BEHAVIOURAL PARENT TRAINING FOR HIGH-RISK PARENTS: EFFECTS OF THE TRIPLE P PATHWAYS PROGRAMME ON PARENTS' COGNITIONS

A dissertation

submitted in partial fulfilment

of the requirements for the Degree

of

Master of Education

endorsed in Child and Family Psychology

at the University of Canterbury

by

Shane Stevenson

University of Canterbury, New Zealand

March, 2003

TABLE OF CONTENTS

Page

LIST OF FIGURES AND TABLES

ACKNOWLEDGEMENTS

Firstly, I would likely to acknowledge all the staff (and students) in the Education Department who made this dissertation possible. In particular I must thank my primary supervisor John Church.

Next, I would like to acknowledge the work, support, and patience, of the Methodist Mission and the Home and Family Society who graciously allowed my colleague, David Stebbing, and I to engage in this research with their clients. Thank you Donna Ellen and Trevor Batin. Thank you Beverly, Don, Dione, and Suzie.

I would also like to acknowledge the help of the Triple P team, both here in New Zealand and also in Australia for their help and resources. This research was generously supported by a Triple P scholarship from the Tindall foundation. Thank you Aileen Pidgeon, Mark Conners, and Steven Hayns.

I would also like to acknowledge the participants who were involved in this research and who spent so much time filling out forms, answering questions and being pestered by me. Thank you.

Finally I must acknowledge the support, and help of all my friends and family. Thank you David, Liz, Lynley, Melissa, and Sharon. Thank you Cherin, Jasmine, Kat, and Marg.

In particular I would like to acknowledge my parents, and especially my Mum, who took a young boy with 'Dyslexia', advocated for him, supported him, and taught him. Without that foundation and family support I would never have made it this far.

ABSTRACT

This study was an evaluation of a recently developed intervention for parents who maltreat their children. The aim of the study was to compare the effectiveness of an unmodified Behavioural Parent Training programme (Triple P) with an augmented version of the programme (Pathways). The modified programme was designed to target risk factors associated with maltreatment including attributions and emotional regulation. Fifteen participants whose children had been removed from custody by a statutory agency were divided between the experimental conditions, Triple P (N=8), and Pathways (N=7). The study focused on shifts in parental cognitions. These were evaluated using the following measures: the Eyberg Child Behaviour Inventory (ECBI), the Depression Anxiety Stress Scale (DASS), the Parent Anger Inventory (PAI), Parents Attributions for Child's Behaviour Measure (PACBM), and the Child Abuse Potential Inventory (CAPI).

Due to high attrition in one group (Triple P) a between groups comparison was not possible. However, assessment of improvement in the 10 remaining participants was possible. Overall the findings tended to indicate that the augmented programme did not result in any significant improvement in the parents' self reported problems. Implications of these results are discussed including issues of the utility of Behavioural Parent Training for parents who maltreat their children.

CHAPTER 1

INTRODUCTION

Parental maltreatment of children is of growing concern worldwide, with far reaching social, political, physical and psychological ramifications (Hecht & Hansen, 2001; Sanders, Gravestock, Pidgeon, Connors, & Brown, 2002; Kaplan, Pelcovitz, & Labruna, 1999; Rodriguez & Green, 1997). New Zealand is no exception. Last year alone, the Department of Child, Youth and Family Services (CYFS) investigated nearly 24,000 notifications of children in need of care and protection (Department of Child, Youth and Family Services, 2003). Of these, more than 4,500 children and young people were removed from their homes and placed in the care of the Department. Recently CYFS has begun to contract various community based social service agencies to provide interventions for families where children are being maltreated. This research is an evaluation of one such intervention.

Definition of Child Maltreatment

What constitutes maltreatment is as variable in its definition as it is in its effects. In fact a clear, uniform definition of what constitutes maltreatment does not exist (Hecht & Hansen, 2001). Maltreatment may range from a lack of supervision to the use of a lethal weapon. Four main types of maltreatment have been identified by the literature: Physical abuse, sexual abuse, neglect, and emotional maltreatment (Azar, Ferraro, & Breton, 1998; Rogosch, Cicchetti, Shields, & Toth, 1995). In addition, moral/legal/educational maltreatment has been proposed (Rogosch et al., 1995).

Physical abuse is the most visible form of abuse. With physical abuse the child is subjected to deliberate bodily injury by the parent. This may involve bruises, broken bones, internal injuries or death. Because of its visibility, and the occasional need for medical intervention, this form of abuse has received the most attention.

Sexual abuse has also received a lot of attention in recent years. In its most common form this involves an adult engaging in sexual relations with the child. This may vary from inappropriate touching to intercourse. In it's more extreme forms this can involve the sexual exploitation of the child for money.

Emotional maltreatment is perhaps less well defined because of the difficulty in observing its effects. In its more common forms it can involve name calling, put downs, and scare tactics. In it's more extreme forms this can involve severe punishments that force the child to do degrading activities, and threats to the child's life.

Neglect is becoming increasingly identified as a unique form of child maltreatment. This may vary from the child being left home alone without supervision for short periods of time through to complete neglect of a child's basic survival needs including food, warmth, hygiene, safety and love.

Finally moral, legal or educational abuse can occur. These forms of abuse can involve the child missing school, exposure to smoking or drinking, or criminal activities. While these activities can be child driven, in it's more extreme form these activities are encouraged or even forced on the child by the parent.

Although these definitions are helpful in a categorical sense, in real world terms maltreatment is more complex than this. Rarely is abuse a discrete type perpetrated in a single form. Rather children are subjected to multiple abuses (Azar et al., 1998). It has been reported that 70% of abuse cases involve more than one of these subtypes of abuse (Barnett, Manly, & Cicchetti, 1993).

For the purposes of this study, the term maltreatment will be used to include all of the above forms of abuse with the exception of sexual abuse. The level of maltreatment of interest in this study is that which is of sufficient concern to warrant the removal of the child from their home environment by Child, Youth and Family Service (CYFS) under the Children,

Young Persons, and Their Families Act (1989) section 14. Under the Act children may be removed from their parents if one or more of the following criteria are present:

1. The parent is unable or unwilling to control or look after their child
2. Parental abandonment
3. Parent - child conflict

And, more specifically if the above has resulted in:

1. Impairment of the child's physical, emotional or mental development
2. An inability to form a significant psychological attachment
3. Actual or potential harm, ill-treatment, abuse or deprivation of the child
4. Serious antisocial behaviour by the child or youth to a criminal degree. (This latter factor may, of course, occur independently of child maltreatment).

It should be noted that while the State has the authority to remove a child from their home environment and place them into what is deemed to be more suitable care, this, in fact, is considered to be a last resort. Both the Act and the Department's charter clearly stipulate that where possible it is best to keep the family or whanau unit intact. Hence it is only in the most severe cases of maltreatment and where all other options and avenues have been ruled out, that the child is removed from the family or whanau.

In cases where the child has been removed from their parents, some form of parental access is still ideally maintained. The amount of access may vary from a few hours per month to several days per week and may take place either in the parents' home unsupervised, in the parents' home supervised by a CYFS worker, or in a supervised access centre. (This is a controlled environment especially designed to monitor parent-child interaction.) The level of supervision required depends on the level of concern held by CYFS.

Consequences of Child Maltreatment.

At a sociopolitical level, the costs of child maltreatment are evident in terms of police time, social services and medical expenses. At an individual level, the effects on the child are far more insidious and difficult to measure. While it is true that some children seem to display a certain level of resilience, the vast majority are affected in some way (Hecht & Hansen, 2001).

It is difficult to tease out the complex interrelated variables that accompany maltreatment, or to identify a single pattern of effects (Azar et al., 1998). These may include emotional, cognitive, behavioural and physical problems (Ayoub, Willett & Robinson, 1992) such as attachment problems, sleep problems, anxiety, internalising and externalising disorders, learning difficulties and language delays. Other childhood problems include low self esteem, social-cognitive deficits (e.g. social problem solving, perspective taking, affect recognition) and heightened aggression. These problems place the child on a developmental trajectory which can result in alcohol and drug abuse, health problems, criminal offending, depression, self-injurious behaviour and even suicide (Kaplan et al., 1999; Azar et al., 1998).

Furthermore the consequences of abuse are not unidirectional. The physical, behavioural and developmental problems that result from maltreatment place additional stress on the family unit. This may escalate the potential for further maltreatment of the child. In addition, as an adult, the abused child may treat his or her own children in the same way that he or she was treated. The intergenerational cycle of abuse has been well documented, with studies suggesting that adults who experience maltreatment as children being six times more likely to maltreat their own children compared to adults who have not (Kaufman & Zigler, 1989; Rogosch et al., 1995).

Risk Factors for Parental Child Maltreatment

As already suggested, the etiology of maltreatment is highly complex. There is no single factor that can be viewed as actually causing child maltreatment. Instead, "a multitude of determinants contribute" to its development (Rodriguez & Green, 1997, p.367). These include ecological, social and personal factors, the effects of which are cumulative. The greater the number of stressors and maladaptive factors in the family system, the greater the potential for maltreatment becomes (Rogosch et al., 1995).

A lack of social support and social contacts has been identified as an important risk factor for maltreatment (Chalk & King, 1998; Kaplan et al., 1999). Though not well understood, it is assumed that these factors lead to a lack of emotional support for the parent as well as fewer resources such as assistance with childcare.

Other ecological factors such as unemployment, low income, solo parenting, an impoverished environment and high crime neighbourhood, have all been associated with the maltreatment of children (Schumacher, Slep & Heyman, 2001; Kaplin, Pelcovitz & Labruna, 1999). It is thought that they add further to the stress on families (Hecht & Hansen, 2001). These factors are all correlates of low socioeconomic status (SES) which is one of the most consistently documented risk factors associated with maltreatment (Schumacher et al., 2001; Kaplin et al., 1999).

In addition, variables such as alcohol and drug abuse, marital conflict, and depression are likely to further corrode the family system and adversely influence a parent's ability to interact effectively with the child (Black, Heyman & Slep, 2001; Ayoub et al., 1992; Kinard, 1982).

