study was that these crucial attitude variables which find overt expression in mother-child interaction would show changes in a positive direction following treatment by the DPC program. Further, that the direction of change would be defined by the scales involved. Specifically, the ACCEPTANCE scale was expected to show a significant increase, while the other three scales were expected to show significant decreases.

7. The Child Cooperation Index, (CCI). Those experienced with the DPC program often observe that perfect verbal control of child behaviour is a nearly universal wish among parents. Perfect verbal

control is operationally defined as getting the child to do whatever you want him to do, simply by asking.

The reasons for this wish for verbal control are simple. Words are economical in terms of energy expenditure by parents. Words also constitute the major means of control and communication in adult-to-adult relationships, which are heavily loaded with symbolic-verbal content.

Unfortunately, children often frustrate parental wishes for verbal control. Words have a different meaning to children, whose symbol manipulating skill is less developed. Children may also fail to respond to words because of how parents use them. When children do fail to respond to verbal statements, parents become frustrated. They must then use words differently, or resort to non-verbal, usually physical, means of control by doing something about the child's behaviour.

A commonly observed self-defeating pattern which becomes both circular and escalating, for example, involves parents using typical word patterns several decibels higher than usual when they fail to produce a response from the child. Departures from these statements at the usual level to be self-defeating, since the child learns to "tune out" at higher and higher levels of auditory accomodation until parents can scream no louder, whereupon they stop in defeat, or resort to physical punishment.

Parents may also do other things to subvert their wish for verbal control, mostly by unwittingly not making words matter in their interaction with the child. In view of the complexities of the parent role it is easy to be unwitting about such things. When parents make threats

that are never backed by action, or establish rules that are unenforceable, the value of words is further discounted in the child's mind. In the interest of making sense out of life, the child listens to actions, not words.

It thus seemed important to evaluate verbal control as yet another extra-conditioning variable. The CCI is primarily a measure of how effectively verbal control is used by the parents in the treatment group. Changes in verbal control over time during treatment would have much importance. The variable, Number of Requests, was chosen for study. This referred to the number of times a parent had to request that a task be done before the child started doing it.

To assess changes in verbal control, mean scores were computed for: (a) the number of requests made per day over five trials, or administrations of the CCI, (b) the mean number of requests for the five daily behavioural tasks over the five trials, and (c) the raw score means for Task I through Task 5. The t-test was also used to assess the significance of differences in the means for the five tasks over time. In addition, comparisons were also made for the first two trials with the last two in terms of degree of change.

Hypothesis 6 of the study was that those events specified by the CCI related to child cooperation with parental requests for five daily behavioural tasks, T-I through T-5, would show significant changes in the direction of increased verbal control by parents during treatment with the DPC program.

8. The Patterson Improvement Rating Scale, (PIRS). Subjective

appraisal of therapeutic effectiveness by clients is another extra-conditioning variable with which we were concerned. As a measure of consumer satisfaction, the PIRS is clearly related to the prior existence of positive feelings on the part of clients toward the treatment procedures they encountered (Patterson, 1973).

While such consumer evaluations can be biased, the value of frank opinion material is not to be minimized in short-term evaluative studies, especially when it is supported by other material pointing in the same direction, even by the judgments of several other people familiar with the course of treatment, (Herzog, 1958). In combination with other indicators all pointing in the same direction, a sort of consensual validation effect occurs.

Individual satisfaction with the procedures encountered is obviously facilitative as well in terms of continued application of the things learned in the DPC program. It seemed probable that absence of satisfaction could lead to early rejection of the DPC program as irrelevant. This in turn could lead to non-generalization of the procedures to extra-therapeutic situations.

No treatment program is of value if its consumers fail to make full use of it in their daily lives. Very simply, the more satisfied people are with the treatment experience, the more likely they are to adopt it as their own, and the more likely changes are to become permanent (Herzog, 1958). Such permanence, or the spread of effect of therapy beyond the therapeutic situation, is a major goal of this treatment.

To assess these results of consumer satisfaction on the PIRS, data

for each of the six items were tabulated, and presented as to the number of parents choosing each alternative, as done by Patterson (1973). Mean ratings for each item were then computed. Item seven, SUD level in the home, was also dealt with in terms of mean value.

Hypothesis 7 of the present study was that, since the PIRS is a post-treatment measure, if delivery of the DPC program was successful, all of the ratings by parents of treatment effectiveness would be in a positive direction.

One-Year Follow-up Measures

In contacting parents one year after treatment, the PIRS was again administered, and scored in the same manner as in the post-DPC treatment condition.

In addition, those items from the FSS which were found to discriminate significantly in the pre and post-DPC treatment conditions were again administered. The main concern was with determining if changes in the FSS held over time. A comparison of mean values for each of the 14 significant items was done, with a t-test for significance of mean differences, if any were found. The t-test was also used to analyze mean differences in any of the FSS items which changed still more significantly one year later.

Finally, the fate of the presenting problem target behaviours was evaluated on one-year follow-up. There were 25 such behaviours in all. They were tabulated, and totals recorded in one of four outcome categories: (a) worse, (b) the same (c) much better, or, (d) non-existent.

Summary of Hypotheses

In summary form, the following hypotheses were stated for the present study.

Hypothesis 1: The semantic differential technique would reveal significant changes in the meanings assigned by parents in the treatment group to the seven concepts studied, between the pre and post-DPC treatment conditions. These changes could be in either direction.

Hypothesis 2: The semantic differential technique would also reveal significant changes in the six concept comparisons which were studied in terms of difference scores and relationships between the concepts, under pre and post-DPC treatment conditions. These changes could also be in either direction.

Hypothesis 3: Changes in the WPBIC measures would show significant decreases in each of the five clinical scales, as well as the total score, following DPC treatment.

Hypothesis 4: Changes in the CBRS measures would show significant increases in the direction of better adjustment, following DPC treatment.

Hypothesis 5: Changes in the MCRE measures would show a significant increase in the ACCEPTANCE scale, and equally significant decreases in the other three negative

scales, following DPC treatment.

Hypothesis 6: Changes in the CCI measure, Number of Requests, would show a significant increase in child co-operation and related verbal control by parents, following DPC treatment. This would be reflected in a decrease over the five trials in the number of requests needed to elicit the child behaviours studied.

Hypothesis 7: The PIRS measure of consumer satisfaction would show all ratings by parents of treatment effectiveness in a positive direction, following exposure to the DPC program.

While no formal hypotheses were stated for the FSS, due to its exploratory nature, it was thought that changes in some of the 37 items of this survey might occur following DPC treatment. However, there was no way of knowing a priori which items might be involved.

The SRRS, which was used as a pre-treatment measure, also permitted no formal hypotheses. However, it was assumed that there might be differences in our treatment group in terms of stress level which could distinguish them from a normal population.

Summary Statement of Purpose

The major purpose of this study can be stated as follows:

1. To determine that extra-conditioning variables are not a myth, but do indeed exist and can be specified.

2. To determine whether or not changes in these extra-conditioning variables occur in association with exposure to the DPC treatment.

This study is thus concerned with systematically assessing whether extra-conditioning events occur, and their relationship to treatment outcome via administration of the DPC program.

Alternately, if the search for extra-conditioning variables proved futile, we would be safe in assuming that such variables were mere figments of fevered clinical imaginations. Either alternative seemed equally possible.

CHAPTER III

PRESENTATION AND ANALYSIS OF RESULTS

Prensentation Formata

This chapter presents the results of this study, with appropriate explanatory comments concerning the findings. The order of presentation of the results is as follows:

1. Fate of Initial Referrals.

Pre-DPC Treatment Program Data

2. List of Presenting Problem Behaviours.
3. The Family System Survey Pre-treatment Results.
4. The Social-Readjustment Rating Scale.

Pre vs. Post-DPC Treatment Program Data

5. The Semantic Differential.
6. The Family System Survey, Post-treatment Results.
7. The Walker Problem Behaviour Identification Checklist.
8. The Child Behavior Rating Scale.
9. The Mother-Child Relationship Survey.

In-DPC Treatment Data

10. The Child Cooperation Index.

Post-DPC Treatment Program Data

11. The Patterson Improvement Rating Scale, Post-treatment and 12-month Follow-up Results.
12. The Family System Survey, Post-treatment and 12-month Follow-up Results.

13. Survey on the Fate of Presenting Problem Behaviours on 12-month Follow-up.

This format corresponds to the different phases of the measurement process employed in the study. With the exception of the Social-Readjustment Rating Scale, each of the measuring instruments used was administered more than once.

1. Fate of Initial Referrals. Table 1 presents the fate of the 24 initial referrals for DPC treatment, in terms of completion of the treatment program.

Table 1

Fate of Initial Referrals for DPC Treatment

Fate	Number
Total Referrals	24
Found Inappropriate at Initial Interview	2
Failed to Return After Initial Interview	
Due to not Having Transportation	1
Completed 8 Training Sessions	2
Completed 7 Training Sessions	1
Completed 5 Training Sessions	4
Completed 4 Training Sessions	2
Completed 3 Training Sessions	3
Completed 2 Training Sessions	2
Completed Entire Program	7

Only those parents actually starting treatment were included in the total group sample, while only those actually completing treatment were included in the treatment group. Most of the drop-outs occurred around the fourth and fifth training sessions. In all except two cases, one of which acquired a job which conflicted with treatment scheduling, and the other when the family moved to its summer home too far distant for treatment, the reasons for these drop-outs are not specifically known.

2. Presenting Problems. Table 2 contains a list of presenting problem categories. There were 23 such categories of problem behaviour, with 75 behaviours being reported. Most parents reported more than one problem behaviour. These problem behaviours constituted the primary factors which motivated the parents to seek treatment, and served as the initial targeting framework within which DPC treatment was directed. Not all of the behaviours listed were subject to treatment. The aim of treatment was to teach principles of behavioural management, with the assumption that if parents could modify selected behaviours via DPC treatment principles, they could then proceed to apply the same principles, to other behaviours.

None of the children of the parents in the original total group had ever been diagnosed as being retarded, brain damaged, psychotic, or autistic. The vague term "hyperactive" had been attached to seven of them, however, and these seven children were known to be using either Ritalin hydrochloride or Dexedrine sulfate, both of which are central nervous system stimulants which often have a paradoxical

Table 2

Summary of Presenting Problems for Total Group

As Listed by the Parents

Problems	Number
Hyperactivity	7
Parents Unable to Make Rules and Set Limits	7
Parents Feel Dominated by Child	2
Words Don't Matter, Child Tunes Out Parents	7
Child Too Slow and Pokey	5
Whining Behaviour from Child	4
Child has Tantrums and Rages, Gross Motor Type	6
Child is Argumentative and Loud	4
Parents Feel Guilty Due to Excessive Punishment	5
Child Behaves Poorly in Public	3
Child Behaves Poorly Whenever Parents are Preoccupied	2
Mealtime Eating Problems with Child	3
Child Listens to Parents, but Fails to Comply	1
Bedtime Problems, Child Resists Bed, Sleep, etc.	2
Child has Self-Care Problems With Bathing, Dressing, etc.	3
Child Provokes Open Combat With Siblings and Peers	1
Child is Overly-impulsive	2
Child has Psychosomatic Complaints	3
Child Cries Excessively	3
Child is Picked-on by Peers	2
Child Over-reacts to Failure by Regressing	2
Child Manipulates Parental Guilt	1
Parents Feel Child More Intelligent than They are	1
Total	75

sedative effect on immature neural tissue. In four of the medicated children, the drug had been initiated at the request of the school for purposes of controlling classroom behaviour, while in the other three cases the family pediatrician had begun the drug regimen in response to parental complaints.

3. The Family System Survey Pre-treatment Data. The reader may refer to Appendix F for the table of raw data and mean values for the 37 items of the Family System Survey (FSS). In the first administration, this instrument was used to derive a set of sample descriptors to help us understand something about the characteristics of those parents, and the children of those parents, in the total group.

Items 1 and 2 of the FSS if considered together, constitute the Hollingshead Two-Factor Index of Social Position (Hollingshead, 1957). This is an index of social class, based on two factors, occupation and education, which has found usefulness in studies of socio-economic factors related to mental illness (Myers and Roberts, 1959; Myers & Bean, 1968). In computing the score for this index, the score for occupation is given a weight of 7, while that for education is given a weight of 4, and then both are combined into a total score which is equivalent to a given social class. The range of possible scores for both factors is from 1 to 7.

Thus, for example, the score for a person whose education consisted of graduate professional training would be 7 times 4 = 28, and whose occupation was that of a professional person would be 7 times 7 = 49, for a total score of 77. This hypothetical person would belong in

Social Class V. The range of total scores in corresponding social class ratings on this two-factor index are as follows:

Range	Social Class
11 to 17	I
18 to 27	II
28 to 43	III
44 to 60	IV
61 to 77	V

The mean social class value for the total group was 2.50, with a range of 1 to 5, and a median value of 2.00. The sample was thus predominantly lower-middle class.

Item 3 relates to family income, which is another socio-economic indicator. This item was scored on a five point scale, with a score of 1 being given for incomes under $5,000.00 annually, and a score of 5 assigned to family incomes, over $30,000:00 per year. The mean income level for the group was 2.68, corresponding to an annual income of $5,000.00 to $10,000.00 dollars, with a range of from $5,000.00 to $30,000.00, and a median of 3.00 or $10,000.00 to $20,000.00 annual income.

Item 4 on the FSS related to the size of the home the family lived in, in terms of actual number of rooms. The mean number of rooms for the parents in the total group was 6.81, with a range of 3 to 12 rooms, and a median of 6.00 rooms.

Item 5 asked how many of the above rooms were off-limits to the child with the presenting problems, as a measure of that child's

physical mobility in the home. The mean number of rooms off-limits was 0.86, with a range of 0 to 3, and a median of 0, indicating that, as a group, the parents in the total sample were not overly-restrictive of their childrens' movement in the home.

Item 6 dealt with the age of the child with presenting behavioural problems. The mean age of the children of the parents in the total group for whom data were available was 71.41 months, or 5.95 years, with a range of 2.16 to 11.25 years. All of the children in the sample were thus pre-adolescent, and most were of early elementary school age.

Item 7 dealt with the number of other children in the home. The mean number of children in the homes of the parents in the total group was 1.40, with a range of 1 to 4 children, and a median of 1 other child, for a total of 2 children in the family in all. Small families thus constituted the majority of those in the total group.

Item 8 had to do with the total number of people living in the home with the problem child, other than biological family members. The mean number of outsiders was 0.22, with a range of 0 to 1, and a median of 0. The families in the total group were thus relatively free of extraneous people, such as grandparents, uncles, or whatever, in the immediate home situation.

Item 9 dealt with the tension level in the home prior to treatment, expressed in Subjective Units of Discomfort (SUD). The mean SUD level of the total group was 54.21, with a range of 0 to 100, and a median of 50. Since a normal SUD level would be generally around 20 to 25 units, the perceived tension level in the families of the

total group prior to DPC treatment was fairly high.

Item 10 asked whether both parents would be involved in treatment, only one involved, or if one would be opposed. These options were scored 3, 2, and 1 respectively. The mean for this item was 2.63, with a range of 2 to 3, and a median of 3.00, indicating that for most of the families, both parents planned to be involved in treatment in some way, whether or not they actually attended the training sessions. None of the parents felt their spouses opposed treatment.

Item 11 had to do with the number of influences outside the home which might be operating to reinforce problem behaviour in the child. Such influences, which might include things like the loving granny who indulged the child with candy despite parental prohibitions, might well be beyond the control ability of the parents, hence not subject to treatment effects. This item was scored on a four point scale, a score 4 being given for no outside influences, and 1 assigned if there were more than two such influences. The mean for this item was 2.90 prior to treatment, with a range of 1 to 4, and a median of 4.00. Thus, while the majority of families had no such negative outside influences, many in the total group did.

Item 12 of the FSS is a compound item, consisting of eight sub-items which make up a marital adjustment, or agreement, index between the parents in the total group. The items, which include such things as agreement on financial issues, sex, life philosophy, and so forth, were scored on a six point scale, with a score of 6 being given to the "always agree" choice, and a score of 1 for "always disagree." The

The total possible score thus was 48 points. The mean agreement score for this item was 31.09, with a range of 20 to 44, showing a moderate degree of concordance between parents in the total group on matters of basic values.

Item 13 dealt with how well parents in the total group felt their spouses listened to them when they had something important to say. This item was scored on a five-point scale, with a score of 5 for "always listen" and a score of 1 for "rarely listens." The mean for this item was 2.85, with a range of 1 to 5, and a median of 3.00. Parents in the total group thus did not apparently feel that they were listened to very attentively by their spouses.

Item 14 related to listening on the part of the child in question. This item was also scored on a five-point scale, from a score of 5 for "always listens" to 1 for "rarely listens." The mean for this item was 2.57, with a range of 1 to 5, and a median of 1.00, suggesting that parents in the total group did not feel well-listened-to by their children.

Item 15 had to do with how often parents in the total group confided in their spouses. This item was scored on a five-point scale, with a score of 5 for "always confide", and a score of 1 for "rarely confide." The mean for this item was 3.00, with a range of 1 to 5, and a median of 5.00, which suggested a fair amount of confiding among parents in the group.

Item 16 deals with decision making in the family between parents, and how often the parent has to make decisions alone. This item was

scored on a five-point scale, with a score of 5 for "rarely alone" and a score of 1 for "always alone." The mean for this item was 3.04, with a range of 1 to 5, and a median of 5.00, suggesting that, as a group, the parents engaged in a fair amount of conjoint decision making.

Item 17 had to do with the problem-defining role in the family, in terms of who ususally discovers problems first and initiates coping action. This item was scored on a three-point scale, with a score of 3 for "about equal", a score of 2 for the two options "I do mostly" and "spouse does mostly", and a score of 1 for the options "I always do" and "spouse always does." The mean for this item was 1.86, with a range of 1 to 3, and a median of 2.00, suggesting that, as a group, the parents engaged in a fair amount of mutual problem-definition.

Item 18 dealt with how often parents and their spouses felt they really understood each other when they communicated. This item was scored on a five point scale, with a score of 5 for "always understand", and a score of 1 for "rarely understand." The mean for this item was 2.66, with a range of 1 to 5, and a median of 3.00, indicating a fair amount of perceived mutual understanding among spouses in the total group of parents.

Item 19 was intended to measure the number of times in the average day each parent in the total group talked with the child with problems. This item was scored on a four-point scale, with a score of 4 for "over 15 times" and a score of 1 for "1 to 5 times." The mean for this item was 2.13, with a range of 1 to 4, and a median of 2.00, which corresponded to 6 to 10 times a day in which parents talked with the child in question.

indicating a fair amount of parent-child contact.

Item 20 dealt with the actual number of hours in the average day parents spent with the problem child. The mean for this item was 7.09, with a range of 3 to 15 hours, and a median of 3.00 hours. Considering the predominantly young age of the children in the total sample, the number of hours of parent-child contact was by no means excessive.

Item 21 inquired whether the problems shown by the child in question were also present in other children in the family. This item was scored on a four-point scale, with a score of 4 for "3 or more children" and a score of 1 for "this child only." On this item, a lower score is favorable. The mean for this item was 1.18, with a range of 1 to 3, and a median of 1.00, suggesting that problem behaviour was mostly confined to the child in question.

Item 22 related to outside help with the chores of domestic life and child-rearing, in terms of the number of hours per week such help was available to the family. This item was scored on a nine-point scale, with a score of 9 for "over 30 hours" and a score of 1 for "0 to 1 hours." The mean for this item was 1.90, with a range of 1 to 5, and a median of 1.00, indicating that, as a group, parents in the total sample had very little outside help with family chores.

Item 23 dealt with the actual number of times in an average day the parent praised the child with problems. The mean for this item was 5.54 times, with a range of 4 to 10, and a median of 10.00, indicating that, as a group, the parents in the sample were rather liberal in their praise of the problem child.

Item 24 dealt with social activities of the problem child in terms of the number of visits he received in the average week by other children. This item was scored in terms of actual number of visits. The mean for this item was 3.31, with a range of 0 to 7, and a median 0.00, suggesting that, as a group, most of the parents in the sample allowed very little outside visiting by the child.

Item 25 asked how many times a day, in terms of actual number, the problem child was allowed to leave the home for things other than school. The mean for this item was 4.54, with a range of 1 to 10 times out of the home, and a median of 2.00 outside trips, suggesting a fairly limited amount of outside mobility on the part of children in the total group.

Item 26 dealt with the number of hours in the average day the problem child spent outside the home, not including school. This item was scored on a five-point scale, with a score of 5 for "more than 11 hours" and a score of 1 for "0 to 2" hours. The mean for this item was 1.63, corresponding to "0 to 2" hours, with a range of 1 to 5, and a median of 2.00, corresponding to "3 to 5" hours outside the home, indicating a moderate amount of time outside the home for the children in the sample.

Item 27 asked about the actual number of times per week the family enjoyed doing things together. The mean for this item was 2.36 times, with a range of 0 to 7, and a median of 2.00 times, suggesting that family fun times for the families in the total group were fairly limited.

Item 28 dealt with the actual number of hours per week the parents

in the total group were together without their children. The mean for this item was 5.00 hours per week, with a range of 0 to 20, and a median of 0.00, indicating that, as a group, the parents in the sample had very little time free of their involvement with the parental role.

Item 29 asked about the actual number of hours per week each parent had for themselves, to do with whatever they wanted. The mean for this item was 6.22 hours, with a range of 0 to 30, and a median of 10.00 hours. Thus, as a group, while the parents in the sample apparently did not have much time away from their children, they still managed to find time for personal development and maintenance of themselves.

Item 30 dealt with the stress from economic concerns about money in the family. This item was scored on a five-point scale, with a score of 5 for "not at all stressful", and score of 1 for "very stressful." The mean for this item was 3.04, with a range of 1 to 5, and a median of 4.00, indicating that, as a group, parents in the sample did not suffer greatly from money stress.

Item 31 dealt with the conjugal role relationship between parents in the total group, in terms of sharing the workload around the home. This item was scored on a five-point scale, with a score of 5 for "always share" and a score of 1 for "rarely share." The mean for this item was 2.95 with a range of 1 to 5 and a median of 1.00, suggesting that parents in the treatment group did little sharing of the family workload.

Item 32 dealt with how willing each parent felt their spouse was

to assume responsibility for managing the child's behaviour. This item was scored on a five-point scale, with a score of 5 for "always does" and a score 2 for "rarely does." The mean for this item was 3.23, with a range of 1 to 5, and a median of 5.00, indicating that, as a group, the parents in the sample felt their spouse's were fairly cooperative in helping with child management.

Item 33 asked how effective each parent felt their spouse was in handling the child's behaviour. This item was scored on a five-point scale, with a score of 5 for "very effective" and a score of 1 for "rarely effective." The mean for this item was 2.95, with a range of 1 to 5, and a median of 4.00, indicating that, as a group, parents in the sample felt their spouses were fairly effective in coping with child behaviour.

Item 34 dealt with how well the child responds to the spouse's mode of behavioural management. This item was scored on a five-point scale, with a score of 5 for "very well" and a score of 1 for "very poorly." The mean for this item was 2.42, with a range of 1 to 5, and a median of 1.00, indicating that parents in the total group did not feel their children responded very well to their spouses mode of behaviour management.

Item 35 dealt with the extent to which parents in the total group felt their spouses relied on punishment to control the child's behaviour. This item was scored on a five-point scale, with a score of 5 for "rarely does" and a score of 1 for "always does." The mean for this item was 2.23, with a range of 1 to 5, and a median of 2.00,

indicating that parents in the total group tended to see their spouses as being rather punitive.

Item 36 asked each parent in the total group how effective they personally felt in being a parent. This item was scored on a five-point scale, with a score of 5 for "very effective" and a score of 1 for "rarely effective." The mean for this item was 3.13, with a range of 1 to 5, and a median of 4.00, indicating that, as a group, parents in the sample felt rather effective, even prior to treatment.

Item 37 dealt with how effective each parent in the total group thought their spouse felt in being a parent. This item was again scored on a five-point scale, with a score of 5 for "very effective", and a score of 1 for "rarely effective." The mean for this item was 3.33, with a range of 1 to 5, and a median of 4.00, indicating that parents tended to feel that their spouses also felt fairly effective in the parent role.

4. The Social-Readjustment Rating Scale. Table 3 presents the results of the Social-Readjustment Rating Scale (SRRS), in terms of expected and observed mean Life Change Unit (LCU) values. A comparison is made between the LCU values for the total group, treatment group, and the group of parents who did not complete treatment, called the drop-out group.

Parents in the total group are thus seen to differ significantly from normative expectations in terms of mean LCU level. The differences involved were in the direction of greater stressfulness assigned to life-events which they experienced, than would be expected, based

on the norms for the SRRS. The expected mean value of the LCU scores would have placed the total group within the moderate range of adaptive stress. However, the observed values placed them in the severely stressful range.

Table 3

Summary of t-test Values for the Social-Readjustment Rating Scale

Comparison	Means	t
Total Group		
Expected	230.85	
Observed	353.90	3.31*
Treatment Group		
Expected	222.42	
Observed	282.28	1.20
Drop-out Group		
Expected	264.24	
Observed	433.41	1.50

$p < 0.005$

While the total group differed significantly from the normative values expected on the SRRS, and were, as a group, more stressed than a normal group of people would be, they did not differ significantly from each other. The data in Table 3 suggest that there were no significant differences between the treatment group and the drop-out group in LCU level.

5. The Semantic Differential. Table 4 shows the analysis of variance results for the seven main concepts used with the semantic differential technique. Those concepts were, MY FAMILY, THE IDEAL CHILD, MY CHILD, A PROBLEM CHILD, THE IDEAL PARENT, ME AS PARENT, and, MY SPOUSE AS PARENT.

As shown in Table 4, significant F-values were obtained for three of the above concepts, MY CHILD, THE IDEAL PARENT, and, ME AS PARENT. This indicates that the conceptual and affectual meaning which parents in the treatment group assigned to these concepts changed between pre and post-treatment conditions.

A comparison was made for each of the above three concepts in terms of mean differences between pre and post-DPC treatment conditions for each of the three semantic differential factors, Evaluation (E), Potency (P), and Activity (A). A table of pre and post-treatment means and mean differences appears in Appendix F.

Table 5 shows the results of t-test comparisons for the three concepts for which significant F-values were obtained, on the three factors Evaluation (E), Potency (P), and Activity (A).

For the MY CHILD concept, significant changes occurred on all three of the factors, E, P, and A, with the first two showing the greatest change. It will be recalled that the Evaluation factor relates to the good/bad dimension. The t-test value of 3.58 in Table 5 is significant at the $p < 0.01$ level. Combined with the mean difference of 3.72 points shown in the table in Appendix F in favor of the MY CHILD concept, it suggests that parents valued their own children

Table 4

Summary of Analysis of Variance for the

Seven Semantic Differential Concepts

Source of Variance	SS	df	MS	F
My Family				
Between	0.33	2	0.16	
Within	32.33	12	2.69	0.06
Ideal Child				
Between	5.33	2	2.66	
Within	52.33	12	4.36	0.61
My Child				
Between	54.85	2	54.85	
Within	15.47	12	2.57	21.26***
Problem Child				
Between	2.04	2	1.02	
Within	51.95	12	4.32	0.23
Ideal Parent				
Between	27.19	2	13.07	
Within	55.47	12	2.21	5.91**
Me as Parent				
Between	37.76	2	18.88	
Within	48.90	12	4.07	4.63*
Spouse as Parent				
Between	8.71	2	4.35	
Within	33.28	12	2.77	1.57

* $p < 0.05$

** $p < 0.025$

*** $p < 0.005$

Table 5

Results of t-test Comparisons between the Three Single Semantic Differential Concepts for which significant F-values were Obtained for the Three Factors, Evaluation, Potency, and Activity

Concept	t
My Child	
Evaluation	3.58***
Potency	3.56***
Activity	2.66*
Ideal Child	
Evaluation	5.11****
Potency	3.71***
Activity	1.92
Me as Parent	
Evaluation	3.27**
Potency	3.94***
Activity	2.70*

* $p < 0.05$
** $p < 0.02$
*** $p < 0.01$
**** $p < 0.001$

as being more "good" following DPC treatment.

Measuring the strong/weak dimension of connotation, the Potency factor also showed significant changes between pre and post-DPC treatment conditions for the MY CHILD concept. The t-test value of 3.56 is also significant at the $p < 0.01$ level. Combined with a mean difference of 3.29 points, as shown in Appendix F, in favor of MY CHILD, it appeared that parents in the treatment group valued their own child as being more "strong" following DPC treatment.

The Activity factor, which measures the active/passive concept dimension, also showed significant changes between pre and post-DPC treatment conditions. The t-test value of 2.66 obtained for it is significant at the $p < 0.05$ level. Combined with a mean difference of 0.14 points in the opposite direction away from the MY CHILD concept, it suggests that parents tended to perceive their children as being less "active" following DPC treatment.

For the concept IDEAL CHILD, the obtained t-value of 5.11 for the Evaluation factor is significant at the $p < 0.001$ level. The data in Appendix F show a mean difference of 0.43 points away from IDEAL CHILD following treatment. This suggests that parents in the treatment group tended to value the IDEAL CHILD concept as being somewhat less "good" after exposure to the DPC program. Supportively, as shown before, they valued their own children more.

The Potency factor for IDEAL CHILD also showed changes between pre and post-DPC treatment conditions, the t-value of 3.71 shown in Table 5 for this factor being significant at the $p < 0.01$ level.

Combined with the mean differences of 1.00 in favor of IDEAL CHILD shown in Appendix F, this suggests that parents in the treatment group tended to value the IDEAL CHILD concept as being somewhat more "strong" following DPC treatment.

The Activity factor for the IDEAL CHILD concept showed no significant changes between pre and post-DPC treatment conditions.