All of these risk factors are interwoven in a complex and reciprocal way to raise the risk of maltreatment. For example, economic pressure is linked with greater parental

depression and marital conflict (Rogosch et al., 1995). A lack of social support is linked to unemployment and alcohol and drug abuse (Rogosch et al., 1995; Hecht & Hansen, 2001).

While no single factor causes child maltreatment, some factors are more central and pivotal than others. Those factors mentioned so far can be viewed as exerting stress on the family system and parent-child relationship. Whereas maladaptive parenting skills and faulty attributions about children, on the other hand, represent an actual deficit in the parent-child relationship. This distinction is important, given that it is possible to design interventions to improve parenting skills but much more difficult to change macro system variables such as S.E.S (Bronfenbrenner, 1989; Tomison, 1998).

Parenting Skills

Parental maltreatment of children appears to result from "grossly inadequate or destructive patterns of parenting" (Rogosch et al., 1995, p.127), and "the most pervasive disturbance seen in abusive parents is a variety of parenting skill deficits" (Azar et al., 1998, p.485). Abusive parents have been found to lack both child rearing skills and knowledge (Twenty & Plotkin, 1982; Tomison, 1998). They tend to explain things less to their children, particularly when disciplining, and they show poor problem solving abilities in relation to child rearing practices (Azar et al., 1998).

Abusive parents display poor abilities to cope with and manage stressful parenting situations and are often dissatisfied with their parental role (Hecht & Hansen, 2001). They often demonstrate unrealistic and inflexible expectations regarding child behaviour (Milner, 1986; Twentyman & Plotkin, 1982), and they tend to over-rely on punitive responses and harsh punishments.

Given that maltreating parents have poor parenting skills, it seems logical that parent training may be an appropriate intervention for parents who maltreat their children.

Behavioural Parent Training (BPT)

Behavioural parent training programmes (BPT) have received extensive empirical support and are often considered "best practice" when working with dysfunctional families (Brestan & Eyberg, 1998; Dadds, 1997). In particular, this approach has been shown to be effective when working with the parents of children with extreme behavioural problems (Brestan & Eyberg, 1998; Reid, 1993).

Parent training programmes are based on research which shows that parenting deficits underpin the child behaviour problems, as explained by Patterson's (1982) Coercion Theory. Studies of family processes show that parents can inadvertently reinforce misbehaviour while at the same time punishing or ignoring more desirable pro-social behaviour. As this continues, parents begin either to give in to the child's coercive behaviour, or resort to coercive behaviour (e.g. harsh punishment) themselves.

As the name implies, the aim of Behavioural Parent Training is to improve parenting skills. More specifically, the goal is to teach parents the concept of differential reinforcement. This involves becoming attuned to and monitoring the child's behaviour, rewarding pro-social behaviour (using strategies such as star charts, and praise) while ignoring or punishing negative and coercive behaviour (with the use of appropriate consequences such as time-out) (McMahon, 1999: Sanders, 1999; Dadds, 1997; Assemany & McIntosh, 2002).

Research has shown that the use of BPT can reduce the potential for maltreatment by providing maltreating parents with skills and knowledge that promote a more positive parent-child relationship (Chalk & King, 1998; Sanders and Cann, 2002), and by reducing unrealistic expectations and a reliance on harsh, coercive discipline strategies (McMahon, 1999; Taylor & Biglan, 1998).

The Positive Parenting Programme (Triple P)

One well-developed behavioural parent-training programme is that of Sanders and his associates, known as the Triple P – Positive Parenting Programme. Over the past 12 years, the Triple P organisation has conducted a great deal of empirical research which has focused on assessing and evaluating various behavioural strategies that make parenting easier. The Triple P programme is a multilevel parenting and support initiative designed to provide professional support and advice to families who have children with behavioural problems (Sanders, 1999). Within the Triple P framework, five core positive parenting competencies are targeted in order to alleviate common behaviour and developmental problems faced by children and their families (Sanders, 1999). These competencies include:

1. *Ensuring a safe engaging environment.* This component focuses on educating parents about how to provide a protective atmosphere for the child's healthy and secure learning. This includes adequate supervision and monitoring of children.

2. *Creating a positive learning environment.* This section emphasises the important part parents play in their children's learning process. It teaches parents how to provide discrete sequential learning steps (the "Ask, Say, Do" technique) for their children, involving everyday activities (incidental learning).

3. *Using assertive discipline.* Here the emphasis is on providing alternative discipline practices to the ineffective/coercive methods that parents may otherwise use. This includes how to set and discuss rules with children, how to give instructions and how to deal with misbehaviour (including planned ignoring, logical consequences, quiet time (non exclusionary time out) and time out).

4. *Having realistic expectations*. Here parents are taught to examine the reasons for their children's behaviour and how to set achievable and practical targets for both the child and themselves. Emphasis is on developing realistic and age-appropriate expectations.

5. *Taking care of oneself as a parent.* The aim of this component is to teach parents to be aware of the multitude of variables that affect them, and their behaviour as a parent. It focuses on self care, well being, and the development of coping skills.

Another essential component of the Triple P programme is the belief in a minimal level of intervention that result in real benefits for children and their families. The key to this less-is-better notion is to ensure that parents develop sufficient self-regulatory skills to help them avoid subsequent problems and manage their children's behaviour in a positive manner. To achieve this, Sanders and his associates have developed a multilevel model that provides a range of support strategies for parents as determined by their current level of need in terms of managing their child's behaviour problems. These levels are as follows:

Level One: Universal Triple P. This level of intervention is aimed at entire populations e.g. national, local community, school etc. Delivering health promotion and social marketing strategies through a coordinated media campaign, this level covers a wide range of common behaviour and development problems. The aim of the programme is to familiarise parents with the general principles of positive parenting and provide them with the knowledge of where to seek help.

Level Two: Selective Triple P. This level of intervention is aimed at specific subgroups of the population, for example all parents of toddlers. Delivered through primary care services, which are most often provided by family doctors, this programme targets those identified as being at greater risk of significant behavioural problems. It uses primary care services, family doctors, day care centres, kindergartens and schools to deliver preventative parenting programmes, with a focus on the management of identified child behaviour problems.

Level Three: Primary Care Triple P. This strategy concerns parents experiencing issues with milder child behaviour problems such as tantrums, as opposed to children who

meet the full criteria for a behavioural disorder. In addition to the Level 2 components, Level 3 parents receive active skills training.

Level Four: Intensive Parenting Skills Training. The target group for Level 4 Triple P is parents of children with multiple behaviour problems. Parents at this level are provided with a variety of skills and knowledge surrounding child behaviour and development, primarily involving differential reinforcement. This includes the use of calm clear instructions, contingent attention and praise for socially desirable behaviour, planned ignoring, logical consequences, quiet time or time out for child misbehaviour and forward planning for higher risk situations.

Three formats are offered: Group Triple P, an eight session programme that provides parents, not only the aforementioned training components, but also with the support of other parents who have children with similar problems. Standard Triple P is a 10-session programme similar to that of Group Triple P, but which provides individualised attention. Self Directed Triple P again provides the same basic manualised information as the other two options at this level, but is able to be self administered for people who are unable to otherwise access a training provider (if, for example, they live in a remote area). This latter programme can also be offered with telephone assistance.

Furthermore, the Level Four programme has been recently developed and modified to include specific programme for parents with adolescents who are experiencing problems.

Level Five: Family Intervention. At this level, parents not only experience severe child behavioural problems with their child but also a variety of personal and interpersonal problems. This level of intervention involves intensive individualised attention aimed at the parent's specific problem areas, including marital difficulties and emotional problems. Parents are provided training in mood management and general coping skills. In addition, home visits are provided to enable coaching and feedback on parents' use of the programme's parenting

strategies. This level of intervention is recommended when the parent has not benefited from a Level 4 intervention, or it is obvious that they would not.

Within each level a variety of delivery modes are utilised to maximise potential audience inclusion. Furthermore, a specialised training and accreditation process has been developed by Triple P to ensure the Triple P positive parenting strategies can be administered in a standardised manner by professional and non-professional alike.

Parental Attributions

The utility of generic BPT programmes with maltreating parents has been questioned in the literature (Tomison, 1998; Sanders et al., 2002; Ayoub et al., 1992; Jones, 1987). While BPT provides skills and knowledge, it has been argued that maltreating parents have additional needs and deficits that are not meet by a standard BPT programme. Increasing knowledge about *treatment resistant* parents tends to indicate that maltreating parents are less likely to benefit from a standardised programme. The augmentation of this approach with specific components linked with maltreatment risk factors has been gaining favour (Tomison, 1998; Cohn & Daro, 1987). In particular, the importance of considering the role of parental cognitions has been recommended (Bugental & Johnston, 2000). It is argued that BPT will be less successful if parents have negative beliefs about their children. This is because deficits in parental skills and negative parenting experiences lead to the development of entrenched negative views about the child. Attempts to teach new parenting skills will be filtered through these 'attributional biases'.

While the concept of attributions is not new (Heider, 1958) it is only in recent years that this concept has been applied to the role of parenting (Miller, 1995; Bugental & Johnston, 2000). Attributions are defined as the judgements which a person makes in an attempt to help

them understand their environment and make it more predictable (Jenson, Green, Singh, Best, & Eliss, 1998).

One of the most influential models of causal attributions is that of Weiner (1985). Weiner identified three dimensions: Locus of Control - whether the behaviour of others is attributed to an internal source such as personality type or effort, or an external source such as the situation; Stability - whether the behaviour is seen as stable, that is, reoccurring, or unstable, something that is unexpected; Controllability - whether the behaviour is seen as controllable, or uncontrollable.

Using this model, Dix and Grusec (1985) have attempted to provide an overview of the relationship between attributions, affect and behaviour. Dix and Grusec argue that the attributions parents make about their child's behaviour influences their emotional state and, hence, how they respond to that behaviour. For example, a negative behaviour by a child that is attributed by the parent to an internal locus of control (to do with the child rather than the situation), stable (likely to occur again) and controllable by the child (something the child choose to do or could have avoided) is more likely to result in feelings of anger or frustration and a punitive reaction from the parent. However this relationship is not simply linear. According to this model, although attributions affect emotions and consequent behaviour they can also be used to rationalise, and hence promote, the continued use of behaviours such as harsh disciplinary reactions (e.g. because they punished the child, the child must have been bad).

Empirically, this conceptual model seems to be supported, in the sense that certain attributional styles have been observed in parents who maltreat their children (Miller, 1995). Specifically, research indicates that compared to non-maltreating parents, parents who maltreat their children tend to more often attribute their child's negative behaviour to stable, internal attributions, and are more likely to attribute their children's positive behaviour to

external influences (Rogosch et al., 1995; Hecht & Hansen, 2001; Dix, 1993; Rosenberg & Reppucci, 1983; Joiner & Wagner, 1996). They are likely to attribute malevolent intent and high blame to negative behaviour (Bauer & Twentyman, 1985; Bugental, Mantyla, & Lewis, 1989)

Furthermore, this attribution style has been linked to affect regulation, including anger control and negative mood. This indicates that parents' negative attributions are more easily triggered by aversive childhood behaviour, and they are more likely to react negatively (Bugental, Mantyla & Lewis, 1989). Research is beginning to suggest that attributions may affect emotional regulation, and that these two factors may work in conjunction to foster and sustain poor parenting practices (Dix, 1991, 1993). It appears that as a parent's mood becomes increasingly more negative, the likelihood is that they will not only interpret their child's behaviour in a negative light, but that they will also use more severe discipline strategies (Dix, 1993; Bugental Mantyla & Lewis, 1989).

The influence of these attributions has been explained, using the concept of parental learned helplessness (Abramson, Seligman, & Teasdale, 1978; Bugental, Blue, & Cruzcosa, 1989). This suggests that maltreating parents have a tendency to view their child's misbehaviour as something that is out of their control. An explanation that is supported to some degree, by the research literature (Bugental, Blue, & Cruzcosa, 1989).

It is important to note that while attributional bias of maltreating parents has been associated with a variety of additional problems including marital discord, child health problems, and behaviour problems (Joiner & Wagner, 1996) the causal path is not clear. The study of parental attributions is a relatively new field and the exact role of attributions has yet to be determined (Miller, 1995; Bugental & Johnston, 2000).

Nevertheless, the seemingly pivotal role of parents' attributions, not only in their interactions with their child but also in influencing the acquisition of new parenting skills, has

resulted in their inclusion as a component in some BPT programmes (Miller, 1995; Griest, Forehand, Rogers, Breiner, Furey, & Williams, 1982). However, these attempts at modifying BPT programmes have yet to determine how, if at all, the addition of an attributional component contributes to the success of a BPT programme.

Behavioural Parent Training Based Intervention Involving Maltreating Parents

Despite the increasing rates of childhood maltreatment and the number of families who present as at risk for child maltreatment, only three studies could be found which have evaluated the effectiveness of parenting programmes with this particular group.

In a study by Whipple and Wilson (1996), the effectiveness of a community-based parent support and education programme for maltreating parents was evaluated. The programme was run by a local social service agency that focussed on decreasing risk factors associated with physical child abuse. Thirty-two percent of the participants were referred to the programme by a community professional or the court system, and sixty-six percent were included in the programme on the basis that they presented with numerous factors associated with child physical abuse. Sixty-nine percent of participants were from low-socioeconomic families (>US$25,000). Twenty-four percent of the participants had current or previous involvement with child welfare authorities.

Several programmes were offered to participants. The first programme provided a respite service, where parents could leave their child in a safe environment for up to two-and-half hours per day. The second programme focussed on positive discipline strategies, identifying and expressing emotions and stress reduction, and ran for up to two hours per day. The third programme was designed to increase parents' understanding of child development, increase parents' use of positive discipline strategies, and decrease the use of punitive strategies. This programme was conducted over fifteen two-hour sessions. The fourth

programme focussed on issues such as working through feelings of separation, and facilitating the child's individuality. There were also some components that focussed on responsible parenting practices, such as ensuring that the child had the necessary vaccinations. This programme ran for 20 2.5-hour sessions. Parents were free to decide which programme or programmes they would receive.

Thirty-four participants were involved in the study. Fifty-six percent were referred because of concerns regarding their parenting practices. Of those, half were involved with child protection agencies. Data was collected over a 9-month period on three different occasions, through interviews, questionnaires and telephone contact. By the third stage of data collection, 30 participants remained in the study.

The results indicated that programme involvement was significantly associated with a decrease in parental depression and stress. Parents who were highly involved in the programmes (i.e. attended three to four programmes) displayed the most significant decrease in their level of depression. Reductions in the level of stress were the same across highly involved participants and participants who had a low level of involvement. However, no data was provided on the effects of the programmes on abusive behaviour, and this limits the utility of this study.

Iwaniec (1997) compared the effectiveness of individual and group based parenting programmes for parents who were emotionally abusive and/or neglectful (as assessed by mental health professionals). Parents were assigned to either an individual parent-training programme or a group based parenting programme. Of the participants in the individual condition, eight families were described as working class, and two were described as middle class. The mean age of parents in this group was 26 years. Nine of the participants in the group-based approach were described as working class and one was described as middle class. The mean age of this group was 27 years.

Participants in the individual treatment group received ten 2-hour sessions, one per week. Sessions focussed on improving parent-child interactions and relationships, managing misbehaviour in an appropriate and unthreatening manner and teaching parents to have accurate expectations based on their child's age and developmental level. Participants in the group approach also received the ten 2-hour sessions once per week. Parents received relaxation training, which involved teaching the parents to identify and manage stress through relaxation techniques. They also received self-control training, which involved teaching parents to effectively manage feelings of anger and frustration. In addition, parents were instructed in problem solving.

The measures used by Iwaniec (1997) included therapists' reports of participant goal attainment, observations of parent-child interactions, observation of the child's proactive and reactive behaviour, parental stress self-reports, the State-Trait Anxiety Inventory and a parental questionnaire which assessed changes in parental perceptions of their situation at different stages of the programme.

The study showed that at the two-year follow-up, the parents who received group training had better outcomes than those who received individual parent training. Although both groups displayed similar improvements on measures that assessed the parent-child relationship, participants who received the individual programme were less confident in dealing with problems, and showed greater levels of anxiety and stress when confronted with difficulty.

The most recent study was conducted by Sanders, Gravestock, Pidgeon, Connors and Brown (2002). Sanders et al. compared the effectiveness of the Standard Triple P with an extended version of the programme, known as the Pathways programme, with parents identified as being at risk for child maltreatment. The Pathways programme was designed to

place specific emphasis on issues of parental attributions and emotional regulation, given their prominence in the literature on the causes of abuse.

Approximately five percent of the participants were referred through the child protection authority. The remaining participants were recruited through an outreach campaign that targeted parents who were concerned about their level of anger, or who were worried that they may harm their child. Ninety-eight parents were involved in the study. Forty-eight were assigned to the Standard Triple P group and 50 were assigned to the Pathways group.

Participants in each group received four two-hour parent training session. Following completion of these sessions, all participants received four 15-30 minute telephone consultations. All participants were instructed in 17 central child management strategies. Ten strategies were designed to promote children's development and capabilities, and seven strategies were aimed at enhancing parental management of misbehaviour. Parents in the Pathways programme received an additional four two-hour sessions. These sessions were aimed at challenging parental beliefs about their own behaviour and their child's behaviour. They were also prompted to change any negative parenting practices they used that were based on these beliefs.

Measures included both a self report instrument battery and direct observations of parent child interactions in the home environment. The battery included general measures of parenting and child behaviour (the Parenting Scales, the Parent Sense of Competency, the Home and Community Checklist, the Parent Daily report Checklist, the Eyberg Child Behaviour Inventory, and the Parent Problem Checklist) as well as more specific measure of maltreatment and risk factors relating to maltreatment (the Parental Anger Inventory, Child Abuse Potential Inventory, the Depression-Anxiety-Stress, the Parent Opinion Questionnaire, and the State-Trait Expression Inventory).

Sanders et al. (2002) reported that all participants in the study showed treatment gains. Although participants in the Pathways group showed a greater reduction in their potential for abuse immediately after treatment, both groups demonstrated equally significant reductions across all measures at their 6-month follow-up. Even though the amended version did not seem superior in the end, Sanders et al. (2002) still seem to contradict the growing body of literature already mentioned (Assemany & McIntosh, 2002; Ayoub, et al., 1992; Tomison, 1998) which suggests that standard short-term, group-based BPT is not sufficient for this parent group. However, given the preliminary and mixed nature of these findings, further research is clearly needed before any firm conclusions can be drawn. The present study sought to replicate Sanders et al.'s (2002) study with maltreating parents in New Zealand.

The Current Study

Two local social service agencies, the Methodist Mission Child and Family Service, and the Home and Family Society, had secured a funding contract with CYFS to provide training for maltreating parents whose child or children had been placed in the care of the Department. Given the funding criteria of their contract with CYFS a brief, group format, programme was required and the Pathways programme was chosen. Though still in its pilot study stage, staff within these agencies were well versed in the Triple P model, and through their contacts with the Australian programme developers, were able to access the necessary programme and training resources.

Faced with a contractual obligation, a strong belief in providing an accountable community service, and questions about the effectiveness of the new programmes, help was sought from the University of Canterbury to undertake an evaluation study of the Pathways programme. This evaluation was undertaken by two postgraduate students who worked in

collaboration. One evaluated for changes in parental cognitions (the present study), and one evaluated changes in parental behaviours (David Stebbing's study).

The aim of the evaluation studies was to assess whether the Triple P programme could be enhanced for use with high risk families, here in New Zealand, by introducing the additional components inherent in the Pathways programme. The present study sought to find out whether these modifications resulted in positive changes in parental attributions about children, stress management, emotional affect and regulation, and overall abuse potential.

Despite a dearth of empirical research at an intervention level, the general literature on maltreating parents tends to support the need for training that attempts to help these parents change their attributions and emotional regulation. Hence it is hypothesised that:

1. The Pathways programme would result in more appropriate parental attributions about children, and improved coping skills that would result in lower levels of stress, anger, and feelings such as depression.

2. Furthermore, when compared to an unmodified Triple P programme, the Pathways programme would result in a lowered potential for abuse.