The concept ME AS PARENT also showed significant changes on all three factors, E, P, and A. The t-value of 3.27 found in Table 5 for the Evaluation factor is significant at the $p < 0.02$ level. Combined with the mean difference of 3.71 points shown in Appendix F for this factor, in favor of ME AS PARENT, it suggests that parents in the treatment group tended to value themselves as more "good" following DPC treatment.

The t-value of 3.94 shown in Table 5 for the Potency factor vis-a-vis ME AS PARENT is significant at the $p < 0.01$ level. Combined with the mean difference of 5.29 points shown in Appendix F for this factor, in favor of ME AS PARENT, it suggests that parents in the treatment group valued themselves as considerably more "strong" following DPC treatment.

The Activity factor for the ME AS PARENT concept also changed. The t-value of 2.70 shown in Table 5 for this concept is significant at the $p < 0.05$ level. Combined with the mean difference of 0.71 points shown in Appendix F for this factor, it suggests that parents in the treatment group tended to view themselves as somewhat more "active" following DPC treatment.

Table 6 presents the results of the analysis of variance done for the six semantic differential concept comparisons. The concepts compared were MY CHILD vs. IDEAL CHILD, MY CHILD vs. PROBLEM CHILD, IDEAL CHILD vs. PROBLEM CHILD, MY SPOUSE AS PARENT vs. ME AS PARENT, MY SPOUSE AS PARENT vs. IDEAL PARENT, and, ME AS PARENT vs. IDEAL PARENT.

Significant F-values were obtained for three of the above comparisons, MY CHILD vs. IDEAL CHILD, IDEAL CHILD vs. PROBLEM CHILD, and, ME AS PARENT vs. IDEAL PARENT. For each of these comparisons, some significant changes in conceptual meaning occurred between pre and post-DPC treatment conditions.

Table 7 shows the results of the t-test comparisons for the three compared concepts for which significant F-values were obtained. These t-test comparisons were made for the three factors, E, P, and A.

For the MY CHILD vs. IDEAL CHILD comparison, two of the semantic differential factors, Evaluation and Potency, showed significant changes. Changes in the Activity factor were not significant.

The t-value of 2.61, obtained for the Evaluation factor is significant at the $p < 0.05$ level. In Appendix F will be found a table of mean differences for each of the six compared concepts, with the direction of change, or D, between pre and post-DPC treatment conditions. It will be noted that the mean difference in decrease on the Evaluation factor for the MY CHILD vs. IDEAL CHILD comparison was 4.43 points, though still in favor of IDEAL CHILD. This suggests that parents in the treatment group showed conceptual movement of MY CHILD toward that of the concept IDEAL CHILD following DPC treatment, and that the two concepts

Table 6

Summary of Analysis of Variance for the

Six Semantic Differential Concept Comparisons

Source of Variation	SS	df	MS	F
MY CHILD				
vs. IDEAL CHILD				
Between	50.90	2	36.21	
Within	54.09	12	7.04	5.64**
MY CHILD				
vs. PROBLEM CHILD				
Between	14.47	2	7.23	
Within	59.85	12	4.98	1.45
IDEAL CHILD				
vs. PROBLEM CHILD				
Between	98.71	2	49.35	
Within	116.28	12	9.69	5.09*
MY SPOUSE AS PARENT				
vs. ME AS PARENT				
Between	5.90	2	2.95	
Within	104.09	12	8.67	0.34
MY SPOUSE AS PARENT				
vs. IDEAL PARENT				
Between	19.04	2	9.52	
Within	64.61	12	5.38	1.76
ME AS PARENT				
vs. IDEAL PARENT				
Between	57.16	2	57.16	
Within	18.33	12	3.05	18.09***

* $p < 0.05$
** $p < 0.025$
*** $p < 0.005$

Table 7

Results of t-test Comparisons Between the Three Semantic Differential Concepts Comparisons for which Significant F-values were Obtained for the Three Factors, Evaluation, Potency, and Activity

Comparison	t
MY CHILD vs. IDEAL CHILD	
Evaluation	2.61*
Potency	3.43**
Activity	0.36
IDEAL CHILD vs. PROBLEM CHILD	
Evaluation	4.58**
Potency	0.30
Activity	1.33
ME AS PARENT vs. IDEAL PARENT	
Evaluation	2.62*
Potency	3.43**
Activity	0.00

* $p < 0.05$

** $p < 0.01$

were less differentiated after completion of the program.

The Potency factor for the above comparison showed a t-value of 3.43, which was significant at the $p < 0.01$ level. Combined with a mean difference of 2.29 points in favor of MY CHILD following treatment, it suggests that parents saw their own children as more "strong" than the IDEAL CHILD concept after treatment. Prior to treatment, the difference favored the IDEAL CHILD concept.

For the IDEAL CHILD vs. PROBLEM CHILD comparison, the t-value of 4.58 shown for the Evaluation factor is significant at the $p < 0.01$ level. This is the only significant change found among the three factors, for this set of compared concepts.

The above t-value, combined with the data in Appendix F which indicates a mean difference of 1.43 points in favor of IDEAL CHILD, suggest that in both pre and post-DPC treatment conditions parents in the treatment group favored the IDEAL CHILD concept, but that following treatment they valued it as being somewhat less "good" than they did prior to treatment. In both pre and post-DPC conditions, the IDEAL CHILD was favored.

For the ME AS PARENT vs. IDEAL PARENT comparison, the Evaluation and Potency factors showed significant changes following treatment, while the Activity factor did not.

The t-value of 2.62 shown in this comparison for the Evaluation factor is significant at the $p < 0.05$ level. Combined with the data in Appendix F which show a mean difference of 3.13 points in favor of ME AS PARENT when compared with IDEAL PARENT following treatment. Prior

to treatment, differences favored IDEAL PARENT. This suggests that parents in the treatment group valued themselves as being more "good" than the ideal parent in the parent role following treatment, while before treatment, the values were exactly reversed.

For the Potency factor, a t-value of 3.43 was obtained for the ME AS PARENT vs. IDEAL PARENT comparison. This value is significant at the $p < 0.01$ level. Combined with the data in Appendix F which show a mean difference of 4.57 in favor of ME AS PARENT following treatment, it suggests that parents in the treatment group saw themselves as more "strong" following DPC treatment than they did before. Prior to treatment, differences favored IDEAL PARENT.

6. The Family System Survey, Post-treatment Results.
7. The Walker Problem Behaviour Identification Checklist.
8. The Child Behavior Rating Scale.
9. The Mother-Child Relationship Survey.

Table 8 shows the results of the analysis of variance for the four instruments, Family System Survey, Walker Problem Behaviour Identification Checklist, Child Behavior Rating Scale, and, Mother-Child Relationship Evaluation. The F-values shown in Table 8 show significant changes occurring in each of the above instruments. This indicates that at least some of the scales or items in each of the instruments registered significant changes between the pre and post-DPC treatment conditions.

It remained to be seen which scales or items in each of the instruments showed such changes. To assess this, t-test comparisons were made for each of the above instruments. The results of these t-test

Table 8

Summary of Analysis of Variance of the Total Scores of the Four Instruments, Family System Survey (FSS), Walker Problem Behavior Identification Checklist (WPBIC), Child Behavior Rating Scale (CBRS), and Mother-Child Relationship Evaluation (MCRE).

Source of Variance	SS	df	MS	F
FSS				
Between Subjects	117,353.72	73	1,607.58	
Within Subjects	18,717.66	444	42.15	38.13*
WPBIC				
Between Subjects	5,498.40	11	499.85	
Within Subjects	4,850.56	75	64.67	7.71*
CBRS				
Between Subjects	1,038,188.20	11	94,380.74	
Within Subjects	148,119.12	72	2,057.21	45.87*
MCRE				
Between Subjects	6,018.50	7	859.78	
Within Subjects	1,263.42	40	31.58	27.22*

* $p < 0.005$

comparisons for pre and post-treatment means are shown in Tables 9, 10, 11, and 12 following.

6. The Family System Survey. Table 9 shows the results of pre and post-treatment t-test values for the Family System Survey (FSS). Significant changes between pre and post-treatment conditions were found for 14 of the FSS items. Those items were 5, 9, 11, 14, 19, 20, 23, 25, 26, 30, 34, 35, 36, and 37.

Item 5 of the FSS dealt with the number of rooms in the home off-limits to the child with problems. The t-value of 2.93 shown for this item is significant at the $p < 0.025$ level. This suggests that fewer rooms were off-limits to the child following DPC treatment than in the pre-treatment condition, and that the child's physical mobility was thus enhanced somewhat within the home situation.

Item 9 related to the tension level in the home, as perceived by the parents, in terms of Subjective Units of Discomfort (SUD). The t-value of 4.43 shown for this item is significant at the $p < 0.005$ level, suggesting a marked decrease in perceived tension in the home following DPC treatment.

Item 11 dealt with the number of influences outside the home on the child's problem behaviour. The t-value of 4.06 found for this item was significant at the $p < 0.005$ level. This indicates that there were significantly fewer outside influences on child behaviour following treatment than there were prior to treatment.

Item 14 dealt with how well parents felt their child listened to them. The t-value of 3.27 for this item is significant at the $p < 0.005$

Table 9

Summary of t-test Comparisons for the Family System Survey Items

Item	t	Item	t
1	0.00	20	2.85**
2	0.00	21	0.00
3	0.00	22	1.50
4	0.00	23	2.31*
5	2.93**	24	0.72
6	0.00	25	4.18****
7	1.09	26	2.18*
8	0.00	27	0.27
9	4.43****	28	0.29
10	0.00	29	0.62
11	4.06****	30	2.35*
12	1.70	31	0.85
13	0.44	32	1.82
14	3.27****	33	1.32
15	0.70	34	3.35***
16	0.00	35	4.99****
17	0.51	36	3.90****
18	1.54	37	2.37*
19	2.65**		
Total Score			1.09

* $p < 0.05$

** $p < 0.025$

*** $p < 0.01$

**** $p < 0.005$

level, suggesting that parents felt better listened to following DPC treatment than they did prior to treafment.

Item 19 dealt with the number of times a day the parent talked with the problem child. The t-value for this item was 2.65, which was significant at the $p < 0.025$ level. This suggested that parents in the treatment group felt they talked more frequently to their child after DPC treatment than they did prior to treatment.

Item 20 had to do with the number of hours spent with the problem child in the day. The t-value of 2.85 for this item was significant at the $p < 0.025$ level, suggesting that parents spent more time with the child following treatment than they did before it. In this regard Items 19 and 20 are in some ways complementary.

Item 23 dealt with the number of times per day the parent praised the child with problems. The t-value of 2.31 for this item was significant at the $p < 0.05$ level. This suggested that parents in the treatment group gave more praise to their child following DPC treatment than they did prior to treatment. Thus, not only did they spend more time with their child, as shown in Items 19 and 20, and talk more to their child, but it appeared that more of that indicated interaction was of a positive nature.

Item 25 dealt with the number of times per day the child left the home. The t-value of 4.18 for this item was significant at the $p < 0.005$ level, indicating that parents allowed their children more visits outside the home following treatment than they did prior to treatment.

Item 26 related to the number of hours per day the child spent

outside the home. The t-value of 2.18 for this item was significant at the $p<0.05$ level, indicating that parents in the treatment group also permitted their children more time per day outside the home following DPC treatment than they did prior to treatment.

Item 30 dealt with the stressfulness of money. The t-value of 2.35 for this item was significant at the $p< 0.05$ level, suggesting that parents perceived money as being less stressful following DPC treatment than they had prior to treatment, even though there had been no changes in their gross incomes.

Item 34 of the FSS dealt with how well the child in question responds to the spouse of the parents in the treatment group. The t-value of 3.35 for this item is significant at the $p<0.01$ level, suggesting that parents felt their child's response to their spouse was more positive following treatment than it had been prior to treatment.

Item 35 dealt with the extent to which the above spouse relied on punishment in controlling child behaviour. The t-value of 4.99 for this item was significant at the $p<0.005$ level, indicating that parents in the treatment group felt their spouses were less punitive following DPC treatment than they had been prior to treatment, even though the spouses had not, in most cases, attended active training sessions.

Item 36 dealt with how effective parents in the treatment group personally felt in the role as parent. The t-value of 3.90 for this item was significant at the $p<0.005$ level, suggesting that

parents felt more effective in the parent role following treatment than they did prior to treatment.

Item 37 dealt with how effective parents in the treatment group felt their spouses felt in the parent role. The t-value of 2.37 for this item was significant at the $p < 0.05$ level, indicating that parents perceived their spouses as feeling more effective in the parent role following treatment than they did prior to treatment.

7. The Walker Problem Behavior Identification Checklist. Table 10 shows the t-test values for the Walker Problem Behavior Identification Checklist (WPBIC) under pre and post-DPC treatment conditions. Four of the five clinical scales on the WPBIC showed significant changes, as did the total score. The clinical scales showing such changes were, ACTING-OUT, WITHDRAWL, IMMATURITY, and DISTRACTIBILITY.

For the ACTING-OUT scale, the t-value of 3.48 shown in Table 10 is significant at the $p < 0.01$ level. This indicated that children of parents in the treatment group decreased in acting-out behaviour following the DPC method.

The WITHDRAWL scale showed a t-value of 1.94, which was significant at the $p < 0.05$ level. This indicated that children as assessed by their parents decreased on the withdrawl scale following treatment.

The t-value of 2.05 shown in Table 10 for the IMMATURITY scale was significant at the $p < 0.05$ level. This suggested that following treatment, the parents rated their children as exhibiting less immature behavior than prior to treatment.

The DISTRACTIBILITY scale showed a t-value of 4.00 which was sig-

nificant at the $p < 0.005$ level. This indicated that following DPC treatment program, parents saw their children as less distractible than prior to treatment.

Table 10

Summary of t-test values for the

Walker Problem Behavior Identification Checklist

Scale	t
Acting-out	3.48**
Withdrawl	1.94*
Disturbed Peer Relations	1.87
Immaturity	2.05*
Distractibility	4.00***
Total Score	3.73***

* $p < 0.05$

** $p < 0.01$

*** $p < 0.005$

The WPBIC total score likewise showed a significant decrease between pre and post-DPC treatment conditions. The t-value for the total score in Table 10 was 3.73, which was significant at the $p < 0.005$ level. This decrease in total score is consistent with the decreases shown by the various sub-scales of the instrument.

8. The Child Behavior Rating Scale. Table 11 shows the results of the t-test comparison done for the Child Behavior Rating Scale (CBRS).

All of the five adjustment scores of the CBRS, as well as the total score, showed significant increases between pre and post-DPC treatment conditions. The five scales showing significant changes were SELF-ADJUSTMENT, HOME-ADJUSTMENT, SOCIAL-ADJUSTMENT, SCHOOL-ADJUSTMENT, and PHYSICAL ADJUSTMENT.

Table II

Summary of t-test values for the

Child Behavior Rating Scale

Scale	t
Self-Adjustment	2.26*
Home-Adjustment	1.94*
Social-Adjustment	3.33***
School-Adjustment	2.51**
Physical-Adjustment	3.62***
Total Adjustment	2.01*

* $p<0.05$

** $p<0.025$

*** $p<0.01$

The t-value of 2.26 shown in Table II for the SELF-ADJUSTMENT scale was significant at the $p<0.05$ level. It suggests improved adjustment to self on the part of the children of parents in the treatment group following DPC treatment.

The HOME-ADJUSTMENT scale showed a t-value of 1.94, which was

significant also at the $p < 0.05$ level. This indicated an improved level of home adjustment as assessed by the parents following DPC treatment.

The SOCIAL-ADJUSTMENT scale showed a t-value of 3.33, which was significant at the $p < 0.01$ level. Once again this indicates improvement in terms of social adjustment for children of the parents in the treatment group.

The SCHOOL-ADJUSTMENT scale showed a t-value of 2.51, which was significant at the $p < 0.025$ level. This indicates improved school adjustment on the part of children of parents in the treatment group following DPC treatment.

The t-value of 3.62 found for the PHYSICAL-ADJUSTMENT scale was significant at the $p < 0.01$ level. This indicates improved physical adjustment, in terms of fewer somatic complaints, for children of parents in the treatment group following DPC treatment.

The t-value for the TOTAL-ADJUSTMENT score of 2.01 was significant at the $p < 0.05$ level. This is consistent with the significant changes found in the other CBRS scales.

9. The Mother-Child Relationship Evaluation. Table 12 shows a summary of the t-test values for the four scales of the Mother-Child Relationship Evaluation (MCRE). The four scales are ACCEPTANCE, OVER-PROTECTION, OVER-INDULGENCE, and REJECTION. Significant changes were found between the pre and post-DPC treatment conditions for two of the above scales, OVER-PROTECTION and REJECTION.

The t-value of 2.61 shown for the OVER-PROTECTION scale was sig-

nificant at the $p < 0.025$ level. This suggests that parents in the treatment group rated themselves less over-protective following treatment than they had prior to treatment.

Table 12

Summary of t-test values for the

Mother-Child Relationship Evaluation

Scale	t
Acceptance	0.82
Over-Protection	2.61*
Over-indulgence	0.00
Rejection	2.88*

* $p < 0.025$

The t-value of 2.88 shown for the REJECTION scale was also significant at the $p < 0.025$ level. This suggests that parents in the treatment group perceived themselves as less rejecting of their children following DPC treatment than they had been prior to treatment.

This concludes that part of the present study concerned with changes between pre and post-DPC treatment conditions. We will now turn to a presentation of the results obtained for the one in-DPC treatment measure used.

10. In DPC Treatment Data, The Child Cooperation Index. The Child Cooperation Index (CCI) was used as a measure of changes in

verbal control by parents of child behaviour, expressed as compliance with verbal requests, during the course of treatment. Parents in the treatment group were asked to study five daily behaviours, in terms of the number of requests needed to elicit child compliance. These behaviours were designated tasks, since they usually involved asking the child to do something quite specific. The task behaviours were sampled every two weeks during training for a period of about ten weeks, or for a total of five trials in all. We thus had a five task (T-I, T-2, T-3, T-4, and T-5) by five trial (T-I, T-II, T-III, T-IV, and T-V) measurement situation.

Table 13 presents a total list of the task behaviours selected by parents in the treatment group for use with the CCI. Some parents reported more than five tasks over the period of training, but only the original five tasks which held over the five trials were used for purposes of comparison.

An attempt was made to focus only on behaviours which might be expected to occur daily. If a chosen behaviour occurred intermittently, it was dropped from analysis.

Table 14 presents analysis of variance data for the five tasks used on the CCI over five trials. The analysis of variance was used in order to determine whether there were significant differences in number of parent requests for the five tasks over time.

The F-value obtained in Table 14 is significant at the $p<0.005$ level. This suggests that significant changes did occur over the five trials in the number of requests needed by parents to elicit child

Table 13

Child Cooperation Index Task Behaviours

Task Categories	Number
Self-Care, Bathing, Brushing Teeth, etc.	16
Mealtime Behaviour, Finish Food, Sit Still, etc.	10
Bedtime Behaviour, Get Ready, Stay in Bed, etc.	8
Getting Dressed	6
Put Clothing Away	5
Come in House When Called	2
Pick up Toys	2
Stop Complaining, Whining	2
Take Out the Garbage	2
Get Up in the Morning	1
Sit Still with TV	1
Change Clothing Less Often	1
Read Three Pages a Day	1
Total	57

cooperation. It also suggests a related increase in the amount of verbal control which parents had over the indicated child behaviour.

Table 14

Summary of Analysis of Variance for the Child Cooperation Index Tasks I through 5 over Trials I through V for Number of Requests

Source of Variance	SS	df	MS	F
Between	9,664.22	24	402.67	
Within	4,929.47	126	39.12	10.29*

* $p < 0.005$

The means for the CCI are included in Appendix F for Tasks I through 5 over Trials I through V. They show a general decrease over time. For illustrative purposes, Table 15 shows the grand means for all of the tasks studied via the CCI over each of the trials I through V. These data are also shown graphically in Figure 1.

In addition, the mean number of requests for each of the five tasks was computed, and can be seen in Appendix F. These data show the relative amount of decrease for each of the tasks in number of requests needed to elicit performance from the child over the five trials. The rate of decrease, and task-to-task variability, was substantial, as can be seen in Figure 2.

Table 15

Summary of Grand Means for the Child Cooperation Index for All Tasks Over the Five Trials for Number of Requests

Trial	Mean
I	13.10
II	12.65
III	12.22
IV	10.68
V	8.38

This concludes our consideration of the in-DPC treatment measures. We shall now turn to the data obtained on one year follow-up.

Twelve Month Follow-up

11. The Patterson Improvement Rating Scale. The Patterson Improvement Rating Scale (PIRS) was administered both during the one month after treatment session, when the bulk of the post-treatment measurement was done, and then again one year later. For comparison purposes it seemed most convenient to include data from both PIRS administrations in this section. Of the seven parents who completed treatment, five were available one year later.

Table 16 shows a simple tabulation, with means, of the major PIRS items and their various alternative outcomes, as well as the SUD scale. This presentation follows the format used by Patterson (1973).

Item 1 of the PIRS, with five possible alternatives in terms of

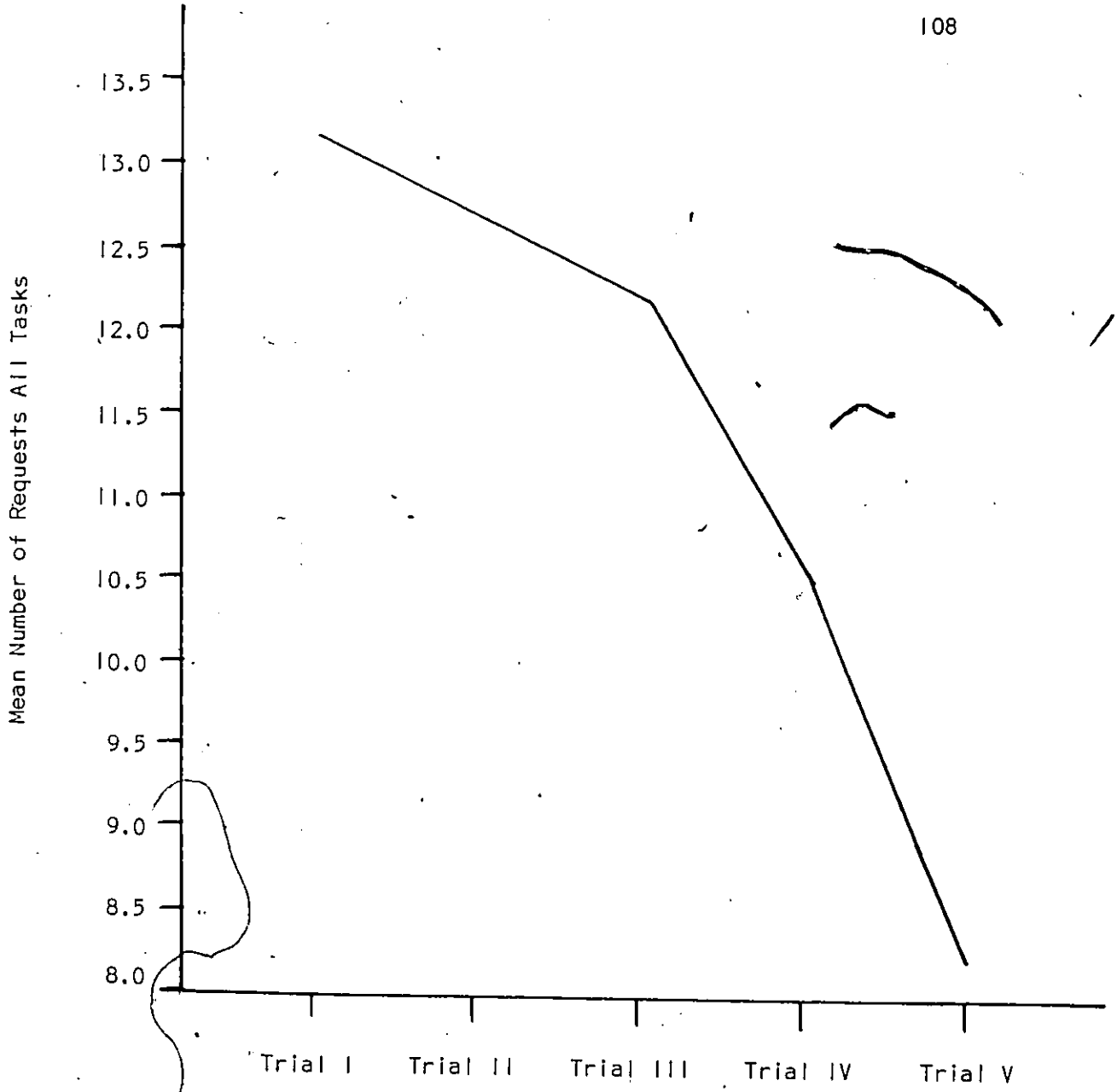


Figure 1. Grand Means for the Child Cooperation Index

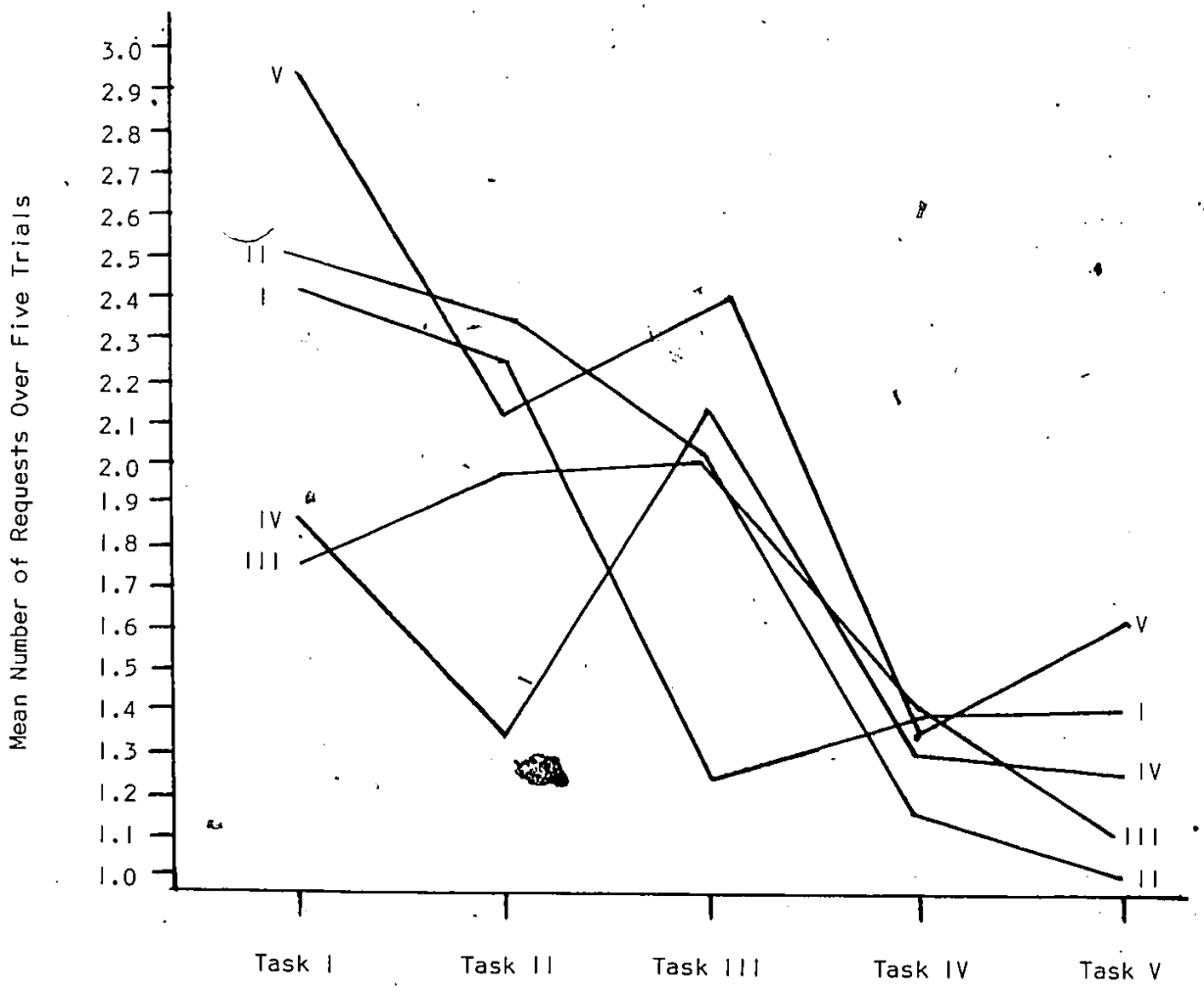


Figure 2. Number of Requests for All Trials for Tasks I through V of the Child Cooperation Index

Table 16

Summary of Patterson Improvement Rating Scale

Items	Number choosing alternative, end of treatment (N-7)	Mean Rating	Number choosing alternative, 12 months later (N-5)	Mean Rating
1. As a result of treatment, your child has				
(1) Become much worse	0		0	
(2) Become slightly worse	0		0	
(3) Not changed	0		0	
(4) Improved slightly	0		1	
(5) Improved markedly	7	5.0	4	4.8
2. In regard to the effect of this treatment, you feel				
(1) Much more negatively toward him	0		0	
(2) Slightly more negative toward him	0		0	
(3) About the same toward him	0		0	

Table 16 CONTINUED

Summary of Patterson Improvement Rating Scale

Items	Number choosing alternative, end of treatment (N-7)	Mean Rating	Number choosing alternative, 12 months later (N-5)	Mean Rating
(4) slightly more positive toward him	0		1	
(5) Much more positive toward him	7	5.0	4	4.8
3. As a result of treatment my family has, on the whole, begun to function				
(1) Better	7		5	
(2) About the same	0		0	
(3) Worse	0	1.0	0	1.0
4. On the whole, I think treatment was				
(1) Harmful	0		0	
(2) Useless	0		0	
(3) Slightly effective	0		1	
(4) Very effective	7	4.0	4	3.8

Table 16 CONTINUED

Summary of Patterson Improvement Rating Scale

Items	Number choosing alternative, end of treatment (N-7)	Mean Rating	Number choosing alternative, 12 months later (N-5)	Mean Rating
5. The effect of treatment on my child was				
(1) Better than I expected	7		5	
(2) About what I expected	0		0	
(3) Worse than I expected	0	1.0	0	1.0
6. As a result of treatment, my child seems				
(1) Less happy at home	0		0	
(2) About the same	0		0	
(3) More happy at home	7	3.0	5	3.0
7. SUDS level at home now	-	28.57	-	24.00

outcome for the child, showed a mean of 5.0 one month after treatment, all parents in the treatment group choosing alternative 5, "improved markedly," for their child in relation to DPC training. One year later, the mean score for this item was 4.8, with four of the five then-available parents choosing alternative 5, and the other one choosing alternative 4, "improved slightly."