CHAPTER 2

METHOD

Participants

Potential participants were referred from CYFS to participate in a parent training programme, run by two local social services agencies: the Home and Family Society and the Methodist Mission. All potential participants had at least one child who had been placed in the custody of CYFS and who was currently in foster care. Of the 20 referrals received, two were excluded as they did not have a child in the target age range of 2 to 12 years. Another two referrals were excluded from the programme because they were receiving respite care for a psychiatric disorder, and did not have current access to their child. A further participant was dropped from the programme when it became apparent, at an initial meeting, that the individual did not have the cognitive capacity to benefit from the programme, or to complete the assessments. All of the remaining 15 participants met the entry criteria in that they had at least one 2- to 12-year-old child currently removed from their custody, to whom they had weekly access, and no physical or mental impairment that would prevent them from attending, or understanding, the programme.

Participants were randomly assigned one of two groups: either a Pathways Group (the experimental condition), or a Triple P Group (the comparison group). Participants' names were first drawn out of a hat, and placed into one of two piles. Due to the small sample size, both groups were then checked to ensure that they were reasonably comparable. Adjustments to the groups as assigned were deemed unnecessary, and a coin was flipped to determine which group would be designated as the comparison group (i.e. the Triple P Group). This being determined, each participant was assigned a number. The Pathways Group participants were numbered 01 to 07, and the Triple P Group participants were numbered 08 to 15. Demographic information for the participants of each group is presented in Table 1.

Table 1

Demographic characteristics of the fifteen participants

Participant number	Age	Gender	Ethnicity	Relationship status	Income	Number of children	Children in Care	Target child's age	Access to target child per week	Care & protection concerns[a]	Previous parent training
1	49	M	European	Married	Benefit	2	1	3	Weekends	Abuse, neglect	Yes
2	35	F	European	Married	Factory	2	1	3	Weekends	Physical abuse, neglect	Yes
3	36	F	Maori	Single	Benefit	6	4	5	1 day	A&D, maltreatment	Yes
4	46	F	Maori	Defacto	Benefit	5	3	3	10 hours	A&D, physical abuse[bc]	Yes
5	43	F	Maori	Defacto	Benefit	6	6	10	2 hours	Physical abuse	Yes
6	38	M	Maori	Defacto	Manual	2	2	10	2 hours	Physical abuse	No
7	38	F	European	Single	Benefit	3	1	12	1 day	Inability to cope	No
Mean	40.7	2M/5F	4M/3E	2S/3D/2M	2W/5B	3.7	2.6	6.6			5Y/2N
8	29	F	European	Defacto	Benefit	2	2	6	2 hours	Neglect	No
9	31	M	European	Defacto	Benefit	2	2	6	2 hours	Abuse	No
10	34	F	Maori	Single	Benefit	4	4	6	Weekends	A&D, physical abuse[b]	Yes
11	30	M	European	Single	Benefit	3	3	7	2 hours	A&D, maltreatment	Yes
12	34	F	Maori	Single	Benefit	4	2	12	1 day	Inability to copy[c]	No
13	32	F	Maori	Defacto	Benefit	5	5	8	1 day	Unknown	Yes
14	39	M	European	Married	Manual	1	1	2	Weekends	A&D, neglect	No
15	39	F	European	Married	Benefit	1	1	2	Weekends	A&D, neglect	No
Mean	33.5	3M/5F	3M/5E	2S/3D/2M	1W/6B	2.8	2.5	6.1			3Y/4N

[a] A&D in this column refers to parental use of alcohol and/or drugs. [b] The physical abuse reports appear in these cases to primarily involve the partner of the participant. [c] Sexual abuse by the partner was suspected also

The Pathways group consisted of seven participants, five of whom were female and two were male. Four participants identified as Maori, and three as Pakeha or European. The Triple P Group consisted of eight participants, six of whom were female, and two male. Three of those participants identified as Maori, and five as Pakeha or European. The mean ages of the parents and the target children in the Pathways group were 40.7 and 6.6 years respectively, while for the Triple P Group they were 33.5 and 6.1 respectively. Both of the groups included two couples (Participants 01 and 02, and Participants 05 and 06 in the Triple P Group, and Participants 08 and 09 and Participants 14 and 15 in the Pathways Group). Eight participants had experienced some type of parent training before (five from the Pathways group, three from the Triple P group). Ten participants had had more than one child removed from their care by CYFS over time. Twelve of the participants were receiving a government benefit. The other three participants had part-time work which would have placed them in one of the two lowest socio-economic levels, according to the Elley and Irving (in press) Socio-economic index.

Following their referral from CYFS, a letter was sent to all participants outlining the programme and their involvement in it. All participants confirmed their attendance at one of four introductory meetings which were held on the premises of the community agency involved. At these meetings, the parent training programme was explained, and participants met with the trainers and a representative from the Home and Family Society and/or the Methodist Mission. Participants also had an opportunity to clarify any issues about the training programme. Consent forms and the first questionnaire were completed when the agency representatives left the meetings.

Settings

The parent training programme for the Pathways Group was held at the Methodist Mission's meeting room in Christchurch. This venue caters for up to 30 people and is comfortably lit with adequate heating, ventilation and seating. Light refreshments, consisting of hot and cold drinks with biscuits, were provided. Training for the Pathways Group was run by two trainers. The first trainer was a female Social Worker with approximately 10 years' experience in parent training work. The second trainer was a female registered psychologist with over 15 years' experience of working with a range of at risk children and parents.

The parent training programme for the Triple P Group was held at the Home and Family Society's meeting room in Christchurch. This venue caters for 15 people and is comfortably well lit and adequately heated. Here, too, light refreshments were provided. Training of the Triple P Group was run by two trainers. The first trainer was a male counsellor with 15 years experience in relationship and family counselling. The second trainer was a female doctoral student from the Psychology Department of the University of Canterbury. She had approximately one year of experience in facilitating parent training with the Home & Family Society.

Participants were allowed weekly access to their target child throughout the course of the programme to allow them to complete homework task and practices.

Self-Report Measures

The assessment battery was a scaled-down version of that used by Sanders et al. (2002). Five instruments were used: the Eyberg Child Behaviour Inventory (ECBI), the Depression Anxiety Stress Scale (DASS), the Parent Anger Inventory (PAI), the Child Abuse Potential Inventory (CAPI) and the Parents' Attributions for Child's Behaviour Measure (PACBM). The decision to reduce the length of the assessment battery was based on the

observation that the participants were likely to find the original battery laborious, and difficult to complete.

The CAPI was included because it appeared to detect some differences between a Triple P Group and a Pathways Group in an earlier study (Sanders et al., 2002). The DASS, PAI, and PACBM were included because of their perceived utility in assessing the added Pathways components which focused on parental attributions, anger management, and stress relief. The ECBI was included because of its ability to monitor possible improvements in child behaviour (as perceived by the participants). With the exception of the PACBM, all the instruments had been used in previous parent training research (McMahon & Forehand 1988; Sanders, 1999; Hansen, Sedlar, & DeRoma, 1998).

Eyberg Child Behaviour Inventory (ECBI). The ECBI is a 36 item inventory designed to measure parent's perceptions of problem behaviour in children aged 2-16 years. Each item produces a Problem score (Yes/No) and an Intensity score on a 7-point Likert scale (1 = *Never*, 2-3 = *Seldom*, 4 = *Sometimes*, 5-6 = *Often*, 7 = *Always*). The Intensity scale provides an estimate of the frequency with which the behaviour occurs and the Problem scale indicates whether the parent views the behaviour as being a problem or not.

The ECBI has good test-retest reliability: .86 for the Intensity scale and .88 for the Problem scale after a three week period (Eyberg & Pincus, 1999). The ECBI Problem scale and Intensity scale have correlations of .67 and .75 with scales on the Child Behavior Checklist Externalising Scale (Boggs, Eyberg, & Reynolds, 1990). The range for the Problem score is 0-36, and for the Intensity score is 36-252. The Problem score and the Intensity score both have cut-off scores that distinguish clinical from non-clinic groups. For the Problem score, a total of $\geq$15 is considered to be of clinical significance, while Intensity scores greater than 132 indicate that the child falls in the clinical range.

Depression Anxiety Stress Scale (DASS). The DASS is a 42-item scale designed to measure adults' symptoms of depression, anxiety and stress. Respondents are asked indicate how much each item applied to them over the past week using a 4-point Likert scale. The DASS has three 14-item subscales. The Depression subscale measures dysphoria, hopelessness, anhedonia, inertia, lack of interest, devaluation of life and self-depreciation. The Anxiety subscale measures autonomic arousal and physical effects, situational anxiety and experiences of anxious affect. The Stress scale measures difficulty relaxing, nervous arousal, agitation, irritability and impatience.

The DASS has adequate test-retest reliabilities of .71 for the Depression subscale, .79 for the Anxiety subscale, and .81 for the Stress subscale after a two week period (Brown, Chorpita, Korotitsch, & Barlow, 1997). The DASS Depression scale and Anxiety scale has correlations with Beck Depression Inventory scores of .75 to .77, and with the Beck Anxiety Inventory score of .83 to .84 (Lovibond & Lovibond, 1995; Brown et al., 1997; Antony, Bieling, Cox, Enns, & Swinson, 1998). The scores for each scale range from 0-42. These scores are banded into severity ranges. On the Depression scale, for example, the ranges are: 0-9 *Normal*, 10-13 *Mild*, 14-20 *Moderate*, 21-27 *Severe*, 28+ *Extremely Severe.*

Parent Anger Inventory (PAI). The PAI is a 50 item inventory that measures respondents' anger in relation to child rearing situations. While there are many anger inventories available, the PAI is unique in its focus on parental anger (Hansen et al., 1998). It provides both a Problem score, using a 'Yes/No' format, and an Intensity score, using a 5-point Likert scale (1 = *not at all*, 2 = *a little bit*, 3 = *somewhat*, 4 = *quite a bit*, 5 = *extremely*). The Problem scale indicates whether the situation is viewed as a problem by the parents and the Intensity scale rates how angry the situation makes the parent.

The PAI has adequate test-retest reliability: .78 to .80 for the Problem scale and .79 to .86 for the Anger Intensity scale after a two-week period (Hansen et al., 1998; Sedlar &

Hansen, 2001). Overall, the PAI correlates moderately with the ECBI scale (r = .57 to .61) (Hansen et al., 1998), though the ECBI Frequency scale and the PAI Problem scale show a stronger correlation of .72 (Sedlar & Hansen, 2001). The range for the Problem score is 0-50, and for Intensity scores the range is 50-250. The Intensity score has a clinically significant cut off at ≥148.

Parents Attributions for Child's Behaviour Measure (PACBM). The PACBM is a 48 item measure designed to assess parental attributions about their child's behaviour. It consists of six vignettes, three *Intentional* situations in which the child is clearly being non-compliant (e.g. the child is told to do something and replies "No I won't"), and three *Ambiguous* situations where the reason for the child's behaviour is not clearly known (e.g. the parent calls out to the child (who is outside) but the child does not respond). Parents are asked to "imagine [*their*] child performing each behaviour in each situation" and then are asked to indicate how much they believe in the eight statements that follow it using a six point Likert scales (1 = *Disagree strongly,* 2 = *Disagree*, 3 = *Disagree somewhat*, 4 = *Agree somewhat*, 5 = *Agree*, 6 = *Agree strongly*). Each statement corresponds to one of three attribution types that could be used to explain why their child might have behaved in the way described in the preceding situation. These are: *Stable* (the parent views the way the child behaves as staying the same, that is, that the child will never change), *Blame and Intentional* (the parent views the child's behaviour as being deliberate (that is, the child acted on purpose and deserves to be held responsible), *Internal* (the parent views the child's behaviour as resulting from internal causes (that is, the behaviour is due to something about the child).

This is a new measure designed by Aileen Pidgeon, a researcher for the pilot study of the Pathways programme (Sanders et al., 2002). The measure was included because of its use in the original Pathways research.). The score for each scale is an average of its item scores, hence the range for each scale is 1-6. Scores that fall within the range 4-6 are considered to be

indicative of parents who hold maladaptive attributional bias about their child's negative behaviour. An attributional bias associated with abusive parenting (Aileen Pidgeon, personal communications, 16 August, 2002; Miller 1995).

Child Abuse Potential Inventory (CAPI). The CAPI is a 160-item inventory which measures parenting values and beliefs, emotional health, and relationships, in order to assess the risk of physical child abuse. It uses a 'Agree/Disagree' format for each item. The CAPI has an overall scale for abuse potential as well more specific subscales for abuse risk factors. These subscales are: *Distress* (anger, frustration, loss of self control, depression and fear), *Rigidity* (believing that children should always be clean, neat, quiet and obedient), *Unhappiness* (lack of pleasure and personal fulfilment), *Problems with child* (the parent sees the child as bad, slow and a trouble maker), *Problems with family* (family members are seen as having problems and fighting) and *Problems with others* (beliefs that others are making life hard and causing pain) (Blinn-Pike & Mingus, 2000). The CAPI also has three built-in validity scales designed to measure response distortions such as attempts to provide socially desirable answers. From these scores it is possible to calculate whether the response distortions are indicative of the parent *faking good, bad* or *randomly.*

The CAPI has good internal consistency reliability (r=.92 to .96 for non-abusers and .95 to .98 for abusers). Test-retest reliability is also adequate at intervals of one day (r=.91), one week (r= .90), one month (r=.83) and three months (r=.75) (Milner, 1994). The reported accuracy of the CAPI for classifying abusive parents is 80-90% (Milner, 1994). The range for the Abuse potential scale is 0-480. The CAPI provides a clinical (5th percentile) cut-off score of $\geq$ 215. The faking scales are also considered elevated if they exceed 6 (for the Random and Inconsistency scales) or 7 (for the Lie scale). When this occurs the manual suggests that test-user should "question the validity of the abuse score" (Milner, 1986, p.11).

Direct Observational Measures

In addition direct observation measures were collected by the second member of the research team. The observations were used to lend support to the self-report measures. These are discussed in Stebbing (2003).

Experimental Design

This study was designed as a between-group, cross-over design. The Pathways Group received the newly-developed Pathways Programme (Sanders et al., 2002), while the Triple P Group received a standard Level 4 Triple P group intervention programme. Having completed their training and the assessments, the Triple P group then received the additional Pathways sessions. This was to avoid the ethical problems created by providing a theoretically inferior treatment to the comparison group, and also to allow further assessment of the hypothesised benefit of the Pathways sessions. All participants completed a questionnaire booklet modified from the Pathways pilot study in Australia (Sanders et al., 2002) on three separate occasions. The design is pictured in Figure 1 and included the following phases.

Baseline measure. The first measures were administered to each group 1-2 weeks prior to the commencement of training. The first questionnaire (Time 1 - Baseline) was completed by participants immediately following the pretraining group meeting. All participants were offered assistance in filling out their questionnaires. Of the 15 participants originally accepted for the study, two accepted assistance with filling out the questionnaire. Participant 11 had a degenerative eye condition (that is, glaucoma) which meant that he was unable to read the questionnaire, while Participant 09 had a reading difficulty. Participants with more than one child were also to identify a *target* child on whom they were to focus for the purpose of the questionnaire. Participants were subsequently reminded, each time they filled out the questionnaire, to focus on the same target child.

Figure 1

Experimental design

Week	The Pathways Group	The Triple P Group
1	Pre-training meetings & Baseline measures	
2	Baseline measures (Observations only)	
3	Group Triple P: Session 1	Pre-training meetings & Baseline measures
4	Pathways Attributions: Session 1	Baseline measures (Observations only)
5	Group Triple P: Session 2	Group Triple P: Session 1
6	Group Triple P: Session 3	Group Triple P: Session 2
7	Group Triple P: Session 4	Group Triple P: Session 3
8	Pathways: Session 2	Group Triple P: Session 4
9	Pathways: Session 3	Phone session: Session 1
10	Pathways: Session 4	Phone session: Session 2
11	Mid-programme measures	Phone session: Session 3
12	Mid-programme measures	Phone session: Session 4
13	Phone session: Session 1	Mid-programme measures
14	Phone session: Session 2	Mid-programme measures
15	Phone session: Session 3	Pathways: Session 1
16	Phone session: Session 4[a]	Pathways: Session 2
17	Post-training measures	Pathways: Session 3
18	Post-training measures	Pathways: Session 4
19		Post-training measures
20		Post-training measures
21	Exit Interviews started	
22		
23		Exit Interviews started

[a] For the Pathways group this session was done in a group format instead of over the phone. Refer to Table 2 for more details.

Phase 1. The Pathways Group participants commenced training first, and received the four standard Level 4 Triple P sessions on parenting skills, interspersed with four sessions on attributions, anger management, and other negative emotions. Two weeks later, the Triple P Group participants commenced their training, and received four sessions on parenting skills training, followed by four telephone sessions. Sessions were held once a week.

Mid-Intervention measure. At the end of their first eight weeks of training, each group completed the assessment instruments a second time. For the Triple P group, this represented the first post-training measure, as they had completed the standard Level four Triple P programme at this point. Assessments were completed at the participants' homes, following completion of the second video observation session. The decision to administer the later questionnaires at the participants' homes was due to their reluctance to attend additional meetings outside those of training, as well as our wish to cause them as little inconvenience as possible, by combining both researchers' measures into one visit.

Phase 2. After the assessments, the Pathways Group completed their programme with three telephone sessions and one final group session, while the Triple P Group received the four additional Pathways sessions on attributions, anger management, and other coping skills.

Post-training measure. The final measure was completed at participants' homes, after Phase 2.

Exit interviews. The exit interviews were structured, and were administered one month after the completion of the intervention, at the participants' homes. The interviews took 30 to 45 minutes to complete. Participants were asked a variety of questions relating to their beliefs and feelings about the course before, and after, what they had learnt, what they thought about the presentation of the course, and what they found to be most and least helpful.

Withdrawal interviews were also planned for participants who left the study. Unfortunately, due to a combination of factors, including the transient nature of the

participants, their general lack of access to telephones, and problems in contacting their Social Workers, most of the participants who dropped out of the programme could not be contacted at the end. As a result, the withdrawal interviews were eventually abandoned.

Training programme

A brief outline of the training sessions received by the Pathways Group and the Triple P Group is outlined in Table 2.

Table 2

A brief description of the goals and content of the 12 parent training sessions

Group Triple P, Level 4 – Group sessions	
1	An introduction to the aims of the programme. Factors influencing children's behaviour were examined, with specific goals for change also set.
2	This session introduced parents to a number of strategies to promote positive child development. Techniques to encourage children to perform desirable behaviours and techniques to teach children new skills were explored. Parents were taught the importance of spending quality time with children, the need to show affection to children, the importance of setting a good example, the importance of providing children with engaging activities, and the use of star charts to encourage positive child behaviour.
3	This session examined the importance of managing child misbehaviour in a consistent and decisive manner. Specific strategies included teaching parents how to establish clear ground rules, the use of clear calm instructions, the use of directed discussion and planned ignoring, and the use of discipline techniques such as logical consequences, quiet time, and time-out.
4	This session described the importance of understanding and being prepared for situations where there is a high-risk that children will misbehave. Six steps designed to assist parents to plan a parenting routine were discussed. These included the need to plan in advance, the discussion of ground rules with children, selecting appropriate activities, how best to encourage appropriate behaviour, the use of consequences for misbehaviour, and holding follow-up discussions with children after a high risk situation has passed.
Group Triple P, Level 4 – Telephone sessions	
1	This session was the first of the telephone sessions. During this session, parents were asked to report on how successfully they had been in using their high-risk coping plan. The remainder of this session was used by parents to address any current issues or concerns. It was stipulated to parents that by this point they should be able to set themselves goals and homework tasks, plan, use and monitor high-risk coping plan, and manage their emotions in high-risk settings.