Item 2 of the PIRS, which dealt with parental feelings about the child as a result of treatment, also had five possible alternative outcomes. The mean for this item was 5.0 one month after treatment, and 4.8 one year later, with the same distribution of parent choices as in Item 1. Thus, at least one parent did not feel as positively about the effect of the DPC program on child behaviour, and so forth, one year after training as they did soon after it.

Item 3 of the PIRS had to do with family functioning in relation to treatment, with three possible alternative outcomes. The mean for this item was 1.0 under both the one month and twelve month follow-up conditions, all parents choosing alternative 1, "better", to describe family functioning as a whole, as a result of treatment.

Item 4 of the PIRS dealt with the effect of treatment, on the whole, and had four possible alternative outcomes. The mean for this item was 4.0 one month after treatment, when all parents chose alternative 4, "very effective." The mean for this item one year later was 3.8, when all but one parent chose alternative 4, and the remaining parent chose alternative 3, "slightly effective." This was the same parent whose appraisal fell somewhat in items 1 and 2.

Item 5 of the PIRS dealt with the effect of DPC treatment on the child, in a better or worse than expected, way. There were three possible alternative outcomes for this item. The mean for this item was 1.0 in both the one and twelve month follow-up conditions, all parents choosing alternative 1, "better than expected" to describe the effect of DPC training on their children.

Item 6 of the PIRS, also with three possible alternative outcomes, dealt with the happiness of the children in the group as a result of treatment. The mean for this item was 3.0 one month and twelve months after treatment, when all parents chose the last alternative, "more happy at home" to describe their childrens conditions resulting from treatment.

Item 7 of the PIRS had to do with the perceived tension in the home, in terms of SUD units. The mean for this item one month after treatment was 28.57, while one year later it was 24.00, suggesting a slight additional drop of 4.57 points in SUD level in the home.

In general, the results in Table 16 appear to indicate that, based on consumer satisfaction, the effects of the DPC program tended to hold well over time. There was only a modest amount of slippage on one year follow-up, and that was confined to one parent.

12. The Family System Survey. This was the third and final administration of the Family System Survey (FSS). This time, only those 14 items which were found to successfully discriminate between pre and post-DPC treatment conditions were administered on one year follow-up. Our main concern was with seeing whether or not the changes

found in the post-treatment condition would hold over time. We were not primarily concerned with additional changes in the FSS items. Nonetheless, some such additional changes were encountered, as can be seen in Table 17 below.

Table 17

Summary of t-test values for those Items on the Family System Survey that were Significantly Different Under Pre and Post-Treatment Conditions with a Twelve Month Follow-up

Item	t
5	0.79
9	2.73
11	1.11
14	0.84
19	3.30*
20	3.12*
23	6.74**
25	2.18
26	1.00
30	3.61**
34	1.73
35	5.00**
36	1.03
37	1.22

* $p < 0.05$

** $p < 0.01$

It thus appeared that for nine of the FSS items, post-treatment changes at least held on one year follow-up, while for the remaining

five items, still more significant changes had occurred one year later.

Those items showing additional changes in the one year follow-up condition were 19, 20, 23, 30, and 35. The first three items all had to do with parent-child interaction, while the last two dealt with money stress and spouse's punitiveness, respectively.

Item 19, which dealt with how often the parent talks to the child with problems (or former problems) in the average day, showed a t-value of 3.30, which was significant at the $p < 0.05$ level. This suggested a further increase in parent-child verbal communication on one year follow-up.

Item 20, which dealt with the number of hours per day the parent spent with the problem child, showed a t-value of 3.12, also significant at the $p < 0.05$ level. This suggested still more time spent by the parent with the child in question on one year follow-up.

Item 23, which related to the amount of praise given by the parent to the child with problems, showed a t-value of 6.74, which was significant at the $p < 0.01$ level. This suggested that parents were still more inclined to praise the problem child on one year follow-up than they had been at the end of treatment.

Item 30, which dealt with money stress, showed a t-value of 3.61, which was significant at the $p < 0.01$ level. This suggested that parents found the money issue still less stressful on one year follow-up than they had at the end of treatment. While no information was sought concerning income increments one year later, money stress depends, relative to certain absolute minima, less on dollar flow per se than it

does on perception and utilization of that flow.

Item 35, which dealt with the perceived punitiveness of their spouses by parents in the treatment group, showed a t-value of 5.00, which was significant at the p 0.01 level. This suggested that parents tended to see their spouses as being still less punitive toward their children one year later than they had at the end of treatment.

13. The Fate of Presenting Problem Behaviours. Finally, a survey concerning the fate of the presenting, or target, problem behaviours was done on one year follow-up. The results of this survey can be seen in Table 18.

When contacted one year later, parents were asked about the current status of the presenting problem child behaviours which had brought them to DPC treatment over a year earlier. The fate of those behaviours was tabulated in four possible categories: (a) worse; (b) same; (c) much better, or; (d) non-existent.

The fourth category, non-existent, meant either that the behaviour in question now had a zero frequency or occurrence, hence was just not a problem any longer, or that it still occurred but was just not defined as a problem any longer by parents. No clear distinction between those two possibilities could be made, nor did it seem very important to make one, since a problem only exists when someone defines it as such. In the fourth category, parents were simply not defining the behaviour as a problem any longer, for whatever reason. In the

Table 18

Survey of the Fate of Presenting Problems

Case	Problem	Worse	Same	Much Better	Non-existent
I	(1) Reminds parents of adoption to cause guilt				I
	(2) Argumentative behaviour				I
	(3) Somatic complaints (stomach aches and hyperventilation)				I
	(4) Tantrums and rages				I
	(5) Changes clothing too often			I	
	(6) Takes Ritalin Hcl.				I
II	(1) Fights with peers, is picked on for looks		I		
	(2) Over-reacts anxiously to trivia			I	
	(3) Hyperactive in school			I	
	(4) Oppositional behavior			I	
	(5) Takes Ritalin Hcl.				I
III	(1) Cries, whines & squeaks				I
	(2) Tunes out, won't listen			I	
	(3) Mealtimes, eats slowly			I	
	(4) Withholds feelings, won't talk about what he feels		I		
	(5) Depends on mother for self-care			I	
	(6) Poor behaviour in public				I

Table 18 CONTINUED

Survey of the Fate of Presenting Problems

Case	Problem	Worse	Same	Much Better	Non-Existent
IV	(1) Cries excessively if frustrated				I
	(2) Mealtimes, eats slowly				I
	(3) Pouts, clenches teeth, shakes body				I
V	(1) Tunes out, won't listen				I
	(2) Mealtimes, eats slowly				I
	(3) Pouts, pretends to cry				I
	(4) Won't pick up toys			I	
	(5) Uses profanity in public				I
Total 25			2	8	15
Per cent			.08	.32	.60

other two categories, the behaviour in question still occurred, with the same, or somewhat decreased frequency.

A total of 25 problem behaviours were studied in the survey on the fate of presenting problems. Of those 25 initial target behaviours, 15 behaviours, or sixty per cent of the total, were defined by parents as non-existent on one year follow-up. Another 8 behaviours, or thirty-two per cent of the total, were defined as being much better on one year follow-up. Two problem behaviours, or eight per cent of the total, were the same.

It thus appears that the DPC is effective in changing, or redefining, target problem behaviours, having had this effect in at least sixty per cent of the cases studied. If one adds the third category, much better, to that, some change or re-definition, occurred in ninety-two per cent of the behaviours initially presented for DPC treatment.

Of the two behaviours which remained the same, one, peer fighting, was clearly not within the ability of parents to control the reinforcers involved. The remaining behaviour, sharing feelings with the parent, was difficult to evaluate since the child in question was only around four-years-old.

CHAPTER IV

DISCUSSION OF RESULTS

This was an exploratory study, aimed at finding and assessing the role of some of the many possible extra-conditioning variables at work in relation to the Directive Parental Counselling Training Program. In being exploratory, it involved a departure from other work done in the field, which has been almost exclusively pre-occupied only with assessing changes in specific target behaviours.

In discussing the explorational nature of the present study, it must be kept in mind that when one explores, one is essentially on a mapping expedition. The initial expedition of this sort into uncharted areas typically leaves much terrain uncovered, and many questions to be answered by future explorers. This discussion will be concerned both with the results obtained, and quasi-results which generate questions yet to be answered by those future expeditions.

In common with the majority of behavioural therapy programs for training parents to be effective modifiers of their children's behaviour, the primary concern has been with changes in parents as a result of treatment which can be communicated to their children. The children of those parents in the treatment group were not seen directly.

This study was thus mainly concerned not with changes in the actual behaviour of the children involved, though such changes probably

did occur, but with parental changes as by-products, or generalization effects, of their application of the DPC program. Thus, information obtained vis-a-vis changes in children as seen by their parents must be regarded as gross estimates of behaviour, although ones made by parents who had been trained to observe behaviour much more carefully and objectively than they had been accustomed to doing prior to treatment.

The actual level of behaviour change shown by the children of the parents in the treatment is less important for our purposes than those changes which occurred in the parents phenomenal appreciation of their children. Interpersonal perception and the ways in which parents and children experience each other are the critical variables. Events at this phenomenal level of appreciation are major determinants of interaction. Changes in such phenomenal events would be reflected in interaction. If parents feel more effective in the parent role following treatment than they did before, this will most certainly have an effect on how they interact with the child. Similarly, if they value the child differently following treatment, that too will be reflected in interaction with the child.

The DPC program can be seen, in one sense, as a vehicle for parent effectiveness training. Unlike the better promoted Parent Effectiveness Training (Gordon, 1970), however, it assumes that real parent effectiveness is not achieved by talking about it, or blaming parents for its absence, but occurs rather on the basis of enhanced actual competence in dealing with child behaviour. As such, the

DPC program does not deliberately set parent effectiveness as its goal, but merely attempts rather modestly to give parents a rationale for coping with behaviour. Increased feelings of effectiveness nonetheless often seem to happen as a by-product of those coping strategies. Given ways of coping with child behaviour, parents feel better, and stress mastery seems to occur.

We will now turn to a consideration of the various results obtained in this study. In discussing these results, we will proceed in the order that they were presented in Chapter III.

Fate of Initial Referrals

Some attempt needs to be made to explain the rather high attrition rate which occurred for the total sample. This will be necessarily speculative, since with one or two exception we do not know why the majority of the drop-outs occurred.

Two general factors may have been important. The first has to do with the nature of our sample selection. The sample selection process involved in the study was typical of front-line contact in clinics, in which whoever walks in the door in seen. Many studies, by contrast, use carefully-pre-selected samples with extensive screening of applicants for service prior to treatment. Lacking pre-screening procedures, it was inevitable that the first several training sessions would be a screening period, during which parents decided whether the DPC program was relevant to their needs or not.

The second factor was probably seasonal. The main training phase of the study was conducted in the summer of 1974. In clinical practice, caseloads typically become variable during the summer months, with increased cancellations, failed appointments, and treatment drop-outs. There is a familiar saying to the effect that people magically become well between Memorial Day and Labor Day. To some extent, the attrition rate found in our study may have been due to this seasonal effect.

The Family System Survey

The Family System Survey (FSS) was devised for the present research (Daly and Brown, 1973), and is presently in a preliminary form. It was intended as a systematic clinical interview guide, designed to elicit information about various dimensions of family functioning which have heretofore simply been ignored by others in the field.

Future research with this instrument is justified. Such research will almost certainly involve restructuring the scoring system, which presently is not always consistent, reorganization of item content, and factor analytic studies.

For now, proceeding in a purely heuristic manner sans benefit of factor analysis, the 37 FSS items seem to arrange themselves into 11 item content clusters:

1. Socio-economic Content

   Items 1, 2, and 3.

2. Child Age Content

   Item 6.

3. Parental Involvement in Treatment Content

   Item 10.

4. Outside Influences on Behaviour Content

   Item 11.

5. Family Physical Environment Content

   Items, 4, 7, and 8.

6. Physical Mobility of Child Content

   Items 5, 24, 25, 26.

7. Parent-Child Communication Content

   Items 14, 19, 20, 21, 23, and 27.

8. Parental Role Stress Content

   Items 9, 22, 29, and 30.

9. Parental Feelings of Adequacy in Parent Role Content

   Items 33, 34, 35, 36, and 37.

10. Parental Communication Content

    Items 12, 13, 15, 18, and 28.

11. Conjugal Role Relationship Content

    Items 16, 17, 31, and 32.

Our discussion will follow the above content array.

As shown by the data obtained for items 1, 2, and 3, of the FSS, our sample was predominantly lower-middle class, as defined by Hollingshead (1957). The parents in it were also of fairly modest income. While their social class status was somewhat below the middle-class ideal toward which most psychotherapy has been biased, they were by no means members of the culture of poverty. Thus, any inferences generated from our results might not apply to lower class populations, or even to higher class ones for that matter.

In terms of the social-class variable, the "welfare mother" has become something of a stereotype in clinical practice, usually applied by middle-class therapists to lower-class parents who do not

share their values or verbal skills. Only one such mother was present in our treatment group. While this mother did have more difficulty with the DPC material at times than the rest of the group, mainly because she found it hard to reward, praise, or be openly affectionate, with her child, having never experienced those qualities in her own life, at the end of training she did about as well as the others.

One important direction for future research would be to extend the DPC program to a group of parents who matched the poverty-parent, lower socio-economic class profile (Rainwater, 1965; Hunt, 1970), and then compare its effectiveness with the results of the present study. A similiar comparison could also be made with higher class families, in either case studying possible barriers to effective behaviour change at both ends of the socio-economic spectrum. This would be important because one strident criticism of psychotherapy in general is that it has been directed primarily at "squeaky-clean middle-class bedwetters," and has no relevance to others.

Item 6, of the FSS indicated that the children of the parents in our sample were young, predominantly of pre-school or early elementary school age. To the extent that the child's age had an influence on treatment outcome, this probably made for a more favorable prognosis. It is simply easier for parents to control the social reinforcers in the lives of young children than it is with older ones. When a child enters adolescence, for example, parental control of social reinforcers typically becomes vanishingly small.

Future research should compare the effectiveness of the DPC program with different age groups. If parents are able to have little impact on the behaviour of their children, the effectiveness of the DPC program will probably be impaired. This has obvious preventive implications, since there may be a point beyond which it is too late for the DPC program to have much effect, based on age alone. That upper limit should be defined.

Item 10 of the FSS, parental involvement, initially indicated that both parents would be involved in treatment. In practice, this did not happen. As in most other research, it was again the mothers who carried the burden of therapeutic change, even in those intact families where both parents were living together. With the exception of one father who attended one session, and another father who attended three sessions, fathers were not directly involved in the training program.

There was, however, no problem with opposition to training from the fathers related to the treatment group. In addition, with the exception of one family, there were indications of a high level of parental communication about the DPC program. We can thus assume that in most of the families, fathers were actively, if not directly, involved in the treatment process.

The importance of having both parents involved somehow in treatment cannot be over-emphasized. However, the problem of getting fathers to be directly involved seems a real one. No innovative

suggestions for doing that come to mind. Perhaps offering some age-appropriate entrinsic reinforcers for direct participation would help. Future research should determine whether direct paternal participation is really necessary, or whether it is sufficient if fathers are active at a distance from the locus of training.

Item 11 of the FSS, outside influences, suggested that our families were fairly burdened with outside controllers of the problem behaviours of their children. These outside includes included such people as teachers, friends, relatives, neighbors, and so forth, who controlled some or all of the reinforcers which maintained the problem behaviour.

This was a major obstacle to an effective treatment outcome. To the extent that control of reinforcers was outside the home, it was also outside the immediate sphere of parental influence. This condition necessitated some external action on the part of parents to either isolate their children from those influences, or stop the influences. Neither of these were easy to do, and both required some fairly assertive action that most parents were not comfortable with. The elimination of such extrinsic controllers of the reinforcers was nonetheless necessary.

Items 4, 7, and 8 of the FSS, which related to the physical environment, showed that most of our parents lived in average six-room house with two children in all, and very few other relatives or extraneous people in the home. Most fit the nuclear family model very

well, with the aforementioned implications of such a family structure for family stress.

At the same time, they were relatively free of propinquity stress from crowding by other family members. If such crowding is severe it can impose barriers to change, based on competing influences. It remains to be seen which factor, nuclear stress or propinquity stress, is most prohibitive in terms of behaviour change. Perhaps the ideal would be a large and caring extended family with enough physical space to avoid excessive propinquity stress. Future research should assess the impact of family size and physical space on treatment outcome more carefully, since these were not significant stressors in the present research.

Items 5, 24, 25, and 26, which related to child mobility and freedom of movement, indicated that our group did not place severe limitations on their children. They were not overly-restrictive of childrens movement in the home. Restrictions in terms of visits by other children were more severe, suggesting that the children of parents in our group were somewhat isolated from peer influences, at least in the home situation.

Somewhat less stringent restrictions were placed on childrens movement outside the home, and the results seemed rather age-appropriate in this regard. If the children of the parents in our group had few visitors in the home , but freer access to the outside world, peer contacts perhaps occurred either at other children's homes or on the street. The results do not necessarily mean social isolation for

for the child. It is difficult to assess the probable impact of these data on treatment outcome.

The relative lack of restrictions on child movement in the home would be seen as favoring a successful treatment outcome. The stress which might be caused by restrictions on the child's physical movement could pose barriers to change.

Barriers to outside visitors to the child in the home are consistent with the contemporary nuclear family description. In the nuclear family situation, people tend to less spontaneous visiting in general than might be true in a more open cultural setting. We do not know what possible implications this might have for the DPC program. Future research might assess the impact of a freer flow of outsiders in the child's life on treatment outcome than was characteristic of our sample. Our families tended to be rather isolated.

Items 14, 19, 20, 21, 23, and 27 of the FSS dealt with parent-child communication. Parents in our group did not generally feel well-listened-to by their children. This suggested a barrier to communication with their children which would have worked negatively in terms of treatment outcome.

Consistent with this, parents in our sample did not initially do a lot of talking with their children, especially in view of the young age of most of the children involved. Similarly, they did not spend a large amount of time with their children in view of their age. These results suggest a rather perfunctory mode of

relating to their children by parents in our group prior to treatment.

Offsetting the perfunctory nature of their interaction with the child, however, was the data concerning number of times per day praise was given to the child. These data are inconsistent with the others concerning initial parent-child interaction modes, but if taken at face value, we must conclude that our parents did a fair amount of praise-giving. This was, however, true only in relation to those families that never praise. If the amount of praising done was as indicated by the early results, this would have had a positive effect on treatment outcome.

Fun-type family activities were initially rather limited for our group, and indications were that these families did not "do" much together. This was certainly consistent with the other data on the FSS concerning initial limitations on family interaction, at least where children were included in the related activities. The implications of joint family activities for treatment outcome are not too clear. The notion of families doing things together is certainly a popular stereotype. Our families did not fit that stereotype well.

Items 9, 22, 29, and 30 of the FSS related to parental role stress. The perceived tension level in the homes of our families was very high initially, and as a group, these parents were very tense. This tension was also reflected in the Social-Readjustment Rating Scale results, which will be discussed later. The high SUD level reported by our parents would have a negative effect on treat-

ment outcome, serving as a possible barrier to effective change. At the same time, it could be seen as motivational, in terms of causing parents to seek help in the first place. To the extent that the DPC program can be effective with parents who were this tense, its clinical efficacy is enhanced.

Our families had very little help from outside the home with family chores. This was consistent perhaps both with their nuclear family status, and lower-middle socio-economic class. Outside help can be seen directly in relation to parental, especially maternal, stress. As such, our group's relative isolation, plus lack of relief from daily chores, both of which meant excessive focussing on the duties of the parental role, would have a negative effect on treatment outcome.

While it would probably be difficult to find many families with extensive outside help, future research could well address itself in comparative terms to the effect of this variable on treatment outcome. It could be stated in terms of confinement of parents within the parental role.

Nonetheless, within the above restrictions, our parents initially indicated a fair amount of time for themselves during the average week, to do with as they wished. This argued against the confinement hypothesis. Perhaps it argued for personal freedom within confined limits. The data on this point are not supportive of meaningful interpretation. In general, however, to the extent that parents feel deprived of time for self-maintenance and development they may

risk personal depletion. Since our parents did not feel deprived, this favored a successful treatment outcome.

Similarly, financial stress did not seem initially very severe for our families. This favored a positive treatment outcome. While money stress is a highly subjective thing, again within certain basic limits, none of our families were in objective poverty either. Future research with the money stress variable might again relate it to the research to be done with the DPC program on different socio-economic class groups. Certainly, groups of parents living in objective poverty would be expected to define money stress differently than ours did.

Items 33, 34, 35, 36, and 37 of the FSS dealt with the parental feelings of adequacy in the parent role. In general, the initial responses our parents made to queries concerning their feelings of effectiveness in the parent role were rather positive. As we shall see later, they nonetheless felt more effective in a number of ways after treatment.

Apart from feeling fairly adequate as parents, our group also initially felt their spouses felt adequate in the parent role as well. They tended to see their spouses as being rather punitive in handling child behaviour, however, and also did not feel their children responded very well to their spouses. An important omission in the FSS items was the inclusion of one or more items related to how much parents, personally relied on punishment to control child behaviour. This should be corrected in future revisions.

The data suggest that perhaps our families initially made something like the traditional division of labor where child control was concerned, with spouses, in this case fathers, since these responses were by mothers, dispensing punishment. To the extent that parents use punishment as a primary means of control, they are likely to have some guilt feelings about it, unless it has strong cultural support. Such cultural support for punishment in child-rearing has been disappearing in recent years. This might lead parents to minimize their own reliance on punishment.

To the extent that our parents as a group were punitive toward their children, this would have acted as a barrier to effective change. Punishment tends to corrupt parent-child relationships if used excessively, and it makes change less possible. One goal of the DPC program is to give parents other modes of coping with child behaviour which make it less necessary for them to use punishment. While punishment can be useful at times in causing the immediate cessation of some behaviour, which may be dangerous to the child or others, such as firesetting (Holland, 1969), it has little effect on the subsequent probability of the behaviour occurring unless alternative adpative behaviours are reinforced as well. Its exclusive use also tends to establish avoidance behaviour on the part of the child which makes constructive parent-child interaction less probable.

We can conclude that initially there was a fair amount of punishing going on in our families, regardless of who did it. As we shall see later, this decreased following treatment. At the

time, our parents were probably not overly punitive, in that they seemed also to have other personal resources available for coping with child behaviour. They were thus probably somewhere in the middle of a continuum of punitiveness.

Future research might determine the effectiveness of the DPC program with parents both more and less punitive than ours were. If the DPC program could successfully decrease reliance on punishment in a group of parents whose primary modes of child-rearing were punitive, support for its potency would be enhanced.

Items 12, 13, 15, 18, and 28 of the FSS dealt with parental communication effectiveness, and the amount of relational sharing done by parents in our group. In a general sense, parents in our group seemed initially to have fairly good relationships with their spouses, at least in terms of the amount of mutuality shown by their patterns of communication. This mutuality was seen before as well, in the amount of communicating they did with their spouses about the DPC program. The existence of such mutuality was appreciated as a positive element, probably favoring a successful treatment outcome.

The parents in our sample showed a fairly high degree of marital agreement on basic issues such as sex, financial management, philosophical values, and so on. They also felt well-listened-to by their spouses, did a fair amount of confiding in their spouses, and tended to feel understood when they did confide. The initial results were very consistent in support of these relationship variables

between these parents, Our parents did not, however, have much time for each other without the children. This was consistent with the other results concerning their lack of outside help, and general isolation within the family unit.

A picture thus emerges of fairly involved adults, with a fair amount of mutuality characterizing their marital relationships, who had problems with their children. These characteristics were favorable for the DPC program in terms of successful treatment outcomes.

This implies that problems for our group tended to be limited to parent-child relationships, rather than to family relationships in general. The DPC program was never conceived to be marital therapy. If parents show a great deal of marital discord, it might confound other treatment effects which the DPC program could produce. On the other hand, marital therapy might be a by-product of DPC training. Presently, we have no way of knowing. At least our parents gave every indication initially of being able to work together in family problem-solving.

Future research should definitely explore the efficacy of the DPC program with parents for whom marital problems are more severe than was true of our group. Since marital discord was not severe then our group, the impact of such discord on DPC treatment outcomes is still unknown.

One important question would be whether or not the DPC program is as effective when there is marital discord as it is when there is

at least a fair amount of marital mutuality. It would be useful to know whether extremely discordant parents might, for example, require a course of marital therpay before starting DPC training. At this point, the efficacy of the DPC program under such discordant conditions cannot be established.

Items 16, 17, 31, and 32 of the FSS dealt with the conjugal role relationship between parents in our group. The ideal conjugal role relationship, in our view, is characterized by a sort of parallelism, in which roles are not assigned based on sex. The opposite would be segregated role relationships with "his", "hers", and "the kids" dimensions, and very little conjointness, (Bott, 1957; Rainwater, 1965).

In one respect this is a social class variable, since various research efforts have established a sort of continuum of conjointness, which is typically high, with little social distance between family members in upper class families, and typically low, with much separation via social distance in lower class families, (Bell, 1960; Bott, 1957; Rainwater, 1960, 1965). Lower-middle class families typically show an intermediate amount of conjointness. Ours was a lower-middle class group.

In the lower-middle class family, parents tend to place more emphasis on the family unit as a whole, than is true of either the upper or lower ends of the conjointness continuum, (Rainwater, 1965). They expect to be together much of the time, and there is little

separate social participation, as is true of lower class families. They are, however, together as husband and wife, father and mother, rather than just as persons who share and value their lives together, as is true of higher class families. There thus tends to be a subtle element of social distance between spouses in lower-middle class families.

The same mutuality that was seen in the results on marital communication also characterized the data for conjoint role relationships in our families. Conjoint decision-making was indicated as the favored decision-making mode by the majority of our families. The same was true of their problem-defining and problem-solving behaviour. The same conjointness also characterized their willingness to share in child management.

This conjointness of problem-defining, solving, decision-making, and child-management was a positive factor, favoring successful treatment outcomes. As noted before, involvement of both parents boosts the power of the DPC program. The conjointness showed by our group is consistent with the lower-middle class description of conjugal role relationships noted above.

Our families tended to be less conjoint in sharing the daily work-load around the home. In this area, they reverted to lower-class patterns of "his" and "her" divisions of labor. Since this translates directly into parental stress, particularly stress for mothers, it has implications for treatment. In the segregated work pattern

suggested here, mothers typically have responsibility for "the home", which is a pervasive term applied to a wide range of domestic events, from house cleaning to childrens problems. To the extent that fathers do not share such duties, mothers often tend to be overwhelmed. There also frequently exists a kind of devaluing of the homemaker role in such situations, with the "work" of fathers being of somewhat higher status. This can be a major source of conflict between parents. Traditionally, we have chosen not to understand how arduous and stressful the homemaker role is. Recently, studies have begun showing what mothers always knew, that being a homemaker is extremely difficult (Ryder, 1974; Vanek, 1974). Maternal stress multiplies to the extent that the job is not shared.

While the amount of conjointness shown by our parents in general was seen as a positive factor which would favor successful treatment outcomes, future research should be done with regard to a comparison of differences in such outcomes, and factors of familial mutuality. This could be done as part of the other research needed on social class variables.

The 14 FSS items which showed significant changes between pre and post-DPC treatment conditions were 5, 9, 11, 14, 19, 20, 23, 25, 26, 30, 34, 35, 36, and 37. We shall discuss these changes as they relate to clusters of item content.

Items 14, 19, 20, 23, and 34 dealt with parent-child interaction. Following DPC treatment, parents in our group felt their children

listened to them better, talked more often to their children, spent less time directly with their children in the course of the average day, praised their children more often, and felt their children responded more positively to their spouses.

These results suggest a clear change for the better in the ways in which parents and children interacted. Their perception of their children as being aversive apparently decreased, making it possible for them to interact quantitatively more with them, and in more positive ways. The data obtained concerning parent-child interaction via the FSS, thus can be interpreted as supporting a positive treatment effect for the DPC program where such human interaction variables are concerned.

Items 5, 25, and 26 related to the physical mobility dimension where children of parents in our group were concerned. Following DPC treatment, there were fewer rooms off limits to the child in the home, and mobility outside the home was apparently increased, parents reporting greater freedom for the child in leaving the home during the day, and staying outside it for longer periods of time.

The above results seem to reflect greater trust on the part of parents in our group toward their children following treatment. To the extent that a child is trusted, he is no longer defined as a problem, and vice versa. Other data to be discussed later also support changes in parental perception of their children along several dimensions supportive of greater trust. The above FSS results are interpreted in that context.