Table 2 (*continued*)

	The importance of being able to access information on parenting issues and get support from family, friends or other group members when necessary was also highlighted. At the conclusion of this session, parents were asked to plan an agenda for the following weeks phone call session.
2	This session was a continuation of the telephone sessions in which the parent determined the content of this session. The expectations, as stated in session 9, were carried over for this session. In addition, parents were now expected to have the skills to solve any parenting problem with minimal help from the group leader.
3	This session was a continuation of the telephone sessions. This session modelled that of session 10.
4	This was the final of the telephone sessions. It represented a continuation of the telephone sessions held over the previous three weeks. It should be noted that this session was a modified by the Pathways Group facilitators, in that it was held in a group format to allow the group to meet one last time.
Pathways – Group sessions	
1	This session explored possible explanations for parents' negative or hurtful behaviour towards their children. The specific nature of this behaviour was examined as were the consequences of this behaviour. An emphasis was placed on teaching parents that it is their unhelpful thoughts, rather than their child's behaviour, which cause them to behave in negative or hurtful ways towards their child. Strategies such as 'helpful thoughts' were taught, to assist parents to act in more positive ways when managing their child's behaviour.
2	This session introduced parents to an array of anger coping skills. Parents were taught the characteristics of anger and specific ways they could prevent anger from escalating (i.e. abdominal breathing, muscle relaxation). The manner in which anger affects how parents behave towards their children was also discussed.
3	This session was used to review parents' strategies for managing emotions. This included the use of relaxation, cognitive restructuring, and behaviour change techniques. Parents were asked to develop a high-risk coping plan for use in difficult situations. A progress report on the changes that the parent had seen in their and their child's behaviour since the beginning of training was also carried out. Finally, parents were prepared for the telephone-call component of training. This involved explaining the purpose of the phone-calls (i.e. to assist them to deal with any remaining issues or concerns in respect to their child's behaviour), and the parents' responsibility concerning appointment scheduling and availability.
4	This session focused on the role of thoughts in experiencing emotion. Parents were taught how to identify distorted negative thoughts and ways to change self-talk to reduce unhelpful emotions. In addition, they were encouraged to develop a list of coping statements to use in particularly stressful situations.

Note. See Figure 1 for the order these session were presented in each group.

CHAPTER 3

RESULTS

This chapter has been divided into the following sections: attrition, analysis of baseline measures, effects of the interventions, and exit interview analysis.

Attrition Rate

The overall attrition rate of participants in this study was 33%, all of whom were from the Triple P Group. In the Pathways group, five participants attended all 12 sessions, one attended 11 sessions, and one attended 10 sessions. Participant 04 missed sessions 4 and 7 for unknown reasons and Participant 07 missed session 5, due to illness. Of the three participants in the Triple P group who finished the programme, all three completed every session.

Of those who dropped out of the Triple P group, two failed to attend any sessions (Participants 14 and 15), two completed the first two sessions (Participants 12 and 13), and one completed three sessions (Participant 11). Reasons cited for dropping out were, new work commitments that conflicted with the course (Participant 12 and 13), concerns about the use of video observations (Participant 14 and 15), and problems with other participants and CYFS (Participant 11). Participant 11 was reportedly told that it was unlikely that they would ever regain full access to their child, even after completing the programme. Participant 11 also reported that his step son had been sexually abused by the son of one of the other participants while the two children were in foster care together.

In all cases, both researcher and trainers actively negotiated and worked with any problems participants may have had at the point at which they dropped out of the programme. However, all attempts were met with some degree of resistance by participants and were unsuccessful. Due to a combination of factors, including the transient nature of this group,

their general lack of telephones, and problems with contacting their Social Workers, most of the participants who dropped out of the programme could not be contacted at the end.

In addition, the data from the baseline measures for Participant 14 and Participant 15 have been excluded from the analysis. Not only did they fail to attend any of the intervention sessions, but they failed to attend any of the pretraining meetings, including a third meeting time which had been arranged specifically for them. When they were finally met at their home, both participants were drinking spirits. Participant 14 completed the questionnaire but did not appear to contemplate the questions, or, at times, even to read them. He completed the questionnaire in approximately 15 minutes, rather than in the more usual 55 minutes. Participant 15 did not complete the assessment battery, answered questions randomly and failed to complete one whole measure. On returning to re-administer the measures, both participants again appeared to be intoxicated, and the decision was made to not re-administer the assessment battery.

Analysis of the Baseline Measures

A two-tailed between-group *t* - test analysis was performed on the baseline data, to ascertain whether the two groups were comparable prior to the intervention. Table 3 shows the means and standard deviations of the scores of the Pathways Plus Group and the Triple P Group on each of the baseline measures.

The results of this analysis indicate that on 24 of the subscales, there were no significant differences between the groups at the 95% confidence interval. On only the CAPI *Problems with others* subscale was a difference between the two groups significant at the 5% level. Differences on three other subscales did, however, approach significance. These were the scores on the *Intensity* subscale of the ECBI ($p = 0.060$), the scores on the PAI *Intensity subscale* ($p = 0.053$) and the scores on the PAI *Problem subscale* ($p = 0.060$).

Table 3

Mean performance of Pathways Plus group and Triple P group on five evaluation measures at Time 1 (Baseline).

Scale	Pathways Plus (*N*=7) Mean	*SD*	Triple P (*N*=6) Mean	*SD*	t^a	*p*
Eyberg Child Behaviour Inventory (ECBI)						
Intensity	114.14	30.86	158.33	44.84	-2.098	0.060
Problem	15.57	8.64	18.67	10.39	-0.587	n.s.
Depression Anxiety Stress Scale (DASS)						
Depression	14.57	13.84	25.00	8.65	-1.593	n.s.
Anxiety	11.14	14.69	11.00	6.29	0.022	n.s.
Stress	17.14	13.26	19.67	9.33	-0.390	n.s.
Parent Anger Inventory (PAI)						
Intensity	84.29	24.66	134.33	55.37	-2.166	0.053
Problem	20.86	4.71	28.83	8.75	-2.094	0.060
Parents Attributions for Child's Behaviour Measure (PACBM)						
Stable						
Ambiguous	2.71	0.78	3.00	1.21	-0.511	n.s.
Intentional	2.86	1.10	3.50	0.94	-1.121	n.s.
Blame & Intentional						
Ambiguous	3.52	0.63	3.89	1.17	-0.715	n.s.
Intentional	3.36	1.02	3.97	1.08	-1.058	n.s.
Internal						
Ambiguous	2.71	1.23	3.44	1.56	-0.952	n.s.
Intentional	3.00	0.92	3.44	1.50	-0.653	n.s.
Child Abuse Potential Inventory (CAPI)						
Abuse	192.29	98.49	291.00	77.01	-1.710	n.s.
Ego	20.14	9.81	10.70	11.02	1.476	n.s.
Loneliness	7.57	4.16	10.70	4.16	-1.420	n.s.
Distress	117.14	68.74	178.00	84.87	-1.079	n.s.
Rigidity	14.43	20.19	26.00	21.17	-1.419	n.s.
Unhappiness	20.14	9.99	29.30	3.79	-1.218	n.s.
Child	12.86	9.46	8.00	5.57	-0.091	n.s.
Family	12.71	17.16	25.00	11.27	-1.840	0.093
Others	15.00	5.16	21.70	1.53	-3.613^b	0.009
Validity						
Lie	7.00	2.38	5.33	4.73	0.607	n.s.
Random	3.14	1.57	4.67	3.51	0.677	n.s.
Inconsistency	6.14	2.73	8.67	4.04	0.412	n.s.

[a]Variance is equal and $df = 11$ unless otherwise specified. [b]Variance is unequal, the appropriate *t* value has been calculated and $df = 7$.

Taken together, these results indicate that the Triple P group reported having significantly more problems with other people and had a clear tendency towards reporting more severe problems with their (target) children, as well as reporting a greater number of problems which resulted in greater feelings of anger.

A comparison of the groups using the clinical cut-off scores for each measure indicates several differences, not only between the groups, but between those participants who dropped out and those who went on to complete the programme. These differences are in the same direction as the differences already mentioned. On the ECBI, the mean score of the Pathways Plus Group was not of clinical significance (clinical cut off $\geq$131) but the mean score of the Triple P Group score was clinically significant. More specifically, five out of six of the Triple P Group participants scored within the clinical range on this scale, whereas only three out of seven in the Pathways Plus Group scored in this range. Furthermore, the Triple P Group had the four highest scores. All of the participants who dropped out had scores in the clinical range, and one participant (Participant 12) achieved the remarkable score of 232 (out of a maximum 252).

Similarly, the mean score on the DASS for depression in the Pathways Plus Group fell in the moderate range while the mean for the Triple P Group fell in the severe range. All of the Triple P Group scores for depression fell in the clinical range (one moderate, three severe, two extreme) while three out of seven in the Pathways Plus Group fell in this range (one moderate, one severe, one extreme). All of the participants who dropped out had scores in the severe-to-extreme range (two severe, one extreme). Participant 01 obtained the maximum possible score (42) on all three subscales of the DASS.

With the PAI, the only participants to score within the clinically significant range ($\geq$ 148) were in the Triple P Group and both of them dropped out (Participant 12, Participant 13).

Again of note is the fact that Participant 12 had the highest score on this item (230 out of a maximum 250). This was nearly triple the Pathways Group mean score.

As a relatively new measure, the PACBM does not currently have clinical cut-offs and, as such, it could not be subjected to an analysis at this level. However, the belief that a child's negative behaviour is something that is stable, internal, and intentional, and is also something for which the child should be blamed, are seen as indicators of abusive parenting. As such, responses that *Agree (Agree somewhat, Agree, Agree strongly)* with these beliefs can be viewed as *of clinical concern.*

Overall, the Pathways Group had a total of 9 out of 42 responses in the *of clinical concern* range, compared to a total of 15 out of 36 for the Triple P group in this range. Of particular note is Participant 12, who again scored the highest on this measure, constantly rating five to six (out of a maximum of six). That participant was the only one to check 'agree' on all nine subscales, and the only participant to score sixes. Participant 01 from the Pathways Group also scored in the *agree* range on five subscales. Two of the drop-outs (Participant 11, Participant 13) also scored in the same range on four and three subscales respectively. All other participants fell into the *disagree* range.

On the last measure, the CAPI, the two groups again appear clinically different. The Triple P Group mean score fell within the clinical range on all of the factor scales that had clinical cut-offs (i.e. Abuse, Distress, Rigidity, Unhappiness, Child, Family, and Others), compared to the Pathways Plus Group who scored in the clinical range only for the Child subscale. All of the participants in the Triple P Group reported having clinically significant problems with their family and other people, and being unhappy, compared to one to three (on average, two) participants for each of these scales in the Pathways Plus Group. For the Abuse Potential scale, five of the six participants in the Triple P Group scored within the clinical range, compared to only two from the Pathways Plus Group. Two of those with the clinically

significant abuse score were participants who left, with Participant 11 scoring the highest rating on this inventory, with an astounding 421 (out of a maximum 480).

It should be pointed out, however, that the majority of participants had elevated CAPI validity scores (10 with elevated lie scores, one with an elevated Random score, and eight with elevated Inconsistency scores). Five of the Pathways subjects' scores, and four of the Triple P subjects' scores, indicated that they were trying to fake good. In this situation, the manual (Milner, 1986) indicates that those scores which are below the cut-off subscale, and which have a validity index that indicates that the participants are *faking good*, should not be interpreted. However, scores above the cut-off, despite having a validity index which indicates that the participants are *faking good*, can be classified. Thus, the lack of clinical range scores within the Pathways Group may be viewed as a result of participants who are potentially 'better fakers'.

Effects of the Intervention

With the collapse of the Triple P Group, no further between-group analyses were possible, and the experimental design was abandoned. Given that the original experimental design meant that both groups ultimately received the same intervention, with only a slight variation in the order of presentation, it was decided to pool the data from the remaining participants into one group, to increase the statistical power of a within-group analysis, and to examine the question of whether there were any changes which could be attributed to the Pathways training programme. As the two groups had received different components of the intervention at the mid-intervention assessment phase, the data from the second evaluation was excluded, and the analysis became a simple pretest - post-test design. A paired one-tailed *t* - test was performed for the purposes of this analysis. The results of this analysis are shown in Table 4.

Table 4

Mean performance of Participants 01-10 on five evaluation measures at Time 1 (Baseline) and Time 3 (Post training).

Scale	Baseline 1 Mean	Baseline 1 *SD*	Post training 3 Mean	Post training 3 *SD*	t^a	*p*
Eyberg Child Behaviour Inventory (ECBI)						
Intensity	119.60	31.61	117.60	30.17	0.207	n.s.
Problem	14.70	8.34	13.90	8.97	0.464	n.s.
Depression Anxiety Stress Scale (DASS)						
Depression	17.80	13.93	15.40	11.03	0.635	n.s.
Anxiety	11.20	12.87	11.00	11.40	0.110	n.s.
Stress	17.40	12.65	16.00	10.75	0.528	n.s.
Parent Anger Inventory (PAI)						
Intensity	88.50	24.39	100.90	26.47	-1.444	-0.091
Problem	22.70	5.01	24.40	7.32	-0.568	n.s.
Parents Attributions for Child's Behaviour Measure (PACBM)						
Stable						
Ambiguous	2.57	0.69	2.30	1.21	0.686	n.s.
Intentional	2.83	0.92	2.30	1.17	1.155	n.s.
Blame & Intentional						
Ambiguous	3.43	0.77	2.53	1.12	2.146	0.030
Intentional	3.35	0.89	3.05	1.00	0.811	n.s.
Internal						
Ambiguous	2.66	1.04	2.30	0.78	1.339	n.s.
Intentional	2.93	0.80	2.43	0.93	2.185	0.028
Child Abuse Potential Inventory (CAPI)						
Abuse	222.00	100.37	222.90	128.66	-0.026	n.s.
Ego	17.30	10.58	17.30	13.97	0.000	n.s.
Loneliness	8.50	4.20	8.80	4.73	-0.205	n.s.
Distress	135.40	74.94	135.30	94.01	0.004	n.s.
Rigidity	17.90	20.06	15.10	17.07	0.657	n.s.
Unhappiness	22.90	9.46	26.30	15.68	-0.484	n.s.
Child	11.40	8.49	11.00	7.01	0.219	n.s.
Family	16.40	16.12	21.60	14.60	-1.221	n.s.
Others	17.00	5.35	15.50	8.96	0.590	n.s.
Validity						
Lie	6.50	3.06	6.40	3.34	0.124	n.s.
Random	3.60	2.22	2.00	1.56	2.138	0.031
Inconsistency	6.90	3.18	6.00	3.27	0.867	n.s.

[a] *df*(9)

The results of the within group *t*-test analysis indicate that there were only three out of the 25 subscales that were statistically significantly different at the 95% confidence interval. Two of these were on the PACBM: the first for Blame and Intentional attributions in the *Ambiguous Situations* ($p = 0.030$), and the second for Internal attributions in the *Intentional situations* ($p = 0.028$). The third was for a minor validity subscale on the CAPI, Random ($p = 0.031$). The change in the mean Internal attribution on the PACBM (for the Intentional situations) results in a move from being close to *Disagree somewhat* (mean = 2.93) to being slightly closer to *Disagree* (mean = 2.43). The change in the mean Blame and Intentional attribution on the PACBM (for the Ambiguous situations) has resulted in a shift that remains within the *Disagree somewhat* response range, moving from the upper end of the range (3.43), to the lower end of the range (2.53). The change in the Random scores on the CAPI validity scales simply indicate that participants' tendency to provide random answers to items on the CAPI has dropped from an average of 3.60 items to 2.00 items.

In addition, the PAI Intensity subscale ($p = -0.091$), shows a tendency towards a significant change in the group's mean in a negative direction. None of the above statistical differences represent a change in a clinical sense. That is, they were within the normal range at baseline, and remained so at post-training.

ECBI scores did not change significantly. The number of participants above the clinical threshold on the Intensity Scale changed from five participants above the clinical cut-off at baseline, to three at post-training. Scores on the DASS showed that some participants (Participants 09 and 10) improved over the 12-week period, and some (Participants 05, 06 and 07) got worse.

The significant increase in the mean Intensity score on the PAI appears to have been largely due to the results of Participant 07 who obtained a score of 74 at baseline and a score of 150 post-treatment. Again for the PAI, the only clinically significant move was at an individual level. This represented an increase in numbers of clinically concerning scores from none at baseline to one at post-training (Participant 06).

All of the PACBM mean subscale scores remained within the disagree range. While there were individual changes in the attribution scores on the PACBM, these tended to cancel each other out. For example, two participants dropped below the level of concern (Participant 01, Participant 03), and one (Participant 02) rose above the level of concern.

On the CAPI, as with the other measures, the majority of the means remained similar over time. Mean scores on the Abuse subscale, the Unhappiness subscale, and the Problem with Child subscale were all above the clinical cut off at both baseline and post-training. One consisting subscale mean, that of Problems with Family, did, however, show a clinically significant change, rising from 16.40 to 21.60 and passing the clinical cut-off ($\geq$18).

Overall, the number of participants with scores above the clinical cut off for the Abuse scale increased from five at baseline to seven at post-training. At an individual level, the Abuse scores tended to change markedly from baseline to post-training. Two participants' scores more than doubled to well above the clinical cut-off (Participant 01, Participant 03), and one participant's score (Participant 10) dropped by over half to below the cut-off.

The abuse score of Participant 01's wife (Participant 02) moved in an opposite direction from that of her husband, in that it dropped from 132 to 35. It should, be noted, however, that the validity scores of Participant 01 and Participant 04 suggest that they were *faking good* and, if that is the case, their scores are not reliable.

Participant 04. In addition to the above note about they CAPI, the scores of Participant 04 were extremely low over all the measures at both baseline and post-training. Her results are the lowest it is possible to score on the ECBI, DASS, and PAI. These results standout as markedly different from the rest of the participants.

Participant 10. Another participant whose results stood out as a notable exception was Participant 10. This, however, was in terms of her marked, and clinically significant, improvement on the ECBI, DASS depression subscale, and the CAPI. However, again, as

already noted, her validity index for the CAPI indicates that she was *faking good*, which at least invalidates her marked improvement on the CAPI.

Amended Analysis

In view of the CAPI manual cautions (Milner, 1986) and research protocols used by other researchers using the CAPI in this area (Sanders et al., 2000) more conservative analysis of the data would ideally have been conducted by removing the scores of those participant who had elevated validity index (indicating they were *faking good*) and sub-clinical Abuse scores. However, the removal of additional participants from the already small group left in the study would have made a *t*-test meaningless, so this analysis was abandoned.

Exit Interviews Analysis

Tables 5 to 8 summarise participants' responses to the questions from their exit interviews. In general, these responses were coded into categories of affect, *Positive, Negative,* or *Ambivalent,* and then tabulated. Where a response did not lend itself easily to classification by affect, additional information was deemed necessary. More definitive response categories were used, as is the case for Tables 6 and 8.

Table 5 summarises the participants' attitudes towards the course before and after its completion. The results suggest a overall shift in attitudes relating to the course, from a negative or ambivalent attitude before the course started, to a more positive attitude after its completion.

Table 5

Participants' attitude towards the course before and after

Question	Response affect		
	Negative	Ambivalent	Positive
Before			
Attitude about the referral	8	0	2
Attitude about the course	5	3	2
Learning expectation	5	1	4
Total	18	4	8
After			
Attitude about the course	1	1	8
Would they recommend the course	1	1	8
Learning outcomes	1	2	7
Total	3	4	23

Participants' negative attitude towards the course, before it started, appear to have resulted from their negative experiences of referral from CYFS. All those who showed such prior negativity or ambivalence were also negative about their referral. Comments such as "We were told if we didn't do it we would lose him" and, "CYFS said I had to do it" were frequently accompanied by feelings of anger and of being judged. In some cases, these feelings, in turn, were accompanied by low or negative prior expectations of learning, expressed as, for example, "Nothing". Four participants felt that they did not need parent training. This emerged in such statements as, for example: "I know how to bring up kids" and, "I'd done it before". However, 40% of the participants reported that they had had positive prior expectations of learning, such as wanting to learn "new skills" or new child management techniques.

Following the completion of the course, the majority of participants (80%) were positive about it, and said that they would recommend it to other people. Indeed, two participants reported that they already had made such recommendations. Comments such as "I'm happy I've done it" and "The course was excellent, I really enjoyed it" were indicative

of participants' attitudes. However, many of these response were centred around social aspects of the course, as in, for example, "It was fun, something to look forward to, not so much the work ... I'd realised fairly quickly I had heard a lot of it before. ... I enjoyed the people and the socialness of it all."

Table 6 provides a précis of participants' responses when they were asked: "What, if anything, did you learn?" Unexpectedly, 90% of the their responses related to self, rather than child management. Remarks included, "The relaxation and stress management parts were good", "Learnt ways to help myself", "To be more positive ... less negative ... calm."