Of the above three items, perhaps item 5, mobility in the home, is most important. While the parents in our group were not highly restrictive in this regard to begin with, to the extent that they were restrictive of the child's movement in the home at all, they indicated a need to protect certain aspects of themselves or their property from the presumed predations of their children. It is seen as important that this need decreased following DPC treatment.

The other two items, which dealt with time spent by the child outside the home, are more ambiguous. Time outside the home can be related either to greater acceptance of the child, or rejection as expressed by the one mother who wished her child would stay outside all day and leave her alone. Still, since other results to be discussed later did show a decrease in that parental attitude called rejection after treatment, perhaps the current FSS results also favor greater acceptance of the child.

Items 35, 36, and 37, which dealt with parental feelings of effectiveness in the parent role, and reliance on punishment to manage child behaviour, also showed significant changes. Parents felt that their spouses relied less on punishment in controlling childrens behaviour following DPC treatment than they did before. This at least indicates some decrease in general punitiveness in our families, even though we lack information concerning punitive measures used by the spouses who completed the FSS items each time.

There were also reported increases in feelings of effectiveness in the parent role, both for spouses, and for the parents completing

the items. Taken together with the results on decreased use of punishment, the data suggest increased reliance on modes of coping with child behaviour which were different, and less punitive, following treatment than had been true prior to treatment. Training in such alternate coping modes is one major goal of the DPC program. The FSS data suggest that this goal was reached.

Item 9 of the FSS, related to tension level in the home, showed a very large decrease, dropping almost in half following DPC treatment. This is reflective of a more relaxed home atmosphere after treatment, as perceived by parents in our group. Within such a relaxed atmosphere, fewer problems would be encountered.

Item 11 of the FSS, which dealt with the number of outside influences on childrens behaviour, likewise showed a marked decrease following treatment. This decrease apparently happened because for the first time in their lives, parents were able to identify and define the affects of such outside influences, and eliminate them. This was a direct result of the DPC program intervention. While most parents do not think in terms of who controls the reinforcers when they begin treatment, this is nonetheless a very important dimension of behaviour change. We must conclude that, as a result of DPC treatment, our parents moved to bring the reinforcers controlling their childrens behaviours more under their own control.

Item 30 of the FSS dealt with the stressfulness of money. Following treatment, financial stress decreased for our parents, even though

there was no objective change in the number of dollars flowing into their lives. The results obtained were reflective of altered perceptions of the importance of money by our parents. As such, it would seem to be part of the general decrease in family tension noted before. When tension level in the home is high, stressor effects are multiplicative, and families tend to find more things to worry about than when tension is low.

The Social-Readjustment Rating Scale

The Social-Readjustment Rating Scale (SRRS) was used as a pre-treatment measure of adaptive stress. We found that parents in our sample differed significantly from normative expectations in the stress value they assigned in terms of Life Change Units (LCU) to the life changes which had occurred in their lives within one year prior to treatment. Differences were in the direction of greater stressfulness, and more reactivity to stress, with consequently greater depletion of coping reserves, according to the basic rationale for this instrument (Holmes and Masuda, 1967, 1972).

The expected mean LCU value for the life change events reported by our parents would have placed them within the moderate range (200 to 299) of adaptive stress. The actually observed values put them in the severely stressful (300 plus) range. Parents in the treatment group did not differ significantly from those in the total group. At one point itwas thought such differences might have some bearing on the attrition rate found in the total group, but they apparently did not.

As seen previously in the results concerning the perceived tension level in the homes of our parents, this was a highly stressed group of people. Increased values for the SRRS are associated with a variety of physical and emotional dysfunctions, and with decreased adaptive efficiency where added new life demands are concerned.

The DPC program represented a new life demand for the parents involved. This would have had a negative effect on treatment outcome, and on the ability of our group to utilize the DPC program effectively. A group of people this tattered and battered by life demands might be expected to have more difficulty making additional changes in their lives, than would be true of a group less stressed.

The activity of coping can lower resistance to a variety of diseases, especially if coping strategies have been faulty. The fact that many of our parents defined themselves as having problems with their children, indicated faulty coping at least in one area. To the extent that the DPC program was able to provide parents with new, more effective, coping strategies it could be expected to reduce the amount of stress experienced by these parents.

The Semantic Differential

The Semantic differential technique is a means of measuring the connotative meaning assigned to different concepts at different points in time. This measurement is accomplished via language. In this study we were concerned with possible changes in perceptual and

conceptual discrimination for seven selected concepts related to family life, and parental perceptions of self, spouse, and child.

It will be recalled that the semantic differential technique is concerned with changes in three factors, Evaluation (E), Potency (P); and Activity (A). Any concept one cares to mention can be factor analyzed along the above three dimensions, and they will account for about ninety-eight percent of the meaning content related to the concept. A surprisingly large number of concepts have already been factor analyzed and their loadings on the three factors reported (Osgood, 1957; Snider and Osgood, 1969).

When any given concept changes in meaning over time, this change can be conceptualized spatially as movement along a horizontal plane from one polarity to another. Technically, this is called a shift in semantic space. It looks like this:

MOTHER

Bad X Good

versus

MOTHER

Bad X Good

In this example, the connotative, emotional, and perceptual meaning attached to the concept MOTHER changed at two different temporal points.

That basic reality called mother need not have changed at all for a shift in meaning to occur. In this example, the meaning of that basic reality moved away from being defined as mostly "bad" to being defined as mostly "good," at two different points in time.

When two concepts are compared with each other at different temporal points, the same kind of shift in semantic space may occur, but now there are two concepts shifting, which we shall label X and Y for illustrative purposes. It looks like this:

MY CHILD IDEAL CHILD

Bad X Y Good

versus

MY CHILD IDEAL CHILD

Bad XY Good

or even

MY CHILD IDEAL CHILD

Bad Y X Good

In this case, two concepts can be seen as either moving closer together through semantic space until they occupy about the same slot in that space, in which case their meanings are nearly identical, or as overtaking each other, in which case their meanings are reversed. When concept meanings overtake each other, as on an imaginary semantic race track, their positions completely crossover; and they come closer to occupying each others' slot in that semantic space.

The above diagraphics correspond to the two levels of measurement for the semantic differential used in this study. In the first instance, we were concerned with changes in single concepts on the three factors, E, P, and A. In the second anslysis we were concerned with changes in comparisons between two concepts.

It will be recalled that the Evaluation, or E, factor measures the good/bad meaning dimension. As used by Osgood (1957), the quality of "goodness" refers to such things as liking the stimulus in question, to approach-eliciting properties of the stimulus, and sometimes to moral value judgments about it.

The Potency, or P, factor relates to the strong/weak meaning dimension of concepts. It refers to certain power and vitality properties of the stimulus object embodied in the concept studies, in a strength-valuing manner.

The Activity, or A, factor measures meaning along the active/passive dimension. It relates to certain kinetic qualities, such as speed and tempo, of the stimulus object. In this regard, the Activity factor does not necessarily express positive attributes, since parents may find such activity frustrating.

The results which we obtained via the semantic differential technique indicated a number of shifts in semantic space, with several crossover effects included. These corresponded in each instance to changes in the meanings assigned to the various concepts studied under the pre and post-DPC treatment conditions.

The changes noted help establish the value of the DPC program for altering that attitudinal dimension related to emotional meaning, or connotation, for the parents in our treatment group. The results show that the DPC program was effective in changing the meanings which parents attach to themselves, and their children. Changes along these dimensions are very important, and serve as one goal of DPC treatment.

Of the seven single concepts studied, significant shifts in connotative meaning occurred for three of the concepts, MY CHILD, IDEAL CHILD, and ME AS PARENT. The other four concepts studied did not show significant changes. Those concepts were MY FAMILY, PROBLEM CHILD, IDEAL PARENT, and MY SPOUSE AS PARENT.

We shall briefly discuss those concepts which did and did not change. Some of the ones that showed no change are as interesting as the ones that did change.

The lack of change shown for the MY FAMILY concept would seem to act in support of the DPC program as a vehicle for changing parent-child relationships, not necessarily relationships between parents and the entire family constellation. That is exactly what the program was intended to do. It thus appears that the DPC program has a fair amount of specificity, on a one-parent-to-one-child basis. The DPC program is in fact structured in that manner, and the non-change seen for this item would seem to support the specificity of its approach.

The non-results obtained for the IDEAL PARENT and MY SPOUSE AS PARENT lend further support to the specificity of effects produced by the DPC program. Our parents were not able to perceive significant changes in their spouses as parents, nor in the hypothetical and abstract ideal parent. As we shall see shortly, they could clearly see changes in themselves however.

It is more difficult to interpret the non-changes shown for the PROBLEM CHILD concept. Again, the concept problem child tended to be an abstraction, removed from any personal involvement for our parents.

The results here may also operate in support of DPC program specificity.

For the MY CHILD concept, which was certainly one of the most crucial ones in terms of establishing the efficacy of the DPC program, the significant changes which occurred on all three of the factors, E, P, and A were very suggestive. They indicate that parents in our group tended to view their own children as being more "good", and as being "stronger" in a strength-valuing way, after treatment than they did prior to it. At the same time, they tended to see their children as being somewhat less "active" following treatment.

The results of the semantic differential for this study can thus be offered in support of the DPC program as a means of changing parental attitudes toward their own children. It is not necessarily effective in changing attitudes toward other peoples children, spouses, or families in general.

The changes shown for the IDEAL CHILD concept are also interesting, since they seem to support changes which occurred in our parents perceptions of their own children. For the IDEAL CHILD concept there was a significant decrease on the Evaluation factor, an increase on the Potency factor, and a slight, but non-significant decrease on the Activity factor. Taken together, the results suggest that following DPC treatment, parents tended to view the IDEAL CHILD connotation as being somewhat less "good" than it had been prior to treatment. It was also somewhat "stronger", which probably meant more attainable for them in relation to their own child, that is, more real.

The results obtained for the ME AS PARENT concept are seen as supporting the efficacy of the DPC program in changing parental attitudes toward themselves. The ME AS PARENT concept showed significant changes in all three factors, E, P, and A. Thus, it can be concluded that following DPC treatment, parents in our group saw themselves as being more "good" than they had prior to treatment. They also saw themselves as being "stronger" in a strength-valuing way, and as being more "active", which may indicate something about increased energy levels in them following treatment.

The changes found on the semantic differential for the single concepts studied thus tend to support the efficacy of the DPC program as a means of changing the attitudes of parents. Attitudinal changes were found with regard to how parents felt about themselves as parents, and how they felt about their children. These changes were all in a positive direction. In addition, while of less direct importance to the DPC program, there were also additudinal changes on the part of pacents in our group with respect to the way they conceptualized the ideal child. The ideal child concept was seen as somewhat less desirable following DPC treatment. At the same time, parents in the treatment group found their own children more desirable, following DPC training.

For the six comparisons of concepts, in which two concepts were compared with each other in the pre and post-DPC treatment condition in terms of possible shifts in semantic space, significant changes were observed for three of the comparisons. Those comparisons were

MY CHILD vs. IDEAL CHILD; IDEAL CHILD vs. PROBLEM CHILD, and ME AS PARENT vs. IDEAL PARENT.

The MY CHILD vs. IDEAL CHILD comparison showed significant changes on both the Evaluation and Potency factors, following DPC treatment. The largest quantitative change occurred on the Evaluation factor, which decreased markedly under post-DPC treatment conditions, though it still favored the ideal child concept. This indicates that after treatment, the ideal child moved closer, semantically, along the good/bad continuum to the meaning attached by our parents to their own children. There was, in effect, less connotative discrimination between the two concepts. In a practical sense, it became less possible for parents to distinguish their own children conceptually from the ideal child.

The Potency factor related to the MY CHILD vs. IDEAL CHILD COMPARISON displayed one of those aforementioned crossover effects. In the pre-treatment condition it favored the ideal child end of the semantic scale, while in the post-treatment condition it went completely over in the direction to favoring own children. This indicates that parents in our group saw their own children as being stronger than the ideal child following DPC treatment, whereas prior to treatment, the ideal child had been assigned more strength, in a strength-valuing manner.

The above results again support the value of the DPC program for changing parental attitudes toward their own children. Once again, the changes observed seem to argue for specificity of treatment effects, which do not spread much beyond the personal level of involvement for

parents with their own children. The DPC program effects seem, however, to be fairly potent where single child-parent interaction units are concerned. This does not necessarily mean that generalization occurs to other children in the family, or to other children in general. We shall return to the generalization-of-effects question later. Presently, the results are ambiguous concerning it.

For the IDEAL CHILD vs. PROBLEM CHILD comparison, significant changes occurred only on the Evaluation factor. The ideal child was still favored following DPC treatment, but significantly less so than prior to treatment. This means that the ideal child and problem child concepts moved closer together on the semantic continuum for the good/bad dimension following DPC treatment. In a practical sense, the ideal child concept became "less good" while the problem child concept became "more good." Since both of these concepts are abstractions, removed from any concrete stimulus objects in our parents natural environments, the results for this comparison can be interpreted as showing some generalization-of-effects beyond the immediate family milieu.

For the ME AS PARENT vs. IDEAL PARENT comparison, significant changes occurred on the Evaluation and Potency factor. For both factors, crossover effects were observed.

The largest change occurred for the Evaluation factor related to the ME AS PARENT vs. IDEAL PARENT comparison. It shifted from being markedly in favor of the ideal parent prior to treatment for our parents,

to favoring themselves as parents following treatment. This indicates a marked shift in attitudes related to themselves as parents, for the parents in our group. This is reflective of a positively altered self-concept in relation to the parenting role, as a result of DPC training. Our parents tended to value themselves as being "more good" following treatment than they did prior to it.

The Potency factor related to the ME AS PARENT vs. IDEAL PARENT comparison also showed a crossover effect. In the pre-treatment condition the ideal parent end of the semantic continuum was valued as being stronger, while in the post-DPC treatment condition, parents in our group valued themselves as being stronger, in a strength-valuing way.

The combined effects of the above changes indicate that the DPC program is of value in changing parental attitudes toward themselves as parents. This was so of liking themselves more, and in terms of seeing themselves as being stronger in the parent role.

The results which we failed to obtain at a significant level for the other concept comparisons may provide some indication of what the DPC program does not do. Such non-results were obtained for the comparisons MY CHILD vs. PROBLEM CHILD, MY SPOUSE AS PARENT vs. ME AS PARENT, and MY SPOUSE AS PARENT vs. IDEAL PARENT.

The PROBLEM CHILD concept showed less change in meaning in relation to MY CHILD than the IDEAL CHILD concept did. This means that parents in the treatment group showed a greater amount of discrimination between their own children and the problem child concept in both the pre and post-DPC treatment conditions. While as noted above, the

the ideal child and my child concepts moved closer together, with less discrimination between them following treatment, the problem child/ my child comparison remained more distant in terms of semantic space.

This lack of change for the two concepts involved probably indicates that parents were reluctant to apply the problem child label to their own children under either pre or post-DPC treatment conditions, even though in other respects their children <u>had</u> problems. They seemed to distinguish <u>having</u> problems from <u>being</u> a problem child, which suggests something about the intensity of their feelings toward their own children. Being a problem child seems to imply a more total and severe judgment about a child, than merely having problems. Children and adults may have problems and still be regarded as basically good.

It thus appears that the DPC program was successful in helping parents define their own children as being "more good" following treatment. At the same time, it did not cause them to see their own children as being a problem in a broader ascriptive sense following treatment.

The two concepts comparisons, MY SPOUSE AS PARENT vs. ME AS PARENT, and MY SPOUSE AS PARENT vs. IDEAL PARENT, both relate to parental perceptions of their spouses. Neither of them showed significant changes following DPC treatment. This again supports the conclusion that the DPC program is not necessarily effective in changing interpersonal perceptions where parent-to-parent relationships are concerned. The DPC program thus once again appears to be primarily effective in altering variables related to parent-child relationships. The DPC program does

not therefore seem to have much potential as a vehicle for marital therapy.

The Walker Problem Behavior Identification Checklist

Four of the five clinical scales, as well as the total score, showed significant decreases for the Walker Problem Behavior Identification Checklist (WPBIC) following DPC treatment. The four scales showing significant decreases were ACTING-OUT, WITHDRAWAL, IMMATURITY, and DISTRACTIBILITY, each of which is concerned with measuring disturbed behaviour.

The ACTING-OUT scale of the WPBIC primarily reflects disruptive, noisey, defiant, aggressive, and physically destructive behaviour on the part of the child. Item 4 is illustrative: "Becomes hysterical, upset or angry when things do not go his way." Such behaviour on the part of the child is most often motivated by anger and frustration. It rarely comes from nowhere, and is most often a response on the part of the child to frustration by external sources, such as parents, teachers, peers or siblings.

When our parents report less acting-out behaviour in their children following DPC treatment, it means either that such behaviour occurs less often, in a target behaviour sense, or that there have been changes in parental perception of, and perhaps tolerance for, behaviour which might be labelled acting-out. As noted earlier, our major concern is with parental changes, and with perceived changes on the part of parents, rather than with specific target behaviours. In that context,

the DPC program appears to be effective in helping parents perceive less acting-out behaviour in their children. As such, this change probably relates to increased tolerance of child behaviour.

The WITHDRAWAL scale of the WPBIC reflects avoidance behaviour, or restricted functioning on the part of the child. Item 15 is illustrative: "Tries to avoid calling attention to himself." The decrease in this withdrawal dimension reported by our parents for their children, would seem to suggest something about the child activity dimension. The data suggest that parents saw their children as being more active following treatment, which would relate to being less withdrawn, and they also saw them as doing less angry acting-out. This seems to indicate that our parents saw their children simply as being more spontaneously active in an acceptable way, following DPC treatment. They were, moreover, apparently pleased with the changes they saw in this regard.

It thus appears that the DPC program may be effective in changing parental acceptance attitudes toward increased activity levels on the part of their children. This, in turn, could well leave the children involved freer to behave in spontaneous ways. We suspect that the results reflect increased parental tolerance for child activity, as a result of DPC training.

The IMMATURITY scale of the WPBIC reflects behaviour related to excessive dependency on the part of the child. Dependency is defined in terms of expecting parents and others to do things for the child which he is, or should be, capable of doing for himself. Items in

this scale tend to show content which depart somewhat from what the author says it measures. The items are heavily loaded with somatic complaints and fear-based behaviour, which may be only indirectly related to dependency.

Several illustrative items will be quoted to help clarify this ambiguity with regard to the IMMATURITY scale. Item 2 asks if the child is "Listless and continually tired." Item 11, "Apologizes repeatedly for himself and/or his behavior." Item 17, "Reacts to stressful situations or changes in routine with general body aches, head or stomaches, nausea." Item 20, "Has nervous tics, muscle-twitching, eye-blinking, nail-biting, hand-wringing." Item 22, "Has enuresis." Item 33, "Complains of nightmares, bad dreams."

While the content of the items on the IMMATURITY scale of the WPBIC may bear some distant relationship to dependency and immaturity, as the author claims, it is a tenuous one at best. On the other hand, these items would qualify quite nicely for an anxiety scale, or even a psychosomatic disturbance scale.

Whichever the case may be, parents in our group saw significant changes in their children on this scale of the WPBIC following DPC treatment. Based on the item content for this scale, it apparently related to a perceived decrease in fear-based symptomatology in the children of parents in our sample. It may thus be concluded that the DPC program is an effective vehicle for changing parental perceptions of fear-based behaviour in their children, which the author of the scale chooses to call immaturity (Walker, 1970).

The DISTRACTIBILITY scale of the WPBIC reflects child behaviours related to short attention span, poor study skills, and school non-attendance. Items 9 and 10 are illustrative. Item 9 states, "Has difficulty concentrating for any length of time," while Item 10 states, "Is overactive, restless, and/or continually shifting body positions."

Parents in our group saw a significant change in their children in terms of distractibility following DPC treatment. This suggests that the DPC program may have some efficacy in enhancing parental perceptions of calmness in their children.

While the observations reported by the parents in our treatment group for the WPBIC remain one step removed from concrete target behaviours, the parents were nonetheless probably seeing some genuine changes in their children. The evidence suggests furthermore than some changes occurred, while others did not. This would argue against simple halo effects based on parental needs to believe that their children had changed, especially when a number of parents reported the same changes. In the unlikely event that a number of parents imagined together that they saw the same changes in their childrens behaviours, this might nonetheless produce positive changes in itself, since children do tend to act in terms of parental expectations. Thus, if parents expect decreases in disturbed child behaviour, and communicate those expectations to the child, then follow them with appropriately reinforcing behaviour of their own, the decreases are apt to become reality.

The DISTURBED PEER RELATIONS scale of the WPBIC was one dimension which showed no significant changes in the post-DPC treatment condition.

As defined by Walker (1970), this scale reflects inadequate social skills, negative self-image, and compulsive behaviour. Items 5 and 45 are illustrative. Item 5 states, "Comments that no one understands him," while Item 45 states, "Does not initiate relationships with other children."

The evidence indicates that parents in our treatment group did not perceive many changes in peer relations for their children.

These results may be due to the fact that child-to-child interaction is much harder for parents to observe directly than any of the other behaviours measured by the WPBIC. This would have been especially true in view of the exclusion of outside child visitors from the home of our parents, as noted earlier in this chapter. Thus, peer-interactive behaviour must, with the exception of siblings, have taken place either at someone else's house, or on the street. In either case it was more removed from parental view. It is thus fair to conclude that our parents were simply not good observers of peer relations among their children. Had they been better observers, perhaps changes would have been thought to occur on this dimension as well.

The Child Behavior Rating Scale

While the WPBIC is an adequate instrument in terms of reliability and validity, as noted before, The Child Behavior Rating Scale (CBRS) is somewhat weaker. The CBRS was included in this study on an exploratory basis because it presumably does reflect something about the

relationship between the rater who completes it, and the child to whom it refers (Cassel, 1962). The criterion variables related to "adjustment" were initially also thought to reflect something about the child's broader adaptation to life than could be specified by a checklist of specific behaviours.

Reviewing the item content of the CBRS reveals that it is essentially a behaviour rating scale, however, which Cassel (1962) relates to the somewhat nebulous concept of adjustment, without clearly explaining the relationship. There are difficulties with the concept of adjustment, which fails to achieve a uniform consensual meaning for everyone. The CBRS items include a mixture of specific behaviours displayed by children which are detectable by direct observation, and a number of items which require inferences about behaviour from the rater. The inferential aspect of the CBRS can be seen as a weakness, since such inferences are open to differing interpretations. This contrasts with the WPBIC discussed before, which dealt only with point-at-able behaviours.

In the CBRS data, we again have parental rating or perceptions of childrens functioning along several dimensions related to each individual child's adjustment. The scales of the CBRS again were, SELF-ADJUSTMENT, HOME-ADJUSTMENT, SOCIAL-ADJUSTMENT, SCHOOL-ADJUSTMENT, and PHYSICAL-ADJUSTMENT, plus a total adjustment score which reflects changes in the other five scales.

All of the above scales, including the total score, showed significant changes between pre and post-DPC treatment conditions. This

indicates that parents in our group saw changes in their children along the adjustmental dimensions measured by the instrument, following treatment.

The SELF-ADJUSTMENT scale of the CBRS primarily reflects item content related to the individual child's behaviour in general. Items 3 and 6 are illustrative. Item 3, which measures a concrete behaviour, states, "Often cries, and with little or no reason." Item 6, which calls for an inference, states, "Often appears to feel unwanted or disliked." Each of the items on this scale, as on the others, can be interpreted as showing some disturbance in the child being rated.

The significant changes found between pre and post-DPC treatment conditions on the SELF-ADJUSTMENT scale, indicate that parents saw less of the disturbed behaviour measured by the scale in their children following treatment. The DPC program might thus be said to be effective in changing parental views in this area.

The HOME-ADJUSTMENT scale of the CBRS reflects a variety of item content which is presumably somehow related to the child's adaptation to home life. While the items of the above Self-Adjustment scale are at least consistent in relating to the child, the same consistency is not found on the HOME-ADJUSTMENT scale. Items on this scale range from relatively relevant to probably irrelevant as measures of the child's adjustment to the home.

Items 21 and 37 are illustrative. Items 21 states, "Often expresses strong dislike for home and family" which could be relevant, while item 37 states, "Family lives in a multiple family dwelling," which

probably has nothing to do with child adjustment.

The irrelevancies and weaknesses shown by the HOME-ADJUSTMENT scale make the significant results obtained for it somewhat suspect. While parents in our group reported significant changes along this adjustmental dimension following DPC treatment, it is not clear precisely what that dimension is.

The same problems exist with the SOCIAL-ADJUSTMENT scale, which also reflects a variety of item content only loosely relevant to social adjustment. Item 44, "Often plays mean tricks on others," Item 55, "Often tends to have stage fright before a group," and Item 60, "Often does not attend Sunday school or church" are illustrative.

While the parents in our group reported significant changes on this scale following treatment, we are again cautious in interpreting the meaning of this change, since it is not really clear what the scale measures. At best it can be concluded that the parents did perceive changes in their childs social-adjustment in some global manner after the DPC program.

The SCHOOL-ADJUSTMENT scale of the CBRS includes item content which is at least consistent in reflecting behaviours which a child might show in the school situation, and sometimes at home in relation to school. Item 61, "Often expresses a strong dislike for school," Item 64, "Often seems afraid to speak out in class," and Item 71, "Seldom works hard or long on school assignments," are illustrative.

The SCHOOL-ADJUSTMENT scale of the CBRS is constructed so that it can be most reliably completed by teachers, or by parents if they have a

fairly intimate knowledge of their childrens functioning in the classroom. All of the children of the parents in our group were in school. They attended either public school, or a local pre-school nursery school. All of our parents reported a high degree of parent-teacher contact and mutual information exchange. Thus, the results obtained on the SCHOOL-ADJUSTMENT scale can be accepted with greater confidence as reflecting changes in parental perceptions of their childrens classroom functioning following DPC treatment.

Since this apparent change in classroom functioning probably did not result from changes in teachers, it must have been reflective of changes seen by parents in their children. The DPC program can thus be seen as perhaps able to produce changes in parental perceptions of school functioning in their children.

The PHYSICAL-ADJUSTMENT scale of the CBRS reflects a variety of item content related to physical problems, ranging from simple matters of hygiene to congential defents. Moreover, there are only six items on this scale, far too few to adequately sample the universe of physical problems it purports to do. Item 73, "Generally is in rather poor health," Item 75, "Teeth often are unclean; and is unkempt," and Item 77, "There is evidence of perceptual malfunctioning," are illustrative.

Because of the limitations of the PHYSICAL-ADJUSTMENT scale, the significant changes found on it following treatment should be accepted with caution.

The Mother-Child Relationship Evaluation

This instrument provides an attitude measure for four attitudes,

ACCEPTANCE, OVERPROTECTION, OVERINDULGENCE, and REJECTION, which are reflected in mother-child interaction. The ACCEPTANCE scale is seen as reflecting a positive attitude, while the other three scales reflect negative attitudes. It was initially expected that the three negative attitude scales would show a decrease following DPC treatment, while the ACCEPTANCE scale was expected to show a significant increase.

The results did not turn out as expected. Significant changes were found only for the two scales, OVERPROTECTION and REJECTION.

The item content of the Mother-Child Relationship Evaluation is consistently related to what it purportedly measures. No inconsistencies were found.

The OVERPROTECTION scale reflects attitudes related to parental anxiety about children. It reflects excessive control of the child's behaviour, prolonged maternal care, and prevention of independent behaviour on the part of the child. This attitude on the part of mothers is expressed by an excessive amount of worrying and obsessing about the child's health, achievement, adjustment to life, and anticipatory fears concerning "what will become of him" in the future when mother is no longer around to help.

The reactions of children to overprotective mothers can be rather severe. In general, such reactions involve prolonged dependency for the child, and a failure to develop responsible characteristics. Such children also are typically fearful, based on contagion effects derived from the many fears expressed by their mothers.

In classical psychodynamic terms, overprotection is often inter-

preted as a reaction formation defense against feelings of hostility in mothers. It may also result from displaced guilt feelings about the rejection of another child. It may also reflect other unhealthy things, such as establishing the child as a compensatory love object.

In less psychodynamic terms, the need to be overprotective, no matter where it comes from, involves mothers in a lot of extra work with their children. It requires them to perform an excessive number of extra operations with the child which become a needless, tiring, and time-consuming nuisance.

The significant changes shown in overprotectiveness by the parents in our group following treatment reflect increased willingness on their part to free their children of excessive involvement with them. As such, it perhaps reflects the increased trust between mother and child which was also seen in the Family System Survey data. This is a positive indication of the efficacy of the DPC program in helping parents be less protective of their children. Being less protective in turn allows the parents to relax about their children, which also allows children the freedom needed to grow.

The REJECTION scale of the CBRS reflects maternal attitudes related to withholding affection from children, as well as overt expressions of hostility toward the child, such as neglect, harshness, severity, brutality, and excessive strictness. Rejecting behaviour from mothers ranges from simply forgetting to feed the child, to overt physical abuse. The reaction of children to rejection depends on its severity. Children may react with attempts to win affection which never succeed,

with attention-getting behaviour, with decreased self-esteem, and sometimes with counter-hostility.

The significant change found following DPC treatment on the REJECTION scale for our parents suggests the efficacy of the DPC program in altering parental attitudes related to rejection. Paradoxically, rejection and overprotection seem to be correlated with each other, in other than merely psychodynamic ways. Overprotection leads to excessive parental stress, which may in turn produce parental resentment of child demands, while at the same time allowing no freedom from those demands. Overprotection is a coercive variable which locks parents into a pattern of behaviour which they feel compelled to perform. When people are coerced, they usually end up resisting that which does the coercing. This can produce rejection of the child, based on stress-overload effects alone.

Thus, to the extent that overprotection and rejection are related to each other, a decrease in one should be accompanied by a decrease in the other. This decrease is reflected in our results.

The data do not show a significant change in either the ACCEPTANCE or OVERINDULGENCE scales. This needs to be explained, since at least to the extent that our parents were less rejecting, they might be expected to also become more accepting. Acceptance and rejection are, after all assumed to be polar opposites.

The ACCEPTANCE scale reflects maternal attitudes related to interest in childrens pleasures, activities, general development, and the perception of the child as being a "good" child. It is reflected in such

maternal behaviours as a common-sense approach to the child, identification with the child, sincere emotional responses to the child, expressions of affection toward the child, providing order in the daily life of the child, and making reasonable demands on the child.

As defined by this scale, most of our parents were already fairly accepting of their children to begin with. While they were also in some ways rejecting, they could not be judged as having been severely rejecting prior to treatment. This was not, for example, a child abusing group of parents. Most of them expressed guilt about the problems they were having with their children, and they all seemed genuinely concerned with changing things.

In view of the already fairly high level of acceptance shown by our parents for their children, large changes could probably not be expected on the ACCEPTANCE scale of the CBRS. It remains to be determined via further research whether the DPC program can be effective in increasing parental acceptance as a specific attitude with parents who show less of it to begin with.

In addition, while this particular scale did not show changes in acceptance, as defined by it, the results of the FAMILY SYSTEM SURVEY and the Semantic Differential did show significant changes along dimensions related to greater acceptance of the child. Those changes were discussed earlier.

The OVERINDULGENCE scale of the CBRS reflects parental behaviour such as spending excessive time with the child, constantly yielding to the child's demands, always defending the child from criticism,

and giving too many material rewards to the child. Superficially it would seem to overlap the overprotection variable, though it apparently measures something with enough qualitative difference to justify a separate scale.

The lack of significant change found on the OVERINDULGENCE scale could be due to the fact that, if anything, our parents went the other way following treatment, as shown by the results of the Family System Survey. They spent more time with their children after treatment, were more praising, and related to them more positively. Since the OVERINDULGENCE scale of the CBRS would rate such changes negatively, no decrease could be expected on it. This perhaps merely serves as further confirmation of the fact that the changes noted on the Family System Survey were indeed real.

While Roth (1961) does not devote much time to discussing the relationships among the scales of the CBRS, except to say that rejection correlates negatively with acceptance, we might speculate that the two remaining scales, OVERINDULGENCE and OVERPROTECTION, both correlate highly with ACCEPTANCE. This might be most true of OVERINDULGENCE, which could be seen as a more direct expression of genuine caring for the child even than OVERPROTECTION might.

It is, in any event, difficult to be as concerned with the pathological effects of the overindulgent behaviours described by Roth (1961) on children as he seems to be. While such overindulgence might, as he suggests, impair the child's frustration tolerance a bit, it seems far preferable and less harmful than parental rejection. The DPC

program is of value in reducing parental rejection, which is probably the most important change found in the MCRE results.

The Child Cooperation Index

The Child Cooperation Index (CCI) was concerned with measuring changes in verbal control of child behaviour by parents which might occur as a result of the DPC treatment (Holland and Brown, 1973). This instrument touches upon a major stressor dimension of the parental role. This dimension is so basic and so important that it is surprising that it has been virtually ignored in other research, which has generally made unrealistic assumptions about the limitlessness of parental energy and frustration tolerance.

Parents must seek verbal control of their childrens behaviour in the interest of their own survival. Traditionally, the favored means of achieving such verbal control was via strictness, supported by prosaic wisdom to not "spare the rod and spoil the child." This meant that parents had to frighten their children into compliance and submission, which are somewhat different than cooperation.

With changes in the child-rearing ethic in the direction of greater permissiveness, this traditional approach has met with increasing ambivalence on the part of parents. However, the alternatives have seldom been clear. The alternative favored by the DPC program is to achieve a more truly cooperative relationship between parent and child, based not on punitive submission by the child, but involving rewards by parents for cooperative behaviour, while they withhold rewards for its opposite.

We believe that most parents want to do a good job of being parents. Most parents do not want to deliberately harm their children. However, each unpicked-up-toy, each unbrushed tooth, each uneaten meal, and every other ignored request for behaviour in the interest of the child, represents a demand on parental concern and energy. Such uncompleted tasks, which parents define as things the child "ought to do" become discriminative stimuli for possible bad consequences, which responsible parents must prevent. Each child presents thousands of stimuli of this sort, from the time he begins ambulating, until he passes finally beyond the realm of direct parental responsibility by growing up and/or leaving home.

The parental role involves a monotonously mind-numbing and nearly endless number of such demands from children. They must be dealt with repeatedly in child training. Each repetition has potential stress value for parents, in terms of autonomic arousal and frustration. After all, they see the value of brushing teeth, why can't the child see.

The above stress multiplies with parental caring and devotion to the parent role. Conversely, it seems to decrease with child neglect. Parents who stop caring usually experience less role stress, since they shift most of the responsibility for child-rearing to the child himself (Hunt, 1970; Lewis, 1966; Malone, 1966; Pavenstedt, 1964).

Faulty verbal control of child behaviour can force parents into a stress overload situation where they become neglectful, and stop caring, based on their own despair. It is difficult to understand why this

simple fact of parental existence is so often ignored by others (Lewis, 1966).

If parents care, but their verbal control of child behaviour is not adequate, they may be forced into one of three response modes:

1. They may begin doing more things for the child that he should reasonably be expected to do for himself, thereby depriving the child of responsibility, and exhausting themselves.
2. They may resort to punitive physical measures, such as yelling or hitting, to force cooperation.
3. They may withdraw some of their efforts to nurture the child, becoming less dedicated to the parent role.

The results which we obtained concerning increased verbal control of child behaviour on the CCI are certainly encouraging where this crucial dimension of parent-child interaction is concerned. The results for the five task behaviours studied showed a significant decrease for all of the tasks during the course of DPC training. Thus, it appears that the DPC program is an effective means of increasing child cooperation, as measured by the number of requests needed by parents to elicit performance from the child of routine daily task behaviours.

It should be explained that the five task behaviours studied via the CCI occurred in a temporal sequence throughout the day. Thus, Task 1, typically occurred early in the day, and involved such things as eating breakfast, making beds, and so forth, while Task 5 typically occurred at the end of the day, and involved things like picking up toys, getting ready for bed, or whatever.

It was presumably more difficult to elicit child cooperation later in the day, due to the cumulative fatigue effects commonly observed in families at the end of the day. Nonetheless, all of the tasks showed a decreasing trend over time in the number of requests needed to elicit cooperation. Task 5, which happened at the end of the day, showed no greater variability than the other tasks. While it started higher in terms of mean number of requests, and ended higher, the rate of decrease in between was on the same downward slope as the other tasks.

This suggests something about the efficacy of the DPC program in terms of enhancing parental verbal control over child behaviour, even under presumably stressful and tiring conditions. It also supports the generalization-of-effects from one behavioural task to another, since parents were using the same means for eliciting cooperation, learned via the DPC material, in each of the tasks.

The results obtained for the CCI also support the changes reflected in the Family System Survey on child-listening behaviour. It acts as a convergent measure in this regard, indicating that enhanced child-listening does carry-over into the daily natural environment of the home as a result of DPC treatment.

One-year Follow-up Results

The Improvement Rating Scale (Patterson, 1973) was included as a sort of measure of consumer satisfaction. Responses to it were nearly identical under post-DPC treatment and one-year follow-up conditions. It thus appears that the consumers of the DPC program sampled here remained rather well satisfied with the results of treatment a year

after concluding it.

As noted before, consumer satisfaction is one variable which psychotherapy has traditionally ignored, perhaps to its own perile in view of the mounting criticism directed its way. The importance of consumer satisfaction again relates to generalization-of-effects from training to daily life, and from one situation to others in the lives of parents. If parents are not satisfied with treatment, or if they do not feel it helped, or was not relevant to their problems, the experience of it is likely to be quickly forgotten. If, on the contrary, they are satisfied with the treatment experience, it will be remembered and used in the future.

The results obtained on the Family System Survey for the fourteen items which showed significant differences between pre and post-DPC conditions also held well on one-year follow-up. Nine of the fourteen items showed no significant change twelve-months later, and five of the fourteen items showed still more significant change on one-year follow-up.

Those items which changed and those which did not are equally important, but in different ways. In all cases, the FSS was administered with the original problem child, for whom parents sought help, in mind. They were asked to respond in relation to that original child with problems.

The results indicate that Item 5, number of rooms off-limits, Item 9, tension level in the home, Item 11, outside influences on child behaviour, Item 14, how well child listens to parents, Item 25, how

often the child leaves home each day, Item 26, number of hours spent by the child outside the home daily, Item 34, how well child responds to spouse, Item 36, parental feelings of effectiveness as parents, and Item 37, effective of spouses as parents, all remained unchanged on one-year follow-up.

Of the FSS items which showed no significant change on one-year follow-up, we can say that at least they showed no deterioration. The changes found one month following treatment were still holding one year later. The evidence that the variables measured by these items did not revert to pre-treatment baseline conditions within the first year after treatment is seen as providing support for the efficacy of the DPC program in producing changes in parental functioning which endure over time, for the variables involved.

The five FSS items which showed still more significant change on one-year follow-up were, Item 19, number of times daily parents talk to the problem child, Item 20, number of hours per day spent with that child, Item 23, number of times daily praise is given to the problem child, Item 30, money stress, and Item 35, parental reliance on punishment.

Items 19, 20, 23, and 35, reflect variables related to parent-child interaction. They all showed still further positive changes one year following conclusion of treatment. Item 20 showed a slight, but significant decrease one year later. This indicated that parents spent somewhat less time in the average day with the problem child. Items 19, 23, and 33 all showed significant increases on one-year follow-up.

Taken together, this may reflect certain qualitative changes in parent-child interaction during the intervening year. While parents may have spent somewhat less time with their children each day, perhaps because the children were still freer to do other things beside sit around the home under the anxious eyes of their parents, parents talked to their children more, gave more praise, and used punishment still less on one-year follow-up than they had at the conclusion of treatment.

The above results offer support for the efficacy of the DPC program for not only producing changes which endure over time, but also in continuing to produce changes in those variables related to parent-child interaction measured by the indicated items. This, in turn, offers further support for a generalization-of-effects far beyond the immediate modification of the problem child behaviours which brought parents to treatment in the first place.

The Survey of the Fate of Presenting Problems done on one-year follow-up dealt with the specific presenting target behaviours which brought our parents to treatment some fourteen months earlier. These were the problem behaviours of their children which our parents were taught to modify via the DPC program. However, not all were included as the specific focus of treatment. As discussed earlier, parents were taught to modify one or two selected problem behaviours, and were then expected to apply the DPC principles they had learned to other problem child behaviours on their lists. Again, the DPC program relies on a generalization-of-effects of its principles from one particular behaviour which acts to focus training, to other problem behaviours which may be shown by the child.

Of the 25 presenting problem behaviours shown in Table 18 of Chapter III, only six behaviours were ever actually dealt with during active DPC training sessions. Changes found on one-year follow-up for the remaining 19 problem behaviours represented either generalization effects from training, or spontaneous remissions of the behaviours involved.

Of the six behaviours dealt with during training, four were "non-existent" on one-year follow-up, and two were reported as being "much better" by parents. Of the 19 behaviours not dealt with in training, eleven were reported as "non-existent", six were "much better", and two were "the same" on one-year follow-up.

The above changes in target behaviours are presented quite tentatively, since it is not possible to draw many inferences from them with any confidence. The behaviour repertoire of small children is quite subject to change over time in any event, and there is no way of knowing how many of the indicated changes would have occurred spontaneously. Unfortunately, nowhere in the literature has anyone done the rather mundane research needed to generate baseline change rates for child behaviours over time. This is seen as yet another need for future research.

We might speculate that some of the remissions in target behaviours were also due to parents specifically and deliberately alterating the reinforcing contingencies related to them. This might be especially true for certain of the behaviours which tend to become fixed and patterned after a time. Manipulation of parental guilt by the child,

for example, tends to become an habitual pattern, but it became non-existant for our patients on one-year follow-up.

Similarly, somatic stress reactions as a function of the child's general tension level tend to become established early in life, leading later to psychosomatic disease (Lang, 1966; Meredith, 1973). Such somatic reactions are notoriously resistant to spontaneous remission, and become well conditioned visceral responses. Our data show four somatically related behaviours, two cases of Ritalin Hydrochloride use, one case of hyperactivity, and one case of specific somatic complaints (stomach aches and hyperventilation) which were either non-existant or much better on one-year follow-up.

While this still does not clearly establish these changes as the result of DPC treatment, it may suggest alterations in child behaviour which were the result of something, besides spontaneous remission.

CHAPTER V

SUMMARY AND CONCLUSIONS

This study was undertaken in an attempt to define some of the many extra-conditioning variables which might be related to the Directive Parental Counselling training program. The potential universe of such variables is indeed very large, and at this point can only be guessed at. This study is the first exploratory attempt to map that universe.

Extra-conditioning variables were defined as those events influencing treatment, and being influenced by it, which are not specific target behaviours. Our concern was with what other effects were produced by the DPC program, besides changes in specific target behaviours, which it was already known could be produced by the program. In defining extra-conditioning effects, in a what-else-can-it-do manner, we also hoped to define a bit more clearly the limits of the program.

Every treatment program has its limits, but few attempt to specify them. When the limits are not specified, needless failures may result. In defining what a treatment program can and cannot do, needless failures may be avoided.

We found that the DPC program is valid in producing changes in parent-child interaction with lower-middle class families who have pre-school and early-elementary school age children. It is also effective with families who show a high level of tension in the home,

and experience much nuclear family stress in terms of relative isolation from external community supports. The parents we studied all had marital relationships characterized by a fairly high degree of mutuality along several dimensions. Their problems seemed limited, for the most part, to their children. These problems showed themselves in a number of ways reflecting disturbed interaction with their children. Our parents were also troubled by a large number of influences on the problem behaviour of their children from outside the immediate family. They also tended to be moderately punitive toward their children, and restrictive in other ways.

A number of changes occurred which were attributed to the effects of DPC treatment. Those changes help define some of the limits of effectiveness of the DPC program.

Significant changes in parental attitudes, and in parent-child interaction were found. As a result of treatment, parents reported that their children listened to them better, that they spent more time with their children, that they praised their children more, and that they punished them less. They also reported a significant decrease in tension level in the home. There was an increase in verbal control of their childrens behaviour by the parents who were treated, and a related increase in child cooperation with parental requests.

Parents saw their children as less disruptive, less anxious, less withdrawn, less distractible, and more outgoing, following treatment. They also permitted their children more freedom in terms of physical mobility, both within the home and outside it, as a result of treatment.

This was seen as reflective of greater trust between parents and their children, and of decreased tension in parent-child relationships.

There was evidence of attitude change in parents toward their children along several dimensions. They became less protective of their children, and also less rejecting of them, as a result of treatment. A related increase in terms of greater acceptance of their children was reflected in several different results obtained by this study. Parents also defined their children as being more "good", as well as stronger, in a strength-valuing way, as a result of treatment.

Changes in parental perceptions of themselves were also noted following treatment. Parents reported increased feelings of effectiveness in the parent role, and felt better able to cope with the demands of parenthood. They liked themselves better as parents following treatment, rating themselves as more "good" and also "stronger" in the parental role than they had prior to treatment.

The number of outside influences on the behaviour of the children of the parents in the study decreased following treatment, as parents moved to bring control of reinforcers more within their immediate sphere of influence. Parents also reported decreased financial stress following treatment, though there were no objective changes in their incomes.

A one-year follow-up study was done, focussed on current interaction with the child who was originally presented as having problems. Some of the same measures which were used one month after treatment were again employed.

It was found that consumer satisfaction with the effects of DPC

training held well on one-year follow-up. This was interpreted favorably in terms of parents continued willingness to apply the principles of the DPC to their lives, based on the apparent continued relevance which those principles had for them.

The positive changes related to tension level in the home, parent-child interaction, the child's response to the other parent, parental feelings of effectiveness, both for themselves and their spouses, child mobility, and outside influences on child behaviour, also held well on one-year follow-up. This was interpreted as supporting the efficacy of the DPC program in producing enduring changes.

In addition, the one-year follow-up results showed continuing significant changes in the amount of time which parents spent with the former problem child, which decreased, while the amount of talking done with the child, and the amount of praise given to the child, both increased. Parents also reported still further decreases in their use of punishment to control child behaviour on one-year follow-up. Money stress also continued to decrease one year following treatment.

A survey on the fate of presenting problem target behaviours one year after treatment showed that around sixty per cent of the initial target behaviours were non-existant one year later. Another thirty-two per cent were reported as being much better. This is suggestive of continued generalization of effects from the DPC program, but could not be interpreted as being so with much confidence, since baseline data for spontaneous behaviour change rates was not available.

The effects of DPC treatment appear fairly specific. For the

most part they are confined to specific parent-child interaction units. They do not seem to generalize to the larger family unit, to children in general, or to other abstractions related to parent-child interaction. Generalization of effects related to specific parent-child interactive units were abundantly demonstrated however.

The efficacy of the DPC program with parents showing different configurations of socio-economic variables has not been established. Future research needs to establish its power particularly with lower-class families which show more discordant patterns of conjugality than was shown by the group studied here.

Therapeutic power is a function of two factors, (1) therapeutic efficiency, and (2) therapeutic effectiveness, (Brown, 1964). Any system of therapy may be efficient but not effective, effective but not efficient, or both effective and efficient.

As here conceived, efficiency refers to the element of parsimony of the system, in terms of how quickly it can intervene in human lives, create conditions for change, and then get out again. The ideal would probably be the mythical "one-shot cure."

Many systems of behaviour therapy are efficient. Their efficiency is enhanced by focussing only on fairly limited and specific targets for change, such as enuretic episodes, sexual dysfunction, or whatever. The same efficiency is true of psychosurgery, electroshock therapy, or a dose of curare.

Effectiveness, on the other hand, refers to the number of different kinds of problems a system of therapy is able to deal with efficiently.

The term problem does not refer to nosological categories, such as schizophrenia, marital dysfunction, or whatever, but rather to the specific difficulties people may have within whatever diagnostic categories they are placed by imaginative clinicians.

Some human interventions, such as supportive therapy via hand-holding and encouragement, are broadly effective in terms of helping most people feel better, but grossly inefficient in terms of rapidly changing specific problems. The same would be true of psychoanalytic or client-centered therapy, which are sometimes effective in non-specific ways, but hardly efficient, since they require large amounts of time to produce their unspecific effects.

The DPC system is seen as being both efficient and effective. In terms of efficiency, it produces changes in twelve weeks or less. In terms of effectiveness it creates change conditions along four main dimensions related to helping parents be therapists for their children:

1. The DPC system produces significant changes in parent-child interaction, in a positive direction.
2. The DPC system produces changes in parental attitudes toward their children, in positive directions.
3. The DPC system produces positive changes in parental feelings of effectiveness in the parental role, with increased liking of themselves as parents on the part of parents exposed to it.
4. The DPC system helps parents achieve more effective control over the reinforcers which control child behaviour in their lives.

In terms of limitations for the DPC program which we found in the present study, there were two main effects.

1. The DPC program is limited in altering the parents role perception of their spouses or their attitudes to the general family situation.
2. The DPC program produces effects which are limited to specific parent-child interactive units, and which do not necessarily extend to the rest of the family unit. However, we obtained no direct information on possible effects directly from siblings.

Successfully nurturing a family is perhaps the ultimate test of a human being's ability to endure, transcend, and live beyond, while at the same time remaining a loving being. Doing it well requires immense patience within an endless process of creative problem-solving. Mundane talent, wealth, and social position are of little help. Intelligence has no value for the task unless it is balanced by compassion.

Being an effective parent means struggles over the breakfast table, the sickbed, and in the middle of the night, if family integrity is to be preserved. It often means few rewards beyond the doing, and the sharing of human bonds. Of all human relationships, the family perhaps comes closest to the transcendent, or the divine. It either ennobles people, destroys them, or is itself destroyed. It continually asks the ancient question posed by philosophers and theologians, how can human beings stand together so that life flows between them and permeates the work they do together. The answers are always difficult. Sometimes

there are none.

If the results of our work with the DPC program can be used in some way as a guide to future applications of the program to help parents with creative problem solving, they are justified. Parents obviously need all the help they can get.

APPENDICES

APPENDIX A

COPIES OF THE MEASURING INSTRUMENTS USED

FAMILY SYSTEM SURVEY

The following questions are to help us understand something about your family situation. The information you give is for treatment and evaluation pruposes only. It will not be shared by us with your spouse. It will not be shared with other outside persons except in the form of statistics in research reports from which all personal identification has been removed.

Name: _____ Age: _____

Living with spouse: Yes _____ No _____

1. Your education (check one)

   Graduate professional training with degree _____

   College of university graduation _____

   Partial college training _____

   High-school graduation _____

   Partial high-school, grades 10-13 _____

   High-school, grades 9 and 10 _____

   Less than 8 years of school _____

2. Your occupation (check one)

   Homemaker _____

   General labor, unskilled work _____

   Semi-skilled work _____

   Skilled trade (such as carpenter, welder, tool & die, etc.) _____

Owner of small business, clerk, salesman, technician _____

Administrator of large business, semi-professional _____

Manager or proprietor of medium-sized business _____

Executive or owner of large business, professional person (such as doctor, teacher, lawyer, etc.) _____

3. Your gross family income yearly (check one)

Under $5,000 _____

5 to $10,000 _____

10 to $20,000 _____

20 to $30,000 _____

Over $30,000 _____

4. Number of rooms in your house (circle one)

1 2 3 4 5 6 7 8 9 10, over 10 = _____ rooms

5. How many of these rooms are off-limits to the child you are having problems with, or his entry restricted in some way (circle one)

0 1 2 3 4 5 6 7 8 9 10, over 10 = _____ rooms

6. Age of the child you are having problems with:

1 to 3 years _____

4 to 6 years _____

7 to 9 years _____

10 to 12 years _____

Over 12 years _____

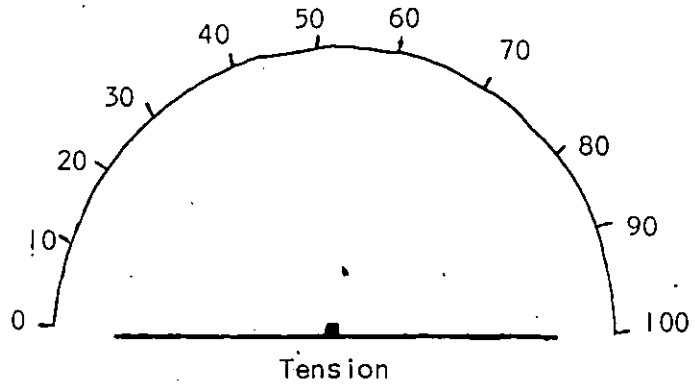
7. How many other children live in the home (circle one)

0 1 2 3 4 5 6 7 8 9 10 11 12, over 12 = _____ children

8. Other people living in the home (such as in-laws, relatives, roomers, etc.)

   0 1 2 3 4 5 6 7 8 9 10 11 12, over 12 = _____ others

9. How tense is the general atmosphere at home, shown on a 100 point scale of tension, with 0 being no tension at all, and 100 being the most tension you can feel. Draw a line.



10. Will both you and your spouse be involved in the treatment of the child's problems? If not is he or she opposed to treatment? Treatment means at home and in the clinic.

    Both parents involved _____

    One parent involved _____

    One parent opposed _____

11. How many people outside the family contribute to the problem behaviour of the child in question, such as grandparents, other relatives. Include influences in the child's life outside the home, such as teachers, neighbors, friends, etc.

No outside influences _____

One outside influence _____

Two outside influences _____

More than two _____

12. Note the approximate amount of agreement or disagreement between you and your spouse on the following items. Please check each item.

ITEM	Always Agree	Almost Always Agree	Sometimes we Disagree	Often we Disagree	Almost Always Disagree	Always Disagree
Handling family finances						
Matters of recreation						
Showing affection						
Friends						
Sex Relations						
Conventionality (right, good, proper, conduct)						
Philosophy of life						
Dealing with in-laws						

13. How well does your spouse listen to you when you really have something to say? (Check the dot on the line below which best describes the situation).

Rarely ——————————— Always

14. How well does your child listen to you when you have something to say? (Check the dot that best describes the situation).

Always ——— Rarely

15. Do you confide in your spouse? (Check the most appropriate dot).

Rarely ——— Always

16. When major decisions are made in the family, how often do you make them alone? (Check the most appropriate dot).

Always ——— Rarely

17. When a family problem comes up, who usually discovers it first and starts action to solve it? (Check one).

I always do ____ I do mostly ____ About equal ____

Spouse mostly ____ Spouse always does ____

18. When you and your spouse communicate, how often do you really understand each other? (Check the most appropriate dot).

Rarely ——— Always

19. About how many times in the average day do you talk with your child for 2 minutes or more? (Check one).

1 to 5 times ____

6 to 10 times _____

11 to 15 times _____

Over 15 times _____

20. About how many hours in the average day or evening are you with the child who has the problem? (Check one). Don't count sleeping time.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

21. Is the child's problem confined to him/her, or has the same problem been found in other children in the family too? (Check one).

This child only _____

1 other child _____

2 other children _____

3 or more children _____

22. About how many hours in the average week does someone from outside the home help with the chores of the family and child-rearing, such as domestic help, babysitters, grandparents who often take the children, etc.? (Check one).

0 to 1 hr. _____

3 to 4 hrs. _____

5 to 6 hrs. _____

6 to 7 hrs. _____

8 to 9 hrs. _____

10 to 15 hrs. _____

16 to 20 hrs. _____

21 to 30 hrs. _____

Over 30 hrs. _____

23. How often in the normal day do you praise your child? (Check one).

0 1 2 3 4 5 6 7 8 9 10, over 10 = _____ times.

24. How many times in the average week do other children enter your home to visit your child? (Check one).

0 1 2 3 4 5 6 7, over 7 = _____ visits weekly

Visitors every other week _____ Monthly _____

Less than monthly _____ Never _____

25. How many times a day does your own child leave the home, including school? (Check one). Include play, trips to the store, etc.

0 1 2 3 4 5 6 7 8 9 10, over 10 = _____ times.

26. How many hours in the average day does your child spend outside the house? DO NOT INCLUDE SCHOOL. (Check one).

0 to 2 hrs. _____

3 to 5 hrs. _____

6 to 8 hrs. _____

9 to 11 hrs. _____

More than 11 hrs. _____

27. In the average week, about how many times does your family do things together for fun, such as going to movies, walks, etc? (Check one).

0 1 2 3 4 5 6 7 8 9 10, over 10 = _____ times.

28. About how many hours a week are you and your spouse together without the children? (Check one).

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20,

over 20 _____ hrs.

29. About how many hours a week do you have for yourself, to do whatever you want? (Check one).

0 1 2 3 4 5 6 7 8 9 10, over 10 = _____ hours.

30. How stressful is the issue of money in your family? (Check the dot on the line below that best describes the situation).

. . . . .

Very Stressful — Not at All

31. How well do you and your spouse share the work load around the home, such as cleaning house, getting the children to bed, picking up the clutter, etc. (Check the most appropriate dot).

. . . . .

Always Share — Rarely Share

32. How willing is your spouse to take responsibility for managing the children and setting rules? (Check the most appropriate dot).

. . . . .

Rarely does — Always does

33. How effective is your spouse in handling your child's (children's) behaviour? (Check the most appropriate dot).

Very effective — Rarely effective

34. How does your child respond to your spouse's way of handling problems? (Check the most appropriate dot).

Very poorly — Very well

35. To what extent does your spouse rely on yelling, spanking, or other forms of punishment to control the child's behaviour? (Check the most appropriate dot).

Always — Rarely

36. In general, how effective and strong do you personally feel most of the time in the job of being a parent? (Check the most appropriate dot).

Very effective — Rarely effective

37. About how effective do you think your spouse feels most of the time in the job of being a parent? (Check the most appropriate dot).

Very effective — Rarely effective

Name: _____

PERSONAL EXPERIENCE RATING SCALE

Please rate each of the following upsetting events which happened in your life in the past 12 months in terms of the amount of stress and upset it caused you, on a scale from 0 (no upset) to 100 (severe upset) and the changes in your life situation which resulted from it.

Life Event	Stress Value
Death of spouse	
Divorce	
Marital separation	
Jail term	
Death of a close family member	
Personal injury or illness	
Marriage	
Fired at work	
Marital reconcilliation	
Retirement	
Change in health of family member	
Pregnancy	
Sex difficulties	
Gain of new family member	
Business readjustment	
Change in financial state	

Life Event	Stress Value
Death of a close friend	
Change to different line of work	
Change in number of arguments with spouse	
Mortgage over $10,000	
Foreclosure of mortgage or loan	
Change in responsibilities at work	
Son or daughter leaving home	
Trouble with in-laws	
Outstanding personal achievement	
Wife begins or stops work	
Begin or end school	
Change in living conditions	
Revision of personal habits	
Trouble with boss	
Change in work hours or conditions	
Change in residence	
Change in schools	
Change in recreation	
Change in church activities	
Mortgage or loan less than $10,000	
Change in sleeping habits	
Change in number of family get-togethers	
Change in eating habits	
Vacation	

Life Event	Stress Value
Christmas	
Minor violations of the law	
Others:	

SEMANTIC DIFFERENTIAL

The purpose of this scale is to measure your emotional responses to several factors concerning yourself and your family. This is done by having you judge some items on a series of descriptive scales.

Please make your judgments based on what the item means to you. Do not worry or puzzle over individual items. It is your first impressions, your immediate responses, that we want. On the other hand, please do not be careless, because we want your true impressions.

There are 7 positions on each scale. If you feel that an item is very closely related to one end of the scale, put your check mark next to the appropriate adjective:

Sweet X Sour

or

Sweet X Sour

If you feel that the concept is closely related to one end of the scale (but not extremely so), place your check mark as follows:

Sweet X Sour

or

Sweet X Sour

If the concept seems only slightly related to one side as opposed to the other (but not really neutral), then you should place your check mark as follows:

Sweet X Sour

or

Sweet X Sour

The direction toward which you check depends on which of the two ends of the scale seems most accurate or characteristic in describing the concept.

If you feel the item is <u>neutral</u> on the scale, or if the scale <u>does not apply at all</u> to your life, place your check mark in the middle space.

Sweet ___:___:___:_X_:___:___:___ Sour

MY FAMILY

1.	Worthless	Valuable
2.	Difficult	Easy
3.	Scientific	Unscientific
4.	Passive	Active
5.	Important	Unimportant
6.	Disreputable	Reputable
7.	Weak	Strong
8.	Wise	Foolish
9.	Interesting	Dull
10.	Flippant	Earnest
11.	Bad	Good
12.	Severe	Lenient
13.	Responsible	Irresponsible
14.	Traditional	Innovative
15.	Broad	Narrow
16.	Useless	Useful
17.	Subdued	Flashy
18.	Varied	Monotonous
19.	Practical	Theoretical
20.	Mature	Youthful
21.	Beautiful	Ugly
22.	Serious	Humorous
23.	Sick	Healthy
24.	Slow	Fast
25.	Personal	Impersonal
26.	Fair	Unfair
27.	Feminine	Masculine
28.	Sad	Happy
29.	Hot	Cold
30.	Naive	Sophisticated

THE IDEAL CHILD

1.	Worthless	Valuable
2.	Difficult	Easy
3.	Scientific	Unscientific
4.	Passive	Active
5.	Important	Unimportant
6.	Disreputable	Reputable
7.	Weak	Strong
8.	Wise	Foolish
9.	Interesting	Dull
10.	Flippant	Earnest
11.	Bad	Good
12.	Severe	Lenient
13.	Responsible	Irresponsible
14.	Traditional	Innovative
15.	Broad	Narrow
16.	Useless	Useful
17.	Subdued	Flashy
18.	Varied	Monotonous
19.	Practical	Theoretical
20.	Mature	Youthful
21.	Beautiful	Ugly
22.	Serious	Humorous
23.	Sick	Healthy
24.	Slow	Fast
25.	Personal	Impersonal
26.	Fair	Unfair
27.	Feminine	Masculine
28.	Sad	Happy
29.	Hot	Cold
30.	Naive	Sophisticated

MY CHILD

1.	Worthless	Valuable
2.	Difficult	Easy
3.	Scientific	Unscientific
4.	Passive	Active
5.	Important	Unimportant
6.	Disreputable	Reputable
7.	Weak	Strong
8.	Wise	Foolish
9.	Interesting	Dull
10.	Flippant	Earnest
11.	Bad	Good
12.	Severe	Lenient
13.	Responsible	Irresponsible
14.	Traditional	Innovative
15.	Broad	Narrow
16.	Useless	Useful
17.	Subdued	Flashy
18.	Varied	Monotonous
19.	Practical	Theoretical
20.	Mature	Youthful
21.	Beautiful	Ugly
22.	Serious	Humorous
23.	Sick	Healthy
24.	Slow	Fast
25.	Personal	Impersonal
26.	Fair	Unfair
27.	Feminine	Masculine
28.	Sad	Happy
29.	Hot	Cold
30.	Naive	Sophisticated

A PROBLEM CHILD

1.	Worthless	Valuable
2.	Difficult	Easy
3.	Scientific	Unscientific
4.	Passive	Active
5.	Important	Unimportant
6.	Disreputable	Reputable
7.	Weak	Strong
8.	Wise	Foolish
9.	Interesting	Dull
10.	Flippant	Earnest
11.	Bad	Good
12.	Severe	Lenient
13.	Responsible	Irresponsible
14.	Traditional	Innovative
15.	Broad	Narrow
16.	Useless	Useful
17.	Subdued	Flashy
18.	Varied	Monotonous
19.	Practical	Theoretical
20.	Mature	Youthful
21.	Beautiful	Ugly
22.	Serious	Humorous
23.	Sick	Healthy
24.	Slow	Fast
25.	Personal	Impersonal
26.	Fair	Unfair
27.	Feminine	Masculine
28.	Sad	Happy
29.	Hot	Cold
30.	Naive	Sophisticated

THE IDEAL PARENT

1.	Worthless	Valuable
2.	Difficult	Easy
3.	Scientific	Unscientific
4.	Passive	Active
5.	Important	Unimportant
6.	Disreputable	Reputable
7.	Weak	Strong
8.	Wise	Foolish
9.	Interesting	Dull
10.	Flippant	Earnest
11.	Bad	Good
12.	Severe	Lenient
13.	Responsible	Irresponsible
14.	Traditional	Innovative
15.	Broad	Narrow
16.	Useless	Useful
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20.	Mature	Youthful
21.	Beautiful	Ugly
22.	Serious	Humorous
23.	Sick	Healthy
24.	Slow	Fast
25.	Personal	Impersonal
26.	Fair	Unfair
27.	Feminine	Masculine
28.	Sad	Happy
29.	Hot	Cold
30.	Naive	Sophisticated

ME AS PARENT

1.	Worthless		Valuable
2.	Difficult		Easy
3.	Scientific		Unscientific
4.	Passive		Active
5.	Important		Unimportant
6.	Disreputable		Reputable
7.	Weak		Strong
8.	Wise		Foolish
9.	Interesting		Dull
10.	Flippant		Earnest
11.	Bad		Good
12.	Severe		Lenient
13.	Responsible		Irresponsible
14.	Traditional		Innovative
15.	Broad		Narrow
16.	Useless		Useful
17.	Subdued		Flashy
18.	Varied		Monotonous
19.	Practical		Theoretical
20.	Mature		Youthful
21.	Beautiful		Ugly
22.	Serious		Humorous
23.	Sick		Healthy
24.	Slow		Fast
25.	Personal		Impersonal
26.	Fair		Unfair
27.	Feminine		Masculine
28.	Sad		Happy
29.	Hot		Cold
30.	Naive		Sophisticated

MY SPOUSE AS PARENT

1.	Worthless	Valuable
2.	Difficult	Easy
3.	Scientific	Unscientific
4.	Passive	Active
5.	Important	Unimportant
6.	Disreputable	Reputable
7.	Weak	Strong
8.	Wise	Foolish
9.	Interesting	Dull
10.	Flippant	Earnest
11.	Bad	Good
12.	Severe	Lenient
13.	Responsible	Irresponsible
14.	Traditional	Innovative
15.	Broad	Narrow
16.	Useless	Useful
17.	Subdued	Flashy
18.	Varied	Monotonous
19.	Practical	Theoretical
20.	Mature	Youthful
21.	Beautiful	Ugly
22.	Serious	Humorous
23.	Sick	Healthy
24.	Slow	Fast
25.	Personal	Impersonal
26.	Fair	Unfair
27.	Feminine	Masculine
28.	Sad	Happy
29.	Hot	Cold
30.	Naive	Sophisticated

PREVIOUSLY COPYRIGHTED MATERIAL,

IN APPENDIX A,

LEAVES 208-217,

NOT MICROFILMED.

"Walker Problem Behavior Identification Checklist", by Hill M. Walker, Ph.D.,"The Child Behavior Rating Scale", by Russell N. Cassel, Ed.D., "The Mother-Child Relationship Evaluation" by Robert M. Roth, Ph.D. All published by Western Psychological Services, Publishers and Distributors, 12031 Wilshire Boulevard, Los Angeles, California, U.S.A. 90025.

CHILD COOPERATION INDEX

Name:_____

Please list below 5 routine things you ask your child to do each day. Things like get up in the morning, brush teeth, eat meals, take a bath, pick up toys, do homework, get ready for bed, and so forth.

During the week ahead, please observe how the child reacts to your requests to do these things. See: (1) how many times you must ask before he or she starts the task; (2) the time, in minutes, it takes the child to finish the task, and (3) the amount of the task he or she finally completes before you both give up, on a scale from 0 to 9.

For example, if you ask the child to eat breakfast and he or she avoids the table entirely, the task completion score would be 0. Two or three bites of food might get a score of 2. If the whole meal is eaten, the score would be 9, and so forth. RATE EACH TASK ONCE EVERY DAY IF POSSIBLE. In the space below, also note special conditions, if any, such as illness, which may have influenced the child's performance at any particular point.

Task	Times Requested							Minutes to Complete							Amount of Task Completed (0 1/4 1/2 3/4 All = 0 1 2 3 4 5 6 7 8 9)						
	Day 1	2	3	4	5	6	7	Day 1	2	3	4	5	6	7	Day 1	2	3	4	5	6	7
1._____																					
2._____																					
3._____																					
4._____																					
5._____																					

COMMENTS:

IMPROVEMENT RATING SCALE

Please check below the items that most closely describe the current situation with your child at the end of training.

1. As a result of treatment, your child has:

   _____ Become much worse

   _____ Become slightly worse

   _____ Not changed

   _____ Improved slightly

   _____ Improved markedly

2. In regard to the effect of this treatment, you feel:

   _____ Much more negatively toward him/her

   _____ Slightly more negative toward him/her

   _____ About the same toward him/her

   _____ Slightly more positive toward him/her

   _____ Much more positive toward him/her

3. As a result of treatment, my family has, on the whole, begun to function:

   _____ Better

   _____ About the same

   _____ Worse

4. On the whole, I think treatment was:

   _____ Harmful

   _____ Useless

_____ Slightly effective

_____ Very effective

5. The effect of treatment on my child was:

_____ Better than I expected

_____ About what I expected

_____ Worse than I expected

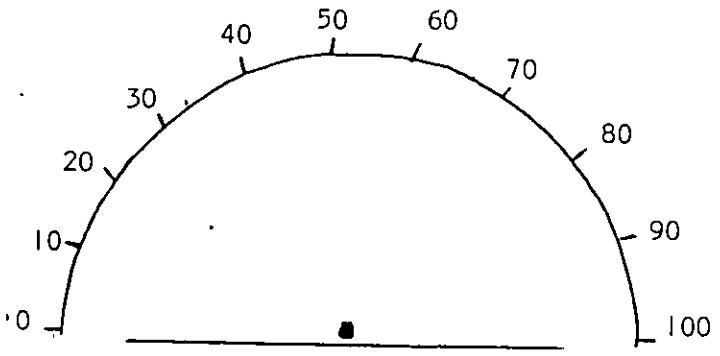
6. As a result of treatment, my child seems:

_____ Less happy at home

_____ About the same

_____ More happy at home

7. How tense is the general atmosphere at home now on a 100 point scale. Draw a line.



APPENDIX B

PARENTS MANUAL

FOR THE DIRECTIVE PARENTAL COUNSELLING TRAINING PROGRAM

DIRECTIVE PARENTAL COUNSELLING

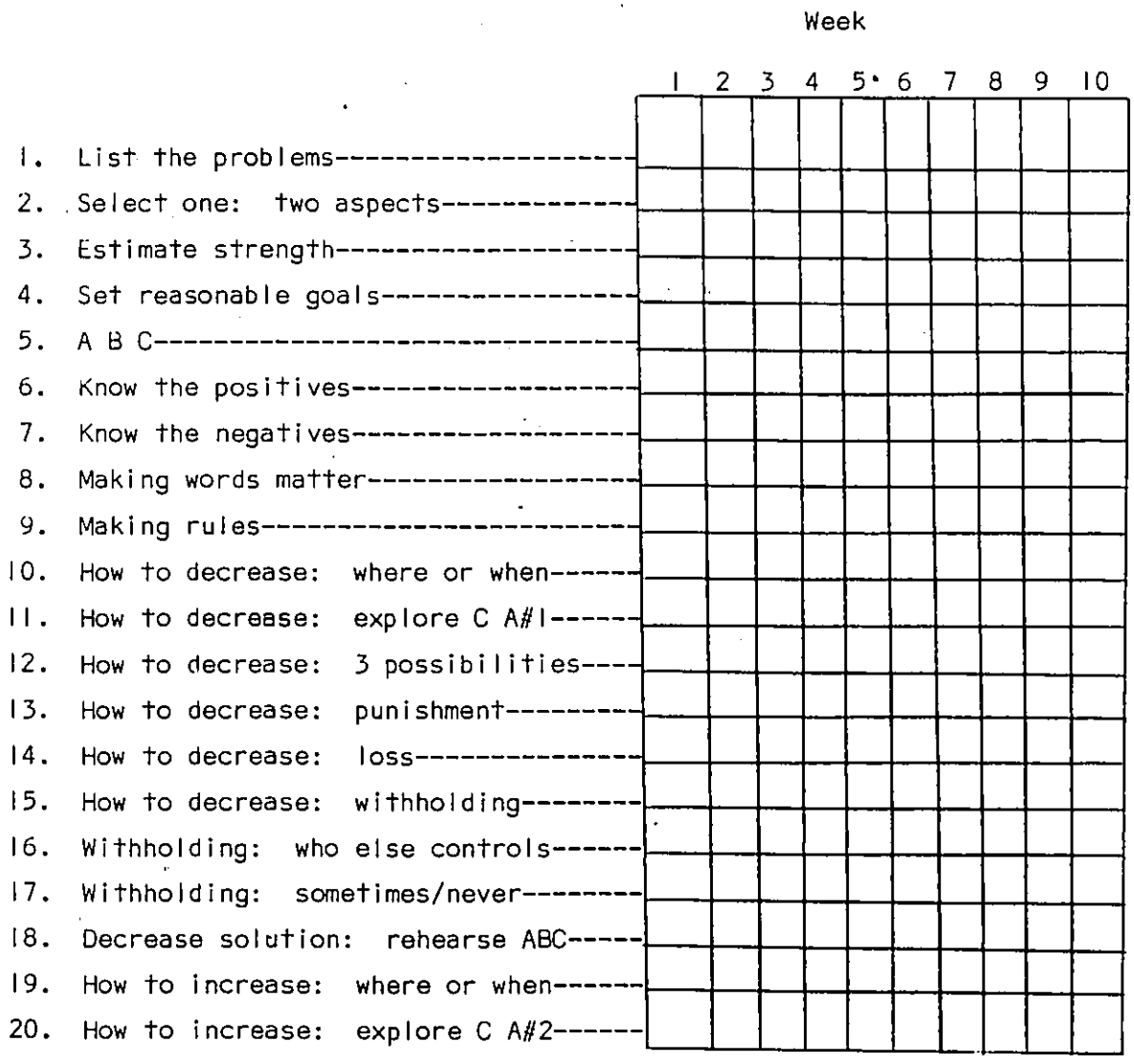
(RCC - IODE HOSP.)

Cornelius J. Holland, Ph.D.

University of Windsor

Windsor, Ontario

Name: _____ Group: _____

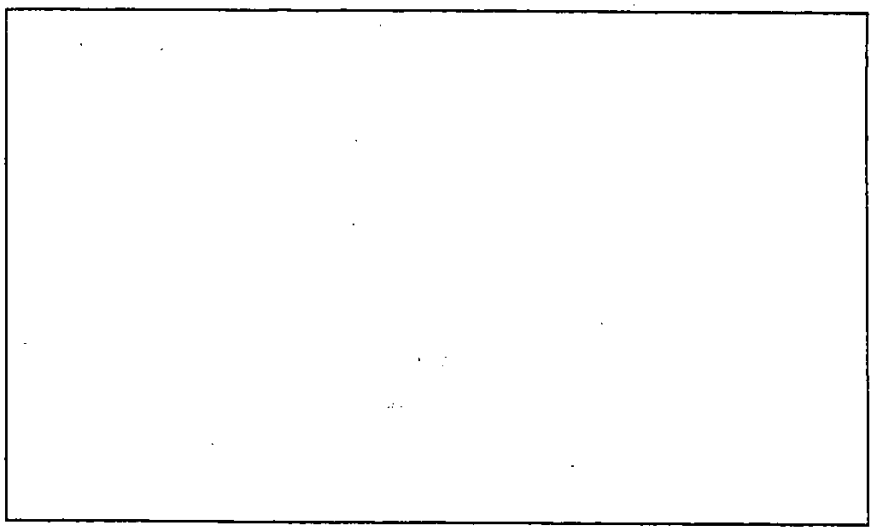


Week

	1	2	3	4	5	6	7	8	9	10
21. How to increase: where or when -----										
22. Reward: immediacy----------										
23. Reward: what is right----------										
24. Reward: step-by-step----------										
25. Reward: structuring or urging-------										
26. Reward: vary type----------										
27. Reward: vary amount----------										
28. Reward: deprive----------										
29. Reward: not all the time----------										
30. Increase solution: rehearse ABC-----										

I. List the Problems

1. Make a list of the separate problems you wish to deal with. Write here:

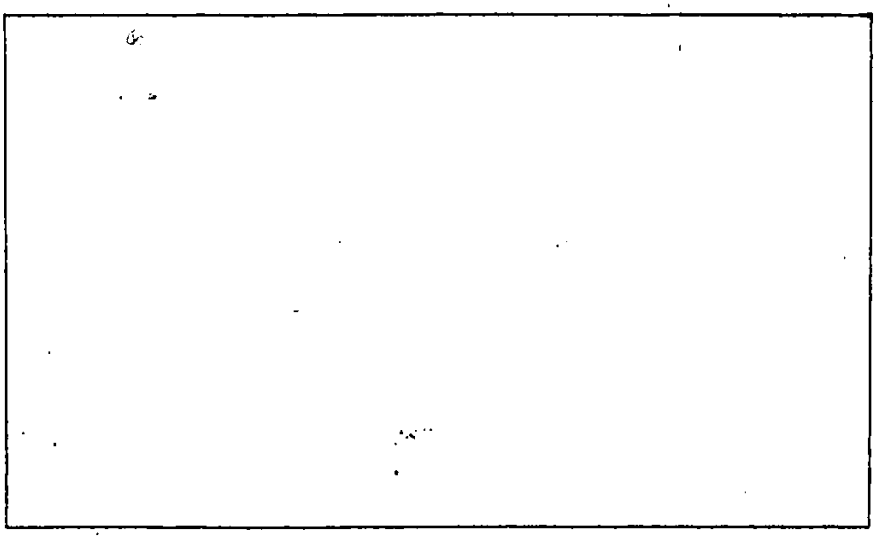


2. Now consider each of these in terms of what you can see or hear about them. That is, what is the child doing or saying when he is acting out the problem?

3. Start getting in touch with what you can see or hear the child doing or saying. How is the child acting?

4. Again consider the problems you have listed above and try to state them, or at least one of them in a way that would tell how the child behaves, or what he does or says.

Write here:



7

2. Select One to Work With

1. Select one of the problems and forget all the other for a while. If you can work your way through one you can work your way through others.

   Write it here:

2. Now look at the problem you have selected from two aspects or two points of view.

   A. From one point of view (aspect #1) some behaviour which is undesirable is occurring too often.

   B. From another point of view (aspect #2) some behaviour which is desirable is not occurring often enough.

3. We are going to try to decrease systematically the undesirable behaviour which is occurring too often and to increase systematically the behaviour which is not occurring often enough.

4. State the problem you have selected (remember, what is it that you see or hear):

   A. What is the too frequent aspect?

Write it here:

B. What is the too infrequent aspect?

Write it here:

3. Estimate Strength

1. For any given time period that you choose, how often:

A. Does the too frequent aspect occur?

Estimate here:

B. Does the too infrequent aspect occur?

Estimate here:

2. How serious do you think the problem is, from your point of view?

Mark your estimate below:

Not serious at all		Extremely serious
0	50	100

4. Set Reasonable Goals

1. Again we want you to consider the problem from each point of view.

2. When you are successful in changing both aspects of the problem, we want you to know this success as clearly as possible.

3. What is a reasonable goal to expect from your child concerning the behaviour that is now occurring too often? That is, to what extent should it decrease?

   Write your estimate of the goal of aspect #1 here:

4. What is a reasonable goal to expect from your child concerning the behaviour that is now not occurring often enough? That is, to what extent should it increase?

   Write your estimate of the goal of aspect #2 here:

5. A-B-C (the core of the programme)

1. There are three basic things we need to know: what happens before the behaviour occurs; what is the behaviour; and what happens after the behaviour occurs. Each of these will be treated in turn. (Some parents find this easier to do if they read through the entire point, then start with B, go to C, and then return to A).

2. A = the ANTECEDENT of "that which precedes the behaviour"

   A = the environment the child is experiencing immediately before or during the behaviour

   A = the signal for the behaviour

   A = the conditions under which the child's behaviour occurs

   A = where or when the child's behaviour occurs

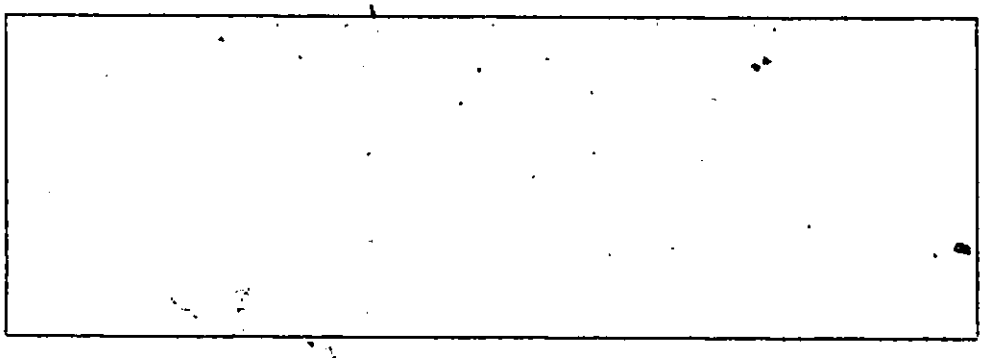
   A = the occasions under which the behaviour takes place

   A = "look before". Discover what happens before.

   (All of the above mean the same thing)

3. What is the A for the problem you selected?

   Write here:



4. B = the BEHAVIOUR of the child which you are concerned about

   B = describe what the child is doing or what the child should be doing but isn't

   B = describe the problem from the two points of view: what is occurring too often; what is not occurring often enough

   B = describe what you <u>see</u> and <u>hear</u> the child doing or not doing

   B = the action or lack of action of the child

   B = describe what your eyes and ears bring to you

   B = don't guess about what is going on inside your child; instead see or hear what is going on

   B = don't confuse your own fear, anger, or disappointment with the actual behaviour of the child

   B = for example, if you were to say your child is angry, describe what you <u>see</u> and <u>hear</u> the child doing or saying that makes you think he is angry

   B = for example, if you were to say your child is spiteful or hyperactive or shy, what would you be seeing or hearing?

5. Describe the B for the problem you selected.

Write it here:

6. C = the CONSEQUENCES of the behaviour FROM THE CHILD'S POINT OF VIEW

   C = What happens after the behaviour occurs

   C = the results of the behaviour for the child

   C = the reason a behaviour is occurring too often or not often enough

   C = why the behaviour is present or absent

   C = the change in the environment that the behaviour brings about

   C = the most important thing we are looking for

   C = whether a behaviour occurs more or less often

   C = the thing that CONTROLS the behaviour

   C = CONTROL

7. The 5 possible CONSEQUENCES or CONTROLS:

   1. A CONSEQUENCE of a behaviour can be positive or pleasant for the child. The behaviour then will INCREASE or occur more often or get stronger. We will call this REWARD.

It's abbreviated (S+).

2. A CONSEQUENCE of a behaviour can remove something negative or unpleasant from the child. As in reward the behaviour then will INCREASE or occur more often or get stronger. We will call this RELIEF. It's abbreviated (-S-).
3. A CONSEQUENCE of a behaviour can be negative or unpleasant for the child. The behaviour then will DECREASE or occur less often or get weaker (but usually only for a short while). We will call this PUNISHMENT. It's abbreviated (S-).
4. A CONSEQUENCE of a behaviour can remove something positive or pleasant from the child. The behaviour will DECREASE or occur less often or get weaker (but usually only for a short while). We will call this LOSS. It's abbreviated (-S+).
5. A CONSEQUENCE of a behaviour can be neutral for the child, neither positive nor negative, neither pleasant nor unpleasant. Usually behaviour will in time DECREASE or weaken permanently. We will call this NEUTRAL. It's abbreviated (So).
6. Summary of point #5

Antecedent	Behaviour	Consequences		Results on B
Where	Behaviour	Reward	(S+)	Increase
or	Action	Relief	(-S-)	Increase
When	Doing	Punishment	(S-)	Decrease
		Loss	(-S+)	Decrease
		Neutral	(So)	Decrease

6. Know the Positives for Your Child

1. We must discover what is considered pleasant or positive from the child's point of view.
2. The first reason for this is that the child may be obtaining as a CONSEQUENCE something that is positive or pleasant (S+) from behaviour that is now occurring too often. Here the CONSEQUENCE must be changed to an (So) by withholding the (S+) so that the behaviour will occur less often.
3. A second reason is that likes or wants which the child already has may be removed as a CONSEQUENCE for behaviour that is occurring too often in order to make the behaviour occur less often (-S+).
4. A third reason is that the child can be given something that is positive or pleasant as a CONSEQUENCE of behaviour that is not occurring often enough in order to make it occur more often (S+).
5. How can we tell what is positive or pleasant, from the child's point of view? There is only one sure way: If the CONSEQUENCE occurs and the behaviour occurs as often as before or more often, then the CONSEQUENCE is positive or pleasant.
6. The following may help you in searching for those things which are likely to be positive and pleasant from the child's point of view.
7. Some (S+) are physical in nature, like coins, candy or toys.

8. Some (S+) are social in nature and come from people, like praise, smiles, compliments, hugs and kisses.

9. Some (S+) are activities like watching T.V., going swimming, playing with friends.

10. Some (S+) are so because the child is like all other children. Food when hungry, drink when thirsty.

11. Some (S+) are so because the child is like many other children. A hockey stick or a Barbie doll.

12. Some (S+) are so because the child is an individual, unlike in some ways to other children. Books on superstition.

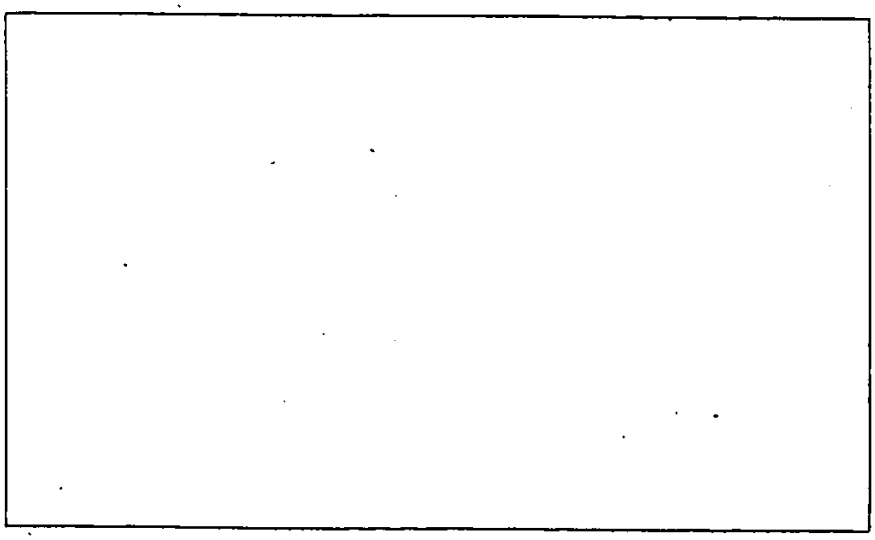
13. THE (S+) ARE ALWAYS FROM THE POINT OF VIEW OF THE CHILD.

14. A chart to gather (S+) ideas looks like this:

	All children	Many Children	Individual Child
Physical			
Social			
Activity			Answering the phone Doing the dishes

16. List these likes or wants which seem to be so for your child, and which are convenient for you to use.

Write here:



7. Know the Negatives For Your Child

1. We must discover what is considered negative or unpleasant from your child's point of view.
2. The first reason for this is that your child may be obtaining as a CONSEQUENCE something that is negative or unpleasant (S-) from behaviour that is not occurring often enough. Here the CONSEQUENCE must be changed to an (So) by withholding, or an (S+) by rewarding so that the behaviour will occur more often.
3. A second reason is that dislikes which the child is already experiencing may be removed as a CONSEQUENCE for behaviour that is not occurring often enough in order to make the behaviour occur more often (-S-).
4. A third reason is that the child can be given something that is negative or unpleasant as a CONSEQUENCE of behaviour that is occurring to order in order to make it occur less often (S-).

   NOTE: THIS IS USED ONLY IF NECESSARY.
5. THE (S-) ARE ALWAYS FROM THE POINT OF VIEW OF THE CHILD.
6. A chart to gather (S-) ideas may look like this:

	All Children	Many Children	Individual Child
Physical			
Social			
Activity		Doing Dishes Doing Homework	Answering the Phone

7. List the dislikes which seem to be so for your child.

Write here:

8. Making Words Matter

1. Much of what you do when you attempt to change your child's behaviour will involve words.
2. In order for your child to realize that your words have real consequences, you must carry out any threat of punishment (S-) or loss (-S+), and fulfill any promise of relief (-S-) or reward (S+).
3. If you made a threat, mean it and back it up with the consequences contained in the threat. It then becomes a real thing to the child.
4. If you make a promise, mean it and back it up with the consequences contained in the promise. It then becomes a real thing to the child.
5. Therefore watch your threats and watch your promises, and when you make them, make them real.

NOTE: Threats are used only if and when necessary.

9. Making Rules

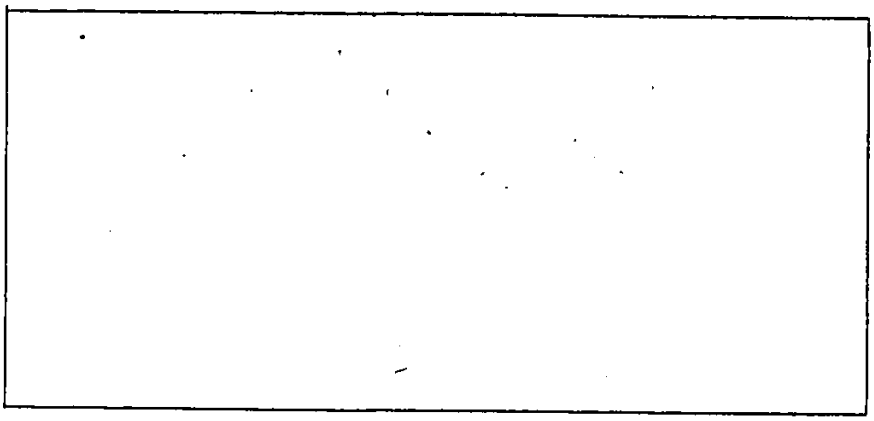
1. Much of what you do when you attempt to change your child's behaviour will involve setting down rules for your child to follow.
2. Rules should contain a behaviour you want the child to do and a consequence that will occur as a result of the behaviour.
3. Rules should be stated positively if possible. This means the behaviour you want is in the rule as well as the positive or pleasant consequences, rather than the behaviour you don't want and the negative or unpleasant consequences.
4. Be sure the child can carry out the behaviour in the rule. If the child can't, then adjust the rule to fit what the child can do.
5. Be as simple and clear and a direct as possible.
6. Be sure the child understands the rule.
7. Give the rule firmly and calmly.
8. Do not argue the rule.

10. How to Decrease: Where or When of Aspect #1

Remember: A is the antecedent or the environment the child is experiencing before or during the behaviour which is occurring too often.

1. Therefore consider where or when does the behaviour you wish to decrease occur?
2. This information is important because it lets you know when to expect the behaviour so that you will be ready to withhold whatever the child is getting, a positive or pleasant consequence from the undesirable behaviour that is now occurring too often.
3. It is also important because it lets you know when to punish most effectively by giving something negative or unpleasant as soon as possible after the behaviour occurs.
4. Further it lets you know when to bring about a loss by taking away something positive or pleasant as a consequence.
5. So be prepared for what you want to do by discovering where or when the behaviour you wish to decrease is likely to occur.
6. Now what are the antecedents for the behaviour that is occurring too often:

Write here:

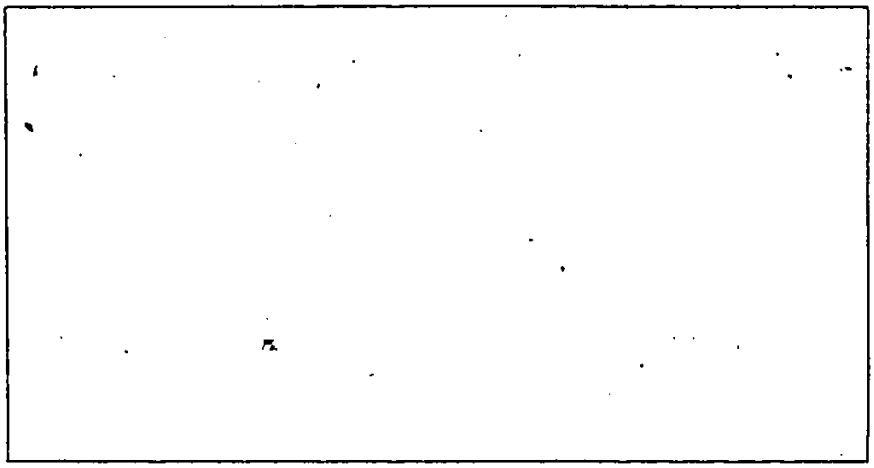


II. Decrease: Exploring for a Solution to Aspect #1

Remember: Behaviour has five consequences which control whether the behaviour will occur too often or not often enough.

1. You have selected your problem and for one aspect of this problem, some behaviour is occurring too frequently.
2. Now consider what happens immediately after this behaviour occurs from the point of view of the child. What is the immediate consequence?
3. Does the behaviour result in something positive or pleasant from the child's point of view (S+)?
4. Does the behaviour remove something negative or unpleasant from the child's point of view (-S-)?
5. If so, the behaviour will persist or occur more often than you want it to.
6. Frequently the solution to the aspect of the problem that occurs too frequently can be discovered by seeing that the child has found a way of gaining something positive (S+) or of removing something negative (-S-), even though this may not seem so from the parents' point of view.
7. Therefore what happens now at aspect #1?

Write here:



12. How to Decrease: Three Possibilities for Aspect #1

Remember: There are three ways of decreasing behaviour that is occurring too often: withhold, punish, and loss.

1. If the behaviour is now receiving from the point of view of the child a positive or (S+) as a consequence and this is withheld (switch to So), the behaviour will occur less often or disappear.
2. If from the point of view of the child the behaviour results in a sufficient punishment (S-) as a consequence, it will decrease at least for a while.
3. If from the point of view of the child the behaviour results in a consequence that is not negative nor sufficient punishment, it will not decrease.
4. If from the point of view of the child the behaviour results in a sufficient loss (-S+) as a consequence, it will decrease at least for a while.
5. If from the point of view of the child the behaviour results in a consequence that is not a sufficient loss, it will not decrease.
6. Decide if you can withhold: Circle one if possible.

   Yes No ?

7. Decide if you can and wish to use punishment.

   Yes No ?

8. Decide if you can and wish to use loss.

   Yes No ?

13. How to Decrease: Punishment or Threat

1. Punishment or threat (S-) is used when behaviour must be decreased in a hurry at least for awhile until other behaviour which is desired can be rewarded (S+).
2. Therefore if you feel punishment is necessary, we will never use it alone but always in combination with rewarding another behaviour.
3. If you feel punishment is necessary, punish swiftly, justly, and without anger if possible.
4. Choose the weakest (S-) that is sufficient to decrease the undesired behaviour at least for a while.
5. Point #7 gave you some idea of the (S-) that may be used as a consequence of the behaviour that is occurring too often.
6. Point #11 gave you some idea where or when the behaviour can be expected to occur.
7. Therefore, whenever or wherever that aspect of the problem which is happening too frequently occurs, punish or threaten to punish it in order to decrease it.
8. Now rehearse this to yourself. Say:

   "When (aspect #1 of the problem) occurs which will likely happen (where or when) I will immediately (apply the negative) by (how)."

9. Now write out what you have rehearsed:

Write here:

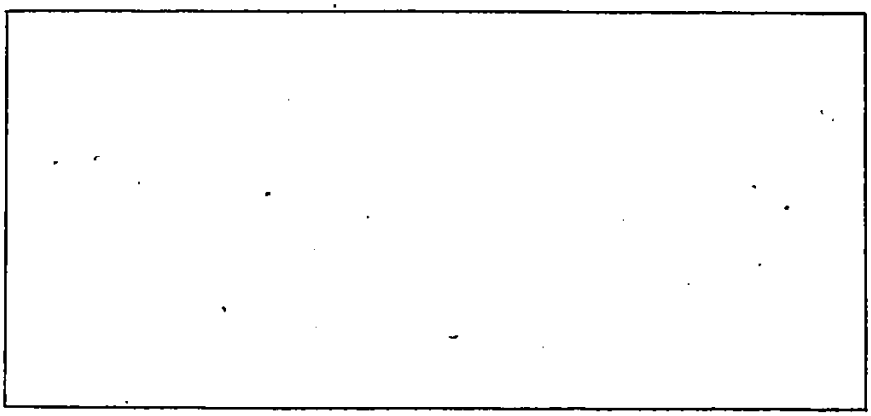
14. How to Decrease: Loss

1. Loss (-S+) is used when behaviour which is not desired is occurring too persistently and we want to emphasize the undesirable nature of this to the child by bringing about a cost for the behaviour.
2. Therefore, if you feel loss is necessary we will never use it alone, but always use it in combination with rewarding another behaviour.
3. If you feel loss is necessary, effect it swiftly, justly and without anger if possible.
4. Choose the weakest (-S+) which you think will decrease the behaviour at least for a short period of time.
5. Point #6 gave you some idea of the S+ that may be taken away as a consequence of the behaviour which is occurring too often.
6. Point #11 gave you some idea where or when the behaviour is expected to occur.
7. Therefore, whenever or whereever that aspect of the problem which is happening too frequently occurs, effect some loss in order to decrease it.
8. Now rehearse this to yourself. Say:

   "When (aspect #1 of the problem) occurs which will likely happen (where or when) I will immediately (remove the positive) by (how)."

9. Now write out what you have rehearsed:

Write:



15. How to Decrease: Withholding

Remember:

1. If the too frequent behaviour is resulting in a positive (S+) or in having a negative removed (-S-) it will not decrease.
2. If the positive (S+) or removal of the negative (-S-) is not forthcoming, the behaviour that is now too frequent will decrease.
3. Point #10 gave you some idea of the (S+) that the child may be obtaining as a consequence of the behaviour which is occurring too often.
4. Point #11 gave you some idea where or when the undesired behaviour can be expected to occur.
5. Therefore discover the immediate consequences of the behaviour that is occurring too often and decide how to change this into a neutral (So).

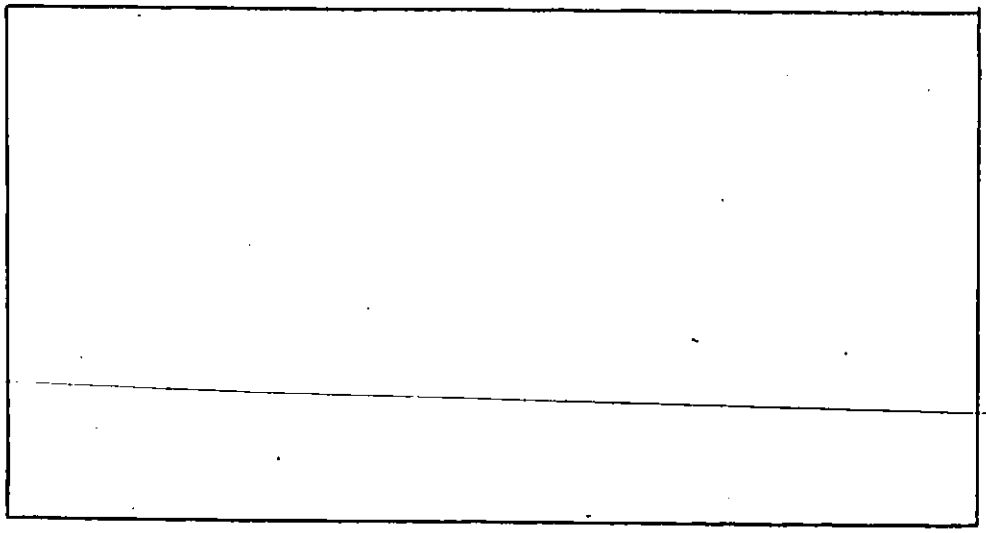
Write here:

6. When withholding is used, the behaviour that is now occurring too often becomes less and less. However at first it may occur more often as the child tests whether or not you are really going to withhold.
7. Simple withholding of the (S+) often takes a long time for the behaviour to decrease. Therefore we will use this in combination with increasing other behaviour that is desired.

16. Withholding: Who Else Controls the Positives?

1. What happens if other people in the child's environment, friends, brothers and sisters, grandparents, neighbours, are giving the child as a consequence of behaviour that is occurring too often the same (S+) the parents are trying to withhold? If this is the case these people will be causing the behaviour to remain at the too frequent level.
2. Therefore, when withholding is used, the parents must influence to every extent possible, anyone around the child who is giving the (S+) for behaviour that is occurring too often.
3. Who else may control the (S+)s which must be withheld?

Write here:



17. Withholding: Sometimes vs. Never

1. To withhold means never giving the (S+) as a consequence of the undesired behaviour. This is very important because if the child sometimes receives an (S+) as a consequence and sometimes doesn't, the behaviour becomes more difficult to decrease.
2. However to withhold completely is easier said than done. It is often very difficult for many parents to withhold the (S+) entirely over a long period of time.
3. Therefore we will withhold as much as we are able but also increase other desired behaviour in order to bring about the desired results.

18. Decrease Solution: Rehearsal ABC

When my child does or says B (Aspect #1)

under the where or when conditions of

A

I am going to C (punish and/or effect loss and/or withhold)

by (describe)

19. Increase - Where or When of Aspect #2

Remember: A = ANTECEDENT or the environment the child is experiencing before or during the behaviour which is not occurring often enough.

1. Where or when do you want the behaviour you wish to increase to occur.
2. This information is important because it lets you know where or when you want the behaviour to increase so that you will be ready to give the child something positive or pleasant as a consequence (S+).
3. So be prepared by deciding where or when the behaviour you want to increase should occur.
4. In most cases this should be the same as the information obtained in point #11.
5. Therefore where or when should the desired behaviour occur?

Write here:

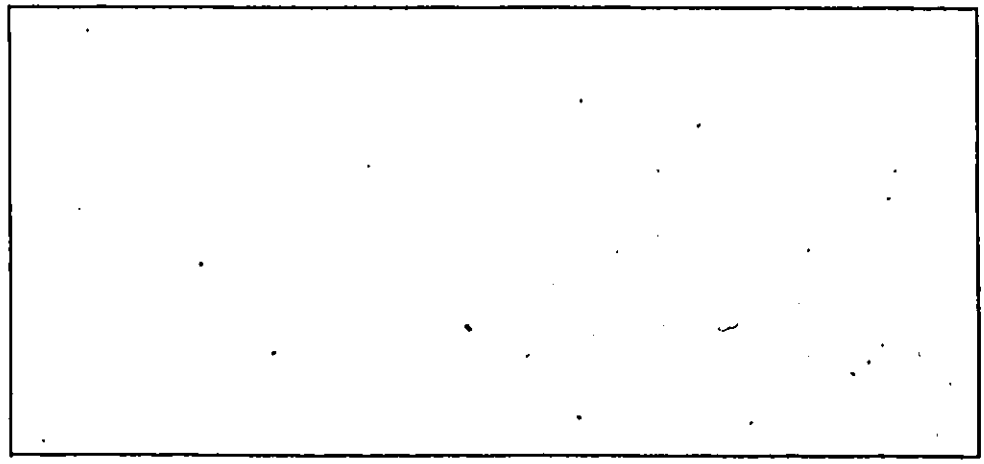
20. Increase: Explore for Solution to Aspect #2

1. Again consider the problem selected at point #2.
2. Now consider the behaviour of the problem that is not occurring often enough and look for the immediate consequence from the point of view of the child.
3. Does the behaviour ever result in something negative or unpleasant for the child (S-)?
4. Does the behaviour result in something positive or pleasant for the child being removed (-S+)?
5. If so the behaviour will not occur as often as you want it to.
6. Frequently with behaviour that doesn't occur often enough the child has found that the behaviour results in an (S-) of some kind or a (-S+) even though from the parent's point of view, the consequences seem negative or unpleasant.
7. Again consider the behaviour of the problem that is not occurring often enough and again look for the immediate consequences from the point of view of the child.
8. Does the behaviour result in something neutral for the child (So)?
9. If so, there will be no reason for the behaviour to occur more often.
10. Very frequently with behaviour that doesn't occur often enough, the child has found that the behaviour results in an (So) either because the parents forget to make it stronger by

giving an (S+) or because the parents think they are giving an (S+) when actually they are not.

11. Therefore what happens now at aspect #2?

Write here:



21. How to Increase: Two Operations, Reward and Relief

Remember: From point #4. There are two ways of increasing behaviour that is now not occurring often enough.

A. By giving a positive (S+) consequence.

B. By removing a negative (-S-) consequence.

1. If the behaviour that is not occurring often enough results in a sufficient (S+) consequence from the point of view of the child it will occur more often.
2. If the behaviour that is not occurring often enough results in a sufficient (-S-) consequence from the point of view of the child, it will occur more often.
3. If from the point of view of the child the behaviour results in a consequence that is not positive nor sufficient, it will not increase.
4. If from the point of view of the child the behaviour results in a consequence that is not a removal of a negative nor sufficient it will not increase.
5. Decide if you can use any removal of a negative (-S-) to increase desired behaviour.

Yes — No?

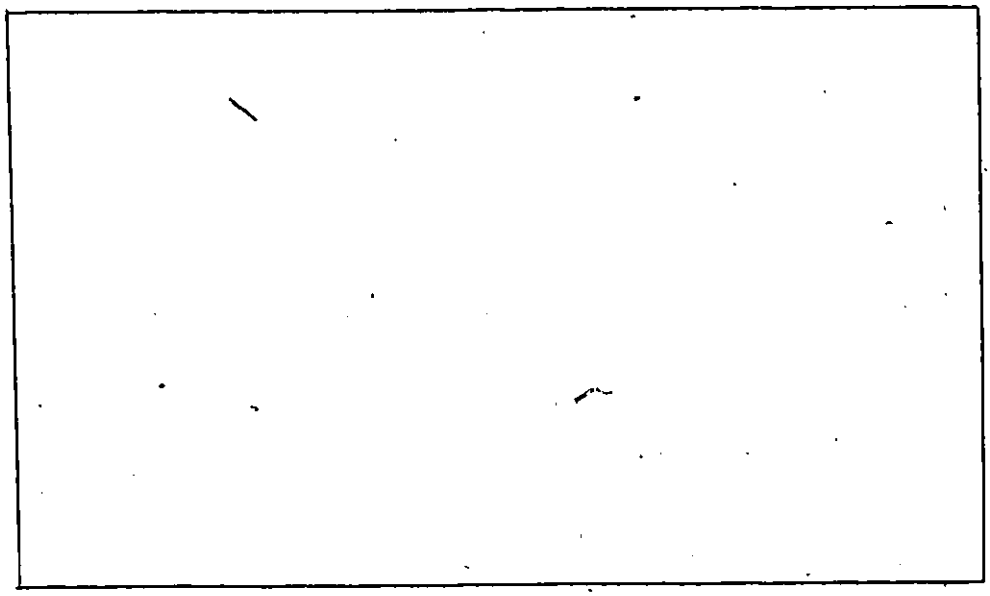
6. The single most powerful and important way known to increase desired behaviour that is not occurring often enough is to give something positive as a consequence when the behaviour occurs (S+).

7. Whether something is an (S+) is always from the point of view of the child.
8. Whether something is really an (S+) to the child can be tested by what effect it has if it's a consequence of a behaviour. If the behaviour increases, it is an (S+).
9. Giving a positive or (S+) for a desired behaviour is the single most important way of letting your child know he or she is doing the right thing.
10. Much of the remaining program will be dealing with ways of giving a positive (S+) in the most effective way possible.

22. Reward: What is the Child Doing Right?

1. Begin to attend to everything that your child is doing right with regard to the problem.
2. This is necessary in order to get into the habit of giving an (S+) when the behaviour you desire occurs.
3. Therefore: what is your child doing right with regard to the problem?

Write here:



23. Reward: Immediacy

1. The second most powerful and important way known to increase desired behaviour is to give something positive or pleasant immediately after the behaviour occurs.
2. Sometimes the child is too far away to give a physical (S+) immediately.
3. Also sometimes the child won't be able to receive the physical (S+) until later.
4. However there are secondary ways of giving (S+)s which often work just as well as physical (S+)s at least for a time.
5. One way of giving a secondary (S+) is by developing a signal system with the child. The signal, it may be a word or a gesture, tells the child that an S+ is available sometime in the future.
6. Another way of giving the secondary (S+) is by developing a charting system with stars or markings. These star or mark systems are designed to tell the child that an (S+) is available sometime in the future if enough are earned.
7. A charting system is important because it makes available many easily used (S+)s.

24. Reward - step-by-step

1. Sometimes it is easier to increase desired behaviour in a step-by-step fashion, than in an all-or-none fashion.
2. Therefore if necessary and possible, break the behaviour down into a series of steps and give an (S+) each step along the way.
3. Even though this may seem too slow a way to proceed, it is usually much faster in the long run.
4. Also a first small step if successfully achieved will let you know some progress is being made.
5. Finally by breaking the behaviour down into a series of smaller steps, you may discover that much more of the desired behaviour is present than is first thought.
6. Therefore if you can, break the behaviour down so that you can know the first few steps of progress toward the eventual goal behaviour:

Step #1 _____

_____

Step #2 _____

_____

Step #3 _____

_____

25. Reward: Structuring or Urging Behaviour to Occur

1. Some behaviours that are desired don't occur often enough to be given an (S+) and therefore must be urged to occur.
2. One way of urging may be through close encouragement or supervision of the desired behaviour or some first step of it. This behaviour or first step is then given an (S+).
3. Another way may be by actively encouraging the child to imitate a desired behaviour or some first step of it. This behaviour or first step is then given an (S+).
4. When the behaviour occurs by urging, any attempt toward the goal is given an (S+). Then the second step, then third and so forth.
5. This point is very close to point #24 except that here the desired behaviour occurs so seldom that a more active effort is necessary to get it to occur.

26. Reward: Vary Type

1. We wish the (S+)s to have as much influence as possible on the child's desired behaviour.
2. One way of doing this is to have many convenient and realistic (S+)s as possible available to you, and to vary the type of (S+) you give.
3. Therefore tell the child he may not receive the same type of reward each time the desired behaviour occurs.
4. However, no matter what type of (S+) is given in addition to the social (S+) always give the social one.

27. Reward: Vary Amount (more or less)

1. We wish the physical (S+)s at first to have as much influence as possible on the child's desired behaviour.
2. One way of doing this is to vary the amount of the (S+) each time the behaviour is rewarded. This tends to strengthen the behaviour more than if the same amount is given each time.
3. Therefore tell the child he will not receive the same amount of reward each time the desired behaviour occurs.
4. However, no matter how much of the physical (S+) is given, always give the social (S+) or praise.

28. Reward: Not All the Time

1. Eventually we wish the child's behaviour to come under the influence of your social (S+) or praise rather than a physical (S+).
2. However we wish the physical (S+)s at first to have as much influence as possible on the child's desired behaviour.
3. We can bring about both of these ends by giving a physical (S+) every time the desired behaviour occurs until it becomes strong, then giving the physical (S+) only occasionally.
4. This will not only make the desired behaviour a very strong habit but will also accustom the child to not receiving a physical (S+) every time.
5. Therefore tell the child he will not receive a physical (S+) every time.
6. However, when you do not give the physical (S+), always give the social (S+) or praise.

29. Reward: Deprive

1. Sometimes if a child has all the (S+)s he desires it is necessary to deprive him in order to make the (S+)s more important.
2. This is seldom necessary to use and is employed only when necessary.

30. Increase Solution: Rehearse A B C

When my child does or says B (aspect #2)

under the where or when conditions of A

I am going to C

(remove a negative or give a positive)

by (describe)

APPENDIX C

PRESENTING PROBLEMS OF CHILDREN

PRESENTING PROBLEMS OF CHILDREN

Description of Behaviour	Number Reporting
Hyperactivity	7
Parents Unable to Make Rules, Enforce Limits	7
Child Dominates Parents	2
Child Tunes-out, Refuses to Listen	7
Child Too Slow and Pokey	5
Whining Behaviour	4
Temper Tantrums, Rage, Gross Motor Type	6
Argumentative, Loud and Bossey	4
Parental Guilt Due to Punitiveness	5
Child Behaves Poorly in Public	3
Child Behaves Poorly Whenever Parents are Busy	2
Mealtime Problems, Child Refuses Food, Plays, etc.	3
Child Listens to Parents, but Won't Complete Tasks	1
Bedtime Problems, Resists Bed, Sleep, etc.	2
Self-care Problems, Child Won't Dress, Bathe, etc.	3
Child Provokes Combat with Siblings and Peers	1
Child is Overly-impulsive	2
Psychosomatic Complaints in Child	3
Child Cries Excessively	3
Child is Scapegoated by Peers	2
Child Over-reacts Regressively to Defeat	2

PRESENTING PROBLEMS OF CHILDREN CONTINUED

Description of Behaviour	Number Reporting
Child Manipulates Parental Guilt	1
Parents Feel Child More Intelligent Than They Are	1
TOTAL	76

APPENDIX D

CHILD COOPERATION INDEX TASK BEHAVIOURS

CHILD COOPERATION INDEX TASK BEHAVIOURS

Description of Task	Number Reporting
Personal Hygiene Tasks (Bathing, Brushing Teeth, etc.)	16
Mealtime Tasks (Finishing Meals, Table Manners, etc.)	10
Bedtime Tasks (Getting Ready, Staying in Bed, etc.)	8
Dressing Tasks (Getting Dressed Without Help)	6
Put Clothing Away	5
Pick up Toys	2
Come in House When Called	2
Stop Complaining, Whining	2
Take out the Garbage	2
Get up in the Morning	1
Sit Still if Watching TV	1
Change Clothes Less Often	1
Read Three Pages a Day	1
Stop Repeated Words, Sentences	1
Sit Down in the Car	1
Don't Crawl Over the Fence	1
Stop Fighting with Siblings	1
TOTAL	61

APPENDIX E

SOME ANECDOTAL STATEMENTS BY PARENTS

SOME ANECDOTAL STATEMENTS BY PARENTS

Parent	Session	Statement
1	2	"All problems are less serious in warm weather. Your approach is so simple, I wonder how I got the other five raised. I would have enjoyed it more with your system."
3	4	"This stuff is boring at first, but I can see it'll pay off in the long run."
4	6	"My D. says I've really changed and I'm more definite now and he wished I'd go back to the way I was before because he doesn't know how to behave."
	7	"Everything fits in so much better with H. now. Even the school says they can talk to her now."
	8	"It's been going better, but twice I lost my temper and hit him. Never did that before because I felt too guilty, but I don't feel guilty now."
4	9	"He's been so good in the past two weeks I don't remember what the problem was."

SOME ANECDOTAL STATEMENTS BY PARENTS CONTINUED

Parent	Session	Statement
6	9	"I used praise with him for two weeks in a row, and hey, it really makes a difference."
7	9	"I was so frustrated I didn't think there was ever any hope of getting that kid to do what I wanted him to and enjoy it too. [redacted]s program really works. I've been telling all my friends about it, and how it really works, but I feel like I'm interfering. It gets in your blood after a while."
3	10	"A few weeks ago I felt like the world's worst child abuser. All I wanted to do was (clenches fist, makes guttaral noises) with R.. Now I don't feel like that."
1	10	"We took B. off Ritalin 3 weeks ago and he's doing fine. Even the nursery school teacher says he's calmer and more controlled."

SOME ANECDOTAL STATEMENTS BY PARENTS CONTINUED

Parent	Session	Statement
5	10	"My mom's been criticizing your program. She said that's not the way she raised her kids, and I should never use it at her house. I just told her I'm not going to make the same mistakes she did."
3	11	"My R. has begun mothering all the little kids in the neighborhood. Before she'd just beat 'em up. And she's doing dishes for the crippled neighbors now."
4	11	"I know this has helped because I look more and listen more than I did before, and all the kids come to me more and share things with me more than they did before. I used to just shut myself in the bedroom to get away from them."
1	11	"Fantastic change in B.. Since we began using star charts he's become the most cooperative kid in the world. I quit biting my nails when he quit yelling and having tantrums. Now he cooperates 95% of the time."

SOME ANECDOTAL STATEMENTS BY PARENTS CONTINUED

Parent	Session	Statement
2	12	"SUDS about 30 now. It was 100. It was an idiot household. I was ready to just run off after 20 years of marriage. Now it's not so desperate like before."
3	12	"My R. came up and said I love you and gave me a big hug. That really felt good; not like when he always used to fight all the time."
7	12	"I'm surprised at myself. I still don't yell and scream like I used to. I just get up in the morning and tell myself to relax all day, and I can actually do it. It's funny. The other night we all began laughing and fooling around together. We never did that before. Even my husband remarked about how new it was."
6	12	"I'm going to confront the school now and tell them what they've been doing. Now I can talk to them and use this program as proof of what I say. They're not the only experts."

APPENDIX F

TABLES OF RAW DATA AND MEANS FOR THE MEASURING INSTRUMENTS USED

Raw Data

The Family System Survey Total Group

	Items								
Ss	1+2	3	4	5	6	7	8	9	10
1	3	4	10	2	--	3	0	90	3
2	2	1	6	1	--	1	1	70	2
3	2	4	10	0	--	3	0	50	3
4	3	1	3	0	--	0	0	70	2
5	3	4	7	0	98	4	0	20	3
6	1	4	9	0	--	4	0	45	3
7	5	3	8	0	102	1	0	00	3
8	2	3	6	0	--	1	0	20	3
9	2	3	6	0	104	2	0	60	3
10	1	3	6	0	--	2	0	80	3
11	2	3	12	3	135	1	0	40	2
12	3	2	4	1	50	2	1	60	3
13	4	2	4	1	--	1	1	50	3
14	1	1	5	2	62	2	0	90	2
15	5	3	8	1	66	0	1	35	3
16	3	3	7	1	--	0	1	85	3
17	2	1	6	0	55	0	0	80	2
18	1	1	4	1	56	1	0	40	2
19	4	5	10	2	36	1	0	30	3
20	3	5	10	3	--	1	0	30	3
21	3	2	6	1	67	0	0	50	2
22	2	1	3	0	26	1	0	100	2
Mean	2.50	2.68	6.81	0.86	71.41	1.40	0.22	54.21	2.63

Raw Data Continued

The Family System Survey Total Group

	Items									
Ss	11	12	13	14	15	16	17	18	19	20
1	4	30	3	2	2	5	3	3	1	4
2	1	20	1	1	1	1	1	1	1	12
3	2	39	3	2	3	4	2	2	1	8
4	1	14	1	5	1	1	1	1	4	12
5	4	41	3	3	3	3	2	4	1	2
6	4	38	2	3	2	3	2	2	3	5
7	2	44	4	3	5	5	2	4	1	3
8	4	40	5	3	4	5	2	4	2	6
9	4	36	3	5	5	1	2	2	1	3
10	3	39	5	1	5	5	2	4	4	15
11	1	34	4	4	5	3	2	4	2	3
12	3	40	5	1	5	5	3	5	2	5
13	4	31	3	1	2	3	3	3	2	12
14	3	14	1	1	1	1	1	1	4	10
15	3	36	3	4	4	5	2	3	1	3
16	3	30	4	4	2	3	1	2	2	4
17	4	17	1	1	2	1	1	1	3	9
18	1	8	1	3	1	1	1	1	3	7
19	4	39	3	2	5	5	3	4	2	3
20	4	43	4	1	5	5	3	4	3	10
21	4	20	1	3	1	1	1	1	2	5
22	1	--	-	-	-	1	1	-	2	15
Mean	2.90	31.09	2.85	2.57	3.00	3.04	1.86	2.66	2.13	7.09

Raw Data Continued

The Family System Survey Total Group

	Items									
Ss	21	22	23	24	25	26	27	28	29	30
1	2	1	3	0	3	1	1	12	0	4
2	1	0	10	7	2	1	3	0	2	1
3	1	5	5	7	5	2	2	8	8	5
4	1	2	10	7	6	2	7	0	0	2
5	1	4	2	1	2	1	1	10	7	4
6	1	4	4	0	2	1	2	5	10	5
7	1	1	2	0	5	2	1	20	10	5
8	1	1	2	0	4	1	1	0	10	5
9	1	2	1	4	10	2	0	10	0	3
10	1	1	8	7	10	2	3	15	9	1
11	1	1	2	4	4	2	4	4	10	3
12	2	1	10	0	1	1	1	0	10	5
13	1	1	5	1	3	1	2	0	2	2
14	3	1	10	6	10	2	0	0	0	1
15	1	1	2	1	2	1	1	1	5	3
16	1	1	5	1	2	1	3	14	0	4
17	1	1	2	4	3	2	1	0	30	1
18	1	1	5	4	10	2	2	0	10	2
19	1	5	10	7	2	1	7	5	2	4
20	1	4	10	7	2	1	7	6	3	4
21	1	2	10	5	2	2	3	0	10	2
22	1	1	4	0	10	5	0	0	0	1
Mean	1.18	1.90	5.54	3.31	4.54	1.63	2.36	5.00	6.22	3.04

Raw Data Continued

The Family System Survey Total Group

	Items							
Ss	31	32	33	34	35	36	37	Total Score
1	4	5	4	4	2	2	4	258
2	1	1	1	1	1	1	1	158
3	1	3	2	2	1	4	5	204
4	1	1	1	2	2	4	4	170
5	2	4	2	3	3	4	5	163
6	1	3	4	4	2	2	4	184
7	5	5	3	3	3	3	3	165
8	3	5	5	3	3	2	4	162
9	5	3	5	1	2	3	3	193
10	5	5	5	5	2	2	4	262
11	5	5	4	3	3	4	4	188
12	5	5	5	1	1	5	5	207
13	3	4	2	2	2	4	5	168
14	1	1	1	1	5	3	1	186
15	5	5	4	4	4	4	4	168
16	4	2	2	2	3	4	3	214
17	1	1	2	1	2	4	3	190
18	1	1	1	1	1	4	1	124
19	5	4	4	4	2	3	3	194
20	5	4	4	3	2	3	3	207
21	1	1	1	1	1	3	1	149
22	1	-	-	-	-	1	-	153
Mean	2.95	3.23	2.95	2.42	2.23	3.13	3.33	184.86

Family System Survey Post-treatment Results

Item	Subjects 1	2	3	4	5	6	7	Mean
1+2 2	2	2	5	3	3	3	3	2.85
3	3	3	3	3	1	2	5	2.85
4	6	12	8	8	6	6	10	7.14
5	0	0	0	0	1	0	1	0.71
6	107	138	69	-	58	70	39	80.16
7	2	1	0	0	0	0	2	0.71
8	0	0	1	1	0	0	0	0.28
9	30	20	50	30	40	10	20	28.57
10	3	2	3	3	2	2	3	2.57
11	4	1	1	1	1	1	2	1.57
12	41	30	29	31	8	23	42	29.14
13	5	4	2	2	1	-	4	3.00
14	5	4	4	5	4	5	4	4.42
15	5	4	3	3	1	-	5	3.50
16	5	3	3	4	1	1	4	3.00
17	3	1	3	2	1	1	2	1.85
18	5	4	3	2	1	3	4	3.14
19	4	2	1	3	4	-	4	3.00
20	14	4	7	15	12	8	13	10.42
21	1	1	1	1	1	1	1	1.00
22	0	0	2	2	4	2	6	2.28
23	10	10	2	10	10	7	10	8.42
24	7	3	2	5	5	5	5	4.57
25	5	6	1	4	3	10	3	4.57
26	1	3	2	3	3	2	1	2.14
27	7	2	1	1	5	5	3	3.42

Family System Survey Post-treatment Results Continued

Item	Subjects 1	2	3	4	5	6	7	Mean
28	7	10	3	15	0	0	2	5.28
29	5	10	1	10	10	7	10	7.57
30	5	3	4	3	3	4	4	3.71
31	4	3	4	4	-	-	5	4.00
32	5	4	2	2	-	-	4	3.40
33	5	4	5	2	-	-	4	4.00
34	5	2	5	2	-	-	5	3.80
35	3	3	5	4	-	-	4	3.80
36	5	5	3	5	5	4	5	4.57
37	5	5	5	2	-	-	5	4.40
TOTAL	217	161	174	191	135	112	205	170.71

Family System Survey One-year Follow-up Results

Items	Subjects 1	2	3	4	5	Means
5	0	0	0	0	0	0.00
9	20	20	30	30	20	24.00
11	1	1	1	1	1	1.00
14	5	5	4	5	5	4.80
19	6	4	4	8	5	5.40
20	12	8	10	6	10	8.00
23	15	7	5	12	10	9.80
25	7	4	20	15	10	11.20
26	3	4	2	2	3	2.80
30	5	5	2	5	5	4.40
34	5	5	-	3	-	4.33
35	5	4	-	5	-	4.66
36	5	5	5	5	5	5.00
37	5	5	-	5	-	5.00

Raw Data

Social Readjustment Rating Scale (SRRS)

Case	Expected LCU Scores	Mild	Mod	Sev	Observed LCU Scores	Mild	Mod	Sev
1	138	x			295		x	
2	132	x			230		x	
3	124	x			225		x	
4	226		x		450			x
5	29	x			30	x		
6	77	x			12	x		
7	85	x			9	x		
8	297		x		400			x
9	53	x			80	x		
10	162	x			330			x
11	586			x	420			x
12	348			x	360			x
13	611			x	1300			x
14	232		x		244		x	
15	60	x			300			x
16	523			x	810			x
17	81	x			175	x		
18	143	x			161	x		
19	265		x		300			x
20	384			x	241		x	
21	292				1060			x
	Mean = 230.85	11	5	5	Mean = 353.90	6	5	10

Mild = 150-199 LCUs

Moderate = 200-299 LCUs

Severe = 300+ LCUs

Raw Data & Means

Semantic Differential Comparison of the Seven Concepts in Terms of pre and post-DPC Treatment Means for the Seven Subjects in the Treatment Group for each of the Factors, Evaluation, Potency, and Activity

	EVALUATION			POTENCY			ACTIVITY		
Concepts	Mean Pre-DPC	Mean Post-DPC	Difference	Mean Pre-DPC	Mean Post-DPC	Difference	Mean Pre-DPC	Mean Post-DPC	Difference
MY FAMILY	13.14	14.71	+1.57	12.42	13.71	+1.29	12.41	13.57	+1.15
IDEAL CHILD	15.57	14.85	-0.72	13.28	14.28	+1.00	13.42	13.28	-0.14
MY CHILD	9.85	13.57	+3.72	11.71	15.00	+3.29	13.85	13.71	-0.14
PROBLEM CHILD	8.00	8.71	+0.71	9.71	11.42	+1.71	11.42	12.28	+0.86
IDEAL PARENT	15.71	15.28	-0.43	12.28	14.85	+2.57	15.00	13.85	-1.15
ME AS PARENT	12.14	15.85	+3.71	9.42	14.71	+5.29	13.71	14.42	+0.71
SPOUSE AS PARENT	13.42	14.00	+0.58	12.42	13.14	+0.72	12.28	11.00	-1.28

Raw Data & Means

Semantic Differential Mean Differences in the pre and post-DPC Treatment Conditions for the Six Concept Comparisons* for the Seven Subjects in the Treatment Group on the Three Factors, Evaluation, Potency, and Activity, and the Direction of Change, or D

	EVALUATION				POTENCY				ACTIVITY			
Comparison	Pre-DPC mean difference	D	Post-DPC mean difference	D	Pre-DPC mean difference	D	Post-DPC mean difference	D	Pre-DPC mean difference	D	Post-DPC mean difference	D
MC/IC	5.71	IC	1.28	IC	1.57	IC	0.72	MC	0.43	MC	0.43	MC
MC/PC	1.85	MC	4.86	MC	2.00	MC	3.58	MC	2.43	MC	1.43	MC
IC/PC	7.57	IC	6.14	IC	3.47	IC	2.85	IC	2.00	IC	1.00	IC
MSP/MAP	1.28	MSP	1.85	MAP	3.00	MSP	1.57	MAP	1.43	MAP	3.42	MAP
MSP/IP	2.29	IP	1.28	IP	0.14	MSP	1.71	IP	2.72	IP	2.85	IP
MAP/IP	3.57	IP	0.57	MAP	2.86	IP	0.14	MAP	1.29	IP	0.57	MAP

* MC/IC = MY CHILD vs. IDEAL CHILD
MC/PC = MY CHILD vs. PROBLEM CHILD
IC/PC = IDEAL CHILD vs. PROBLEM CHILD
MSP/MAP = MY SPOUSE AS PARENT vs. ME AS PARENT
MSP/IP = MY SPOUSE AS PARENT vs. IDEAL PARENT
MAP/IP = ME AS PARENT vs. IDEAL PARENT

Semantic Differential Concept "MY FAMILY"

Pre-treatment

	Polarities and Factors								
Ss	2(P)	4(A)	7(P)	9(A)	11(E)	15(P)	21(E)	24(a)	28(E)
1	1	7	6	2	5	1	6	3	6
2	4	7	7	1	7	1	1	7	1
3	5	7	7	1	7	1	1	7	7
4	4	7	5	2	7	4	4	4	4
5	3	7	6	1	6	4	1	5	5
6	6	6	6	3	7	3	1	6	6
7	7	4	2	2	6	2	4	7	5
8	6	7	7	1	7	1	3	7	7
9	2	3	2	3	2	2	2	6	6
10	6	6	6	2	7	2	2	6	6
11	1	7	5	2	3	4	4	6	5
12	7	7	7	1	7	3	1	4	5
13	5	6	6	1	7	2	2	4	5
14	1	6	1	2	3	1	2	1	2
15	5	4	2	2	6	6	1	5	2
16	7	5	7	2	6	2	2	2	5
17	5	7	7	1	7	2	1	1	6
18	5	3	5	5	3	2	5	5	6
19	6	5	4	4	5	5	4	4	2
Mean	4.52	5.82	5.13	2.00	5.52	2.52	2.47	5.10	4.78

Semantic-Differential Concept "MY FAMILY"

Post-Treatment

	Polarities and Factors								
Ss	2(P)	4(A)	7(P)	9(A)	11(E)	15(P)	24(E)	24(A)	29(E)
1	7	6	7	1	7	4	1	6	7
2	6	7	7	1	7	1	1	7	7
3	6	7	6	1	7	2	1	4	6
4	6	7	7	3	7	2	2	4	7
5	5	6	3	2	6	2	3	6	5
6	3	7	7	1	7	1	1	7	7
7	6	6	5	1	6	3	2	4	6
Mean	5.57	6.57	6.00	1.42	6.71	2.14	1.57	5.42	6.42

Semantic Differential Concept "THE IDEAL CHILD"

Pre-treatment

	Polarities and Factors								
Ss	2(P)	4(A)	7(P)	9(A)	11(E)	15(P)	21(E)	24(A)	28(E)
1	5	6	6	2	7	1	1	6	7
2	1	7	7	1	7	1	1	7	7
3	5	6	6	1	5	1	3	7	7
4	4	6	7	2	4	4	4	4	4
5	7	4	7	2	7	2	1	7	7
6	6	6	4	3	6	3	1	6	7
7	1	7	7	2	6	4	2	7	7
8	3	5	7	1	7	2	3	6	7
9	3	6	6	2	6	2	2	6	7
10	6	5	7	1	7	2	1	5	5
11	4	6	6	1	7	1	4	3	7
12	7	7	7	1	7	3	1	4	5
13	7	7	6	2	7	1	5	6	7
14	1	7	7	1	7	1	1	7	7
15	3	3	5	2	6	4	3	5	5
16	4	6	6	2	7	1	2	6	7
17	7	4	7	1	7	1	4	7	7
18	4	6	6	2	7	2	2	5	7
19	5	6	5	2	6	4	1	4	5
Mean	4.36	5.78	6.26	1.63	6.47	2.10	2.21	5.68	6.42

Semantic Differential Concept "THE IDEAL CHILD"

Post-treatment

	Polarities and Factors								
Ss	2(P)	4(A)	7(P)	9(A)	11(E)	15(P)	21(E)	24(A)	28(E)
1	6	7	7	1	6	4	1	4	7
2	5	7	7	1	7	1	1	7	7
3	6	7	6	2	7	1	1	4	7
4	7	7	7	1	7	1	1	6	7
5	6	7	7	1	7	1	1	7	7
6	6	4	7	1	7	1	1	7	7
7	6	5	5	2	6	3	3	5	6
Mean	6.00	6.28	6.57	1.28	6.71	1.71	1.28	5.71	6.85

Semantic Differential Concept "A PROBLEM CHILD"

Pre-treatment

	Polarities and Factors								
Ss	2(P)	4(A)	7(P)	9(A)	11(E)	15(P)	21(E)	24(A)	28(E)
1	1	6	3	2	3	3	5	4	2
2	1	7	1	1	7	7	1	1	1
3	2	4	5	2	5	3	1	4	4
4	1	1	1	1	2	7	4	1	7
5	4	6	5	5	3	6	6	5	3
6	1	5	7	3	6	5	1	5	3
7	1	7	6	4	2	4	1	2	1
8	1	7	7	1	7	1	3	7	4
9	2	6	5	2	6	3	3	6	6
10	1	7	6	2	5	3	3	6	6
11	2	4	3	3	5	5	4	2	7
12	1	3	1	4	1	5	4	1	2
13	1	4	4	1	4	4	1	2	1
14	1	1	1	7	1	7	7	1	1
15	3	6	3	2	2	4	2	5	6
16	1	7	7	1	4	4	4	4	1
17	1	7	7	1	4	4	4	4	1
18	3	7	4	2	3	4	3	7	1
19	1	7	1	2	1	6	5	6	1
Mean	1.52	5.36	4.05	2.42	3.73	4.47	3.26	3.84	3.05

Semantic Differential Concept "A PROBLEM CHILD"

Post-treatment

	Polarities and Factors								
Ss	2(P)	4(A)	7(P)	9(A)	11(E)	15(P)	21(E)	24(A)	28(E)
1	1	7	7	1	4	4	1	7	7
2	4	7	7	1	7	1	1	7	6
3	3	2	3	4	3	6	4	1	3
4	1	4	4	1	2	4	1	4	1
5	1	1	1	7	1	7	7	1	1
6	1	7	7	4	1	7	1	1	1
7	3	7	3	5	3	5	3	7	3
Mean	2.00	5.00	4.57	3.28	3.00	4.85	2.57	4.00	3.14

Semantic Differential Concept "MY CHILD".

Pre-treatment

	Polarities and Factors								
Ss	2(P)	4(A)	7(P)	9(A)	11(E)	15(P)	21(E)	24(A)	28(E)
1	1	7	6	2	6	5	1	2	4
2	4	7	7	1	1	7	1	7	7
3	1	7	7	1	7	2	1	7	5
4	1	7	4	1	4	4	4	1	7
5	2	7	5	2	6	4	1	4	5
6	3	6	6	2	4	5	1	5	4
7	1	7	7	1	3	7	1	7	1
8	1	7	7	1	3	1	2	7	3
9	2	7	6	2	7	3	2	7	6
10	3	7	6	2	6	3	2	7	6
11	2	6	5	3	7	4	3	6	7
12	3	3	5	1	7	2	1	5	5
13	6	3	6	1	6	2	1	7	6
14	3	3	2	2	3	3	1	6	2
15	5	3	5	1	5	4	1	5	5
16	1	7	7	2	3	4	1	4	7
17	1	7	7	1	4	4	1	4	7
18	5	6	6	1	6	3	1	5	5
19	2	6	5	1	4	5	1	4	7
Mean	2.47	5.63	5.73	1.47	4.84	3.78	1.42	5.26	5.21

Semantic Differential Concept "MY CHILD"

Post-treatment

	Polarities and Factors								
Ss	2(P)	4(A)	7(P)	9(A)	11(E)	15(P)	21(E)	24(A)	28(E)
1	7	7	6	1	6	4	1	4	7
2	6	7	7	1	7	1	1	7	7
3	7	7	7	1	6	2	1	5	6
4	7	7	7	1	7	1	1	7	7
5	5	7	6	1	6	4	1	5	6
6	5	7	7	1	4	1	1	7	7
7	7	5	5	2	6	3	1	6	6
Mean	6.28	6.71	6.42	1.14	6.00	2.28	1.00	5.85	6.57

Semantic Differential Concept "THE IDEAL PARENT"

Pre-treatment

	Polarities and Factors								
Ss	2(P)	4(A)	7(P)	9(A)	11(E)	15(P)	21(E)	24(A)	28(E)
1	3	3	6	2	7	2	4	6	6
2	7	7	7	1	7	1	1	7	7
3	7	7	7	1	7	1	1	4	4
4	4	7	7	4	5	4	4	4	4
5	2	6	5	5	5	2	4	5	3
6	5	4	7	2	7	4	4	5	7
7	1	7	7	1	7	1	1	5	7
8	3	7	7	1	7	1	3	5	7
9	6	6	7	2	6	1	2	6	6
10	6	6	7	2	6	1	2	7	7
11	4	4	6	6	4	4	4	4	7
12	7	7	7	7	7	1	1	7	7
13	5	7	6	6	7	1	2	7	7
14	7	7	7	7	7	1	1	7	6
15	5	3	3	3	6	2	4	4	3
16	7	7	7	1	7	1	4	7	7
17	7	7	7	1	7	1	4	7	7
18	3	6	4	1	7	1	2	6	6
19	4	3	2	5	4	4	4	4	3
Mean	4.89	5.84	6.10	2.05	6.31	1.78	2.89	5.63	5.84

Semantic Differential Concept "THE IDEAL PARENT"

Post-treatment

	Polarities and Factors								
Ss	2(P)	4(A)	7(P)	9(A)	11(E)	15(P)	21(E)	24(A)	28(E)
1	7	7	7	1	7	4	1	7	7
2	4	7	7	1	7	1	1	7	7
3	7	7	7	1	7	1	1	5	7
4	7	7	7	1	7	1	1	4	7
5	6	7	7	1	7	1	1	7	7
6	7	7	7	1	7	1	4	7	7
7	6	6	6	2	6	3	2	4	6
Mean	6.42	6.85	6.85	1.14	6.85	1.71	1.57	5.85	6.85

Semantic Differential Concept "MY SPOUSE AS PARENT"

Pre-Treatment

	Polarities and Factors								
Ss	2(P)	4(A)	7(P)	9(A)	11(E)	15(P)	21(E)	24(A)	28(E)
1	3	6	6	2	6	2	2	6	5
2	1	2	3	7	1	6	7	2	4
3	2	7	7	1	7	3	2	7	6
4	7	7	1	7	2	5	4	7	4
5	2	7	7	3	7	6	4	7	3
6	4	6	6	1	7	4	1	5	5
7	7	7	7	2	7	4	2	7	6
8	7	2	5	1	7	3	2	5	6
9	6	6	6	2	7	2	1	6	6
10	6	6	7	2	7	2	2	7	6
11	1	4	1	4	4	1	4	4	2
12	5	7	5	1	7	1	1	7	5
13	3	2	5	2	5	2	2	6	5
14	1	1	2	6	2	6	7	6	4
15	2	2	3	3	2	6	4	5	2
16	6	7	7	1	7	2	2	6	6
17	7	7	7	1	7	1	4	6	7
18	1	2	1	6	1	7	2	6	1
19	2	6	2	6	1	6	7	6	6
Mean	3.84	4.89	4.63	3.05	4.57	3.63	3.15	5.84	4.68

Semantic Differential Concept "MY SPOUSE AS PARENT"

Post-treatment

	Polarities and Factors								
Ss	2(P)	4(A)	7(P)	9(A)	11(E)	15(P)	21(E)	24(A)	28(E)
1	7	7	7	1	7	4	1	7	7
2	6	6	6	2	7	3	1	4	7
3	7	7	7	1	7	2	1	5	7
4	2	3	3	2	7	2	1	5	5
5	4	4	4	4	4	4	4	4	4
6	4	2	7	1	7	2	2	3	7
7	1	2	2	6	2	7	7	1	1
Mean	4.42	4.42	5.14	2.42	5.85	3.42	2.42	4.14	5.42

Semantic Differential Concept "ME AS PARENT"

Pre-Treatment

	Polarities and Factors								
Ss	2(P)	4(A)	7(P)	9(A)	11(E)	15(P)	21(E)	24(A)	28(E)
1	2	5	6	2	6	6	2	6	3
2	7	7	7	1	5	1	1	7	7
3	5	7	6	2	6	1	2	6	6
4	6	6	7	2	4	4	4	4	4
5	3	5	3	6	5	3	5	4	2
6	5	5	5	4	5	3	4	6	6
7	1	6	2	2	2	2	4	7	2
8	3	7	7	1	5	1	3	7	3
9	4	6	6	2	6	2	2	6	6
10	4	6	6	2	6	2	2	6	7
11	1	2	2	4	3	4	4	2	2
12	7	7	5	1	7	1	1	5	7
13	6	7	7	2	6	1	2	6	6
14	3	5	3	5	3	1	4	1	2
15	2	2	2	2	2	4	3	3	3
16	4	6	7	1	7	1	4	6	7
17	3	5	3	2	7	1	4	5	5
18	5	5	2	5	3	2	6	5	3
19	2	2	2	6	2	6	7	2	1
Mean	3.84	5.31	4.63	2.73	4.73	2.42	3.21	4.94	4.31

Semantic Differential Concept "ME AS PARENT"

Post-treatment

	Polarities and Factors								
Ss	2(P)	4(A)	7(P)	9(A)	11(E)	15(P)	21(E)	24(A)	28(E)
1	7	7	6	1	7	4	5	7	7
2	6	7	7	1	7	1	1	7	7
3	7	7	7	2	7	1	2	5	7
4	7	7	7	2	7	1	2	6	6
5	6	6	6	1	6	1	3	7	5
6	7	7	7	2	7	1	2	7	7
7	6	6	6	2	6	2	4	4	6
Mean	6.57	6.71	6.57	1.57	6.71	1.57	2.71	6.14	6.42

Walker Problem Behavior Identification Checklist

Pre-Treatment

Ss	Acting-Out	With-drawl	Distract-ibility	Disturbed Peer Rel.	Imma-turity	Total Score
1	13	6	7	9	7	42
2	16	5	12	12	6	51
3	21	0	10	5	9	45
4	25	0	13	13	10	64
5	6	0	8	0	2	16
6	3	0	8	0	3	14
7	11	0	3	9	9	32
8	18	6	3	5	1	33
9	13	4	4	6	0	27
10	20	5	9	18	14	66
11	17	0	5	3	6	31
12	19	1	11	4	4	39
13	16	1	8	4	3	32
14	11	11	8	8	2	40
15	21	6	9	6	3	45
16	22	2	11	13	15	63
17	10	0	2	8	5	25
18	17	8	12	20	11	68
19	14	4	8	5	4	35
20	14	0	8	5	5	32
21	5	3	3	2	0	13
Mean	14.85	2.95	7.71	6.72	5.66	38.71

Walker Problem Behavior Identification Checklist

Post-treatment

Ss	Acting-Out	With-drawl	Distract-ibility	Disturbed Peer Rel.	Imma-turity	Total Score
1	6	0	0	0	2	8
2	0	0	0	0	0	0
3	11	0	7	2	6	26
4	8	1	6	0	4	19
5	5	0	5	5	3	18
6	10	0	8	4	4	26
7	0	1	1	0	0	2
Mean	8.00	1.00	5.40	3.66	3.80	16.5

Child Behavior Rating Scale

Pre-treatment

Ss	Self-Adjust	Home-Adjust	Social-Adjust	School-Adjust	Physical-Adjust	Total Adjust
1	55	95	71	41	30	341
2	67	78	30	48	29	338
3	73	97	64	25	36	365
4	34	85	46	26	26	264
5	45	73	87	63	36	299
6	66	101	67	56	34	390
7	76	90	61	38	33	370
8	37	70	44	27	36	241
9	48	80	46	31	32	287
10	23	86	63	30	32	248
11	73	104	64	13	36	367
12	67	88	67	67	34	377
13	58	80	61	37	30	313
14	79	91	96	58	30	398
15	98	77	110	53	35	403
16	44	63	60	6	33	220
17	100	101	93	65	26	467
18	72	62	71	49	36	323
19	56	31	71	0	0	174
20	47	35	42	14	30	192
21	70	84	93	11	28	319
Mean	61.33	79.57	67.00	36.09	31.66	318.85

Child Behavior Rating Scale

Post-treatment

Ss	Self-Adjust	Home-Adjust	Social-Adjust	School-Adjust	Physical-Adjust	Total Adjust
1	51	69	59	37	36	277
2	90	113	96	44	28	450
3	95	63	95	58	30	374
4	114	116	115	71	36	531
5	64	83	76	51	27	345
6	100	120	89	57	29	497
7	52	91	63	30	31	316
Mean	80.85	93.57	84.71	49.71	31.00	398.57

Mother-Child Relationship Evaluation

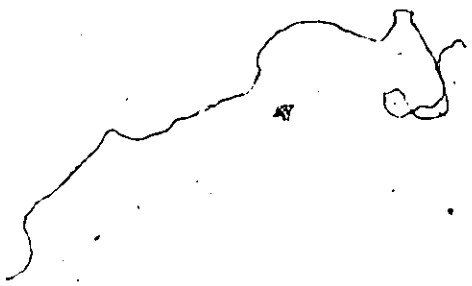
Pre-treatment

Ss	Acceptance	Overprotection	Overindulgence	Rejection
1	41	24	32	28
2	40	39	36	33
3	44	15	28	44
4	35	32	20	48
5	42	35	28	40
6	47	22	26	36
7	25	34	28	49
8	41	25	30	39
9	48	33	29	35
10	40	29	34	39
11	33	28	33	38
12	37	26	29	46
13	47	21	24	38
14	33	41	44	36
15	31	35	38	50
16	32	37	36	42
17	42	32	30	46
18	46	24	31	38
19	36	27	36	48
20	45	29	35	35
21	36	36	34	42
Mean	39.09	29.71	31.47	40.47

Mother-Child Relationship Evaluation

Post-Treatment

Ss	Acceptance	Overprotection	Overindulgence	Rejection
1	36	34	28	40
2	47	25	26	30
3	37	24	30	38
4	42	22	24	36
5	36	29	35	44
6	42	21	28	37
7	40	39	36	33
Mean	40.00	27.71	29.57	36.85



Child Cooperation Index Trial I

Number of Requests

Ss	Task 1	Task 2	Task 3	Task 4	Task 5
1	16	13	7	8	8
2	20	30	14	30	25
3	16	8	6	4	7
4	16	4	5	12	13
5	7	17	19	15	23
6	35	7	0	7	0
Mean	12.30	13.16	10.20	12.66	17.20

Child Cooperation Index Trial II

Number of Requests

Ss	Task 1	Task 2	Task 3	Task 4	Task 5
1	10	19	17	10	10
2	7	7	7	7	7
3	35	8	12	11	22
4	12	11	7	8	12
5	8	12	10	9	10
6	23	27	20	8	16
7	7	13	20	8	13
Mean	14.57	13.85	13.28	8.71	12.85

Child Cooperation Index Trial III

Number of Requests

Ss	Task 1	Task 2	Task 3	Task 4	Task 5
1	8	10	7	8	14
2	13	14	15	9	11
3	2	8	7	9	9
4	11	16	22	24	4
5	9	8	8	7	15
6	7	10	12	10	0
7	15	19	18	25	30
Mean	9.28	12.14	12.71	13.14	13.83

Child-Cooperation Index Trial IV

Number of Requests

Ss	Task 1	Task 2	Task 3	Task 4	Task 5
1	9	17	11	16	11
2	11	7	12	10	9
3	14	8	7	7	9
4	7	7	9	6	5
5	7	2	4	4	5
6	10	9	11	8	11
Mean	9.66	18.00	9.00	8.50	8.33

Child Cooperation Index Trial V

Ss	Task 1	Task 2	Task 3	Task 4	Task 5
1	8	9	8	9	7
2	7	7	9	7	9
3	15	7	7	10	13
4	9	10	7	10	0
Mean	9.75	8.25	7.75	9.00	9.66

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