Table 6

Participants' responses to the question "What, if anything, did you learn?"

	Response category			
	Nothing or Not a lot	General Knowledge about children & parenting	Child management techniques	Self management techniques
No. of response	3	2	3	9

Note. Participants provided a varying number of responses for this item, ranging from 1-5. When a participant's responses fell into different categories each response was tallied separately. Participants were only tallied once for each category. None of the participants' response fell into more than two categories.

Participants were also asked for their views about particular components of the course. Their responses to these questions are summarised in Table 7.

Table 7

Participants' responses to questions about specific components of the course.

	Response affect		
Course component	Negative	Ambivalent	Positive
Manual	6	1	3
Course content	5	1	4
Videos	3	1	6
Homework	10	-	-
Access arrangements	7	1	2
Group	1	-	9
Trainers	-	-	10
Total	24	3	32

Most (60%) of the comments about the manual were negative. Participants felt that it was "too long", "too wordy", "confusing" and "needs to be simplified". Participants appeared to be more divided over the content (40% positive, 50% negative). Of note is the way in which all of the negative response involved comments about the length and pace of the course. Two thought it was "too long" and that "the whole thing could have been done in a few hours." However, the remaining three thought the course was too "rushed" or "fast". Nevertheless, the comments of the latter three cannot be assumed to express a negativity about the course, in that they did not necessarily indicate that they wanted it to continue.

Videos appeared to be a preferred medium for learning with six (60%) of the participants reporting that they were "good" or "really helpful". Thirty percent of the participants felt that the videos were "unrealistic", "too much", or repetitive. The homework tasks were universally seen as difficult or "a waste of time". Issues raised by various participants indicated that those tasks were: "difficult to understand", had confusing phrases, and were irrelevant. However, most parents (70%) found the homework difficult due to a lack of access to their children, which meant that they "didn't have a chance to do it". The three participants who did not find that their access arrangements inhibited the practice of their parental skills were all parents who had one to three days access per week. The other participants had only two to three hours access per week.

All but one of the participants were exceptionally positive about the value of the group. Comments such as "the group was fun!", "hard-case", and "helpful" were common. The value of this component was repeatedly expressed in terms of the social value (e.g. "Meeting new people") and also the support of knowing that they "were not alone" and "seeing other people with similar problems". The one participant who was not positive about the group felt that she would have best benefited from "one-to one", and she found it

"annoying" that the other participants "spent so much time ... continuously griping about CYFS".

While all the comments about trainers were positive, some preferences for individual trainers were expressed. For example, the male participant in the Triple P Group stated that it was "good to have a male to relate to." Nevertheless, an overall trend in favour of any one trainer was not apparent.

When asked "What was the most helpful (or unhelpful)?" the participants responded as shown in Table 8. Participants' first choice, as ranked by themselves, indicated a clear preference for the group experience. The group was seen as helpful because it allowed parents to "share ideas"; "get ideas from other people"; "see others in similar situations", and "see what [they] were going through." It should be noted that all of the first choice responses about the helpfulness of the group came from the Pathways group. Although positive about their experiences as a group, the three participants in the collapsed Triple P Group rated the more individualised help they were able to receive from the trainers as most helpful.

Table 8

Participants' responses to the question "What was the most helpful/unhelpful?"

	Response category				
Category	Content[a]	Group	Setting	Length	Trainers
Helpful:					
1st choice	2	6	-	-	2
2nd choice[b]	4	1	1	-	2
Total	6	7	1	-	2
Unhelpful:					
1st choice	-	1	-	9	-
2nd choice[b]	2	-	2	-	-
Total	2	1	2	9	-

[a]The category content differs from that of the previous Table, and as such includes all responses relating to course material, resources, and information. [b]Not all participants made a comment that fell into a second response category. Hence the total number of responses in this row does not equal the total number of participants.

With the addition of a second choice, comments about the content were the next most common comments about that which was most helpful. These comments included two comments about the videos, and four comments about the "stuff about self", that is, self-management.

In relation to that which was least helpful, all except one of the participants made a response in relation to the length of the course. Seventy percent of the participants saw the course as too short and rushed. When prompted with a question about ways in which this could be changed, participants responded with comments such as: "more than 12 weeks", "put less in each session", "needed to be a bit longer each week as we couldn't finish each part", "less phone sessions, more classes", "more phone sessions", "twice weekly", and so on.

Other responses included: two comments about the difficulty in finding a car park, and the expense of parking in the central city; one comment about group participation, in that "some parents held back a bit"; and one comment about the need for "stuff" to do with older children.

Individual participants. Participant 01, when compared to the rest of the group, was quite negative about the course. He felt that the course "was a waste of time" and "that the whole thing could have been done in a couple of hours". He was adamant that "time-out didn't work" and that "a whack was much more effective". While his partner Participant 02 was also negative in some of her comments, she was more positive and did see some befits in the course.

Also worth individual comment was Participant 07. She also made some negative remarks about her experience, however these were directed at the suitability of the programme for her child who was twelve. She felt that the age focus of the course was to young, and that "there were a couple of things [she] could use with the younger child ...for [the target child] there was not so much", and, unlike everyone else, she felt that she would have benefited more from individualised help, as opposed to group work.

CHAPTER 4

DISCUSSION

A combination of low initial recruitment numbers and a high attrition rate for the Triple P Group meant that it was impossible to complete the between groups comparison design as originally planned, therefore the original aim to replicate the study by Sanders et al., (2002) was not possible. The research hypothesis regarding the effectiveness of the Triple P Group programme with the addition of an attributional focus for maltreating parents was also untestable. Nonetheless, as the results of the remaining participants were analysed as a single group, limited interpretations about the value of this programme for parents who maltreat their children could be made.

The results from this study indicate that, as a group, these maltreating parents had clinically significant abuse potential and moderate to mild symptoms of depression, anxiety, and stress. The results also indicate that these parents had many problems with their children. Surprisingly, however, parents did not report high levels of anger in relation to a number of problems with their children. Nor did their responses indicate the type of attributional biases typically associated with this participant population. In addition, findings from this study tend to support the view that this short term targeted approach (despite modifications) may not be effective on its own and these findings seem to echo conclusions and recommendations found in the literature regarding interventions with maltreating parents.

Limitations and Results of the Study

The subjective nature of the self-report measures was a limitation in this study. Although they are clinically validated and provide a method to assess participants' cognitions

surrounding a multitude of beliefs that may otherwise be difficult or unethical to test in real world scenarios, there is the possibility that these measures may not be an accurate depiction of reality (Reid, Baldwin, Patterson & Dishion, 1987; Patterson, Reid, & Dishion, 1992; Schwarz, 1999). Therefore this study was conducted in conjunction with another researcher, and divided into two parts (behavioural and cognitive). No behavioural measures were collected in this study as the second researcher (David Stebbing) was collecting observational data of the Parent-child interactions, which were to be used to validate the cognitive and affective information gathered in this study.

Concerns around the self-report data obtained in this study should not be underplayed. In general, the participants in this group tended to minimise or deny their role in having lost custody of their children. Instead the cause of the problem inevitably moved onto CYFS or the Social Worker (and, to a lesser degree, their child). Comments such as "I've never hit my kid" or "the Doctor even says there's nothing wrong with him" were not uncommon. Both the trainers and the researchers experienced weekly difficulties in getting the group to stop professing their innocence and blaming the Social Worker for their latest troubles.

In addition, given their involvement with CYFS these parent were extremely use to being observed and evaluated., and were perhaps trying to make a favourable impression. Many of these participants attended the training programme with the view that it would help them "get their kids back". Therefore it was to be expected that the image that this participant group would want to project would be one of 'wrongly convicted' or 'problem-free parents'. Given all of these factors, it would not be surprising to find that there was a level of dishonesty in responses about interactions with their child. This appears to be true, as the validity index on the CAPI indicates that the majority of parents were attempting to *fake good* on this measure.

Indeed, contrary to the literature on the attributions of parents who maltreat their children, the responses of the participants in this study on the PACBM suggest that they did not attribute their child's negative behaviour to internal, stable characteristics about their child. Nor did they tend to see their child's negative behaviour as intentional and deserving of blame. There are three possibilities for this:

1. This particular parent group does not in fact have the attributional biases usually associated with maltreating parents.
2. The measure itself is not an effective measure of parental attributions.
3. The parents were aware of how they should respond and consequently responded in that manner.

While none of these options can be completely discounted it seems unlikely that the attributions of this particular group of parents are distinctively different from other maltreating parents. In fact personal observation in the training and home setting indicated that these parents indeed fit the profile of maltreating parents. For example, the parents in this study tended to report high levels of behaviour problems with their children in the absence of observable child behaviour problems. This seems to suggest that these parents have an attributional bias in which the child is blamed for the problems which the parents are experiencing. In addition reports from Australian research (Aileen Pidgeon, personal communications, 23 November, 2002) indicate that this measure does assess parental attributions of high-risk parents in a reliable way. Therefore the only remaining possibility is that the parents had learned how they should respond on instruments such as the PACBM, and had responded as they believed they should.

In a similar way, one would have expected higher and more clinically significant scores for participants on the PAI as they scored highly on the CAPI which is a measure of physical abuse potential (Milner, 1986). This is not an uncommon finding, and previous

research has found similar low self-reported measures of anger with participants in treatment for child physical abuse (Mammen, Kollo, & Pilkonis, 2002). It has been noted that some abusive parents, though quite angry and irritable, simply do not describe themselves as 'angry' (Peterson, Gable, Doyle, & Ewigman, 1997; Mammen et al., 2002).

The results in this study may be attributed to the focus of the PAI. For while the participants would readily admit that they were angry at their Social Worker and, as one said, wanted to "rip their ----- head off", they readily denied any anger towards their children. Maybe this was because it is easier to deny being angry at one's child if no one can witness it, while it is harder to deny anger at one's Social Worker when one is appearing in court next week for threatening their life.

As noted in the results, one participant's results were constantly low over all the measures and all three assessments. Participant 04's results were the lowest possible score on some measures including the ECBI, DASS, PAI. While individual interpretation of the results is to be avoided, her results are markedly different from the rest of the participants. There seem to be two possibilities. Either Participant 04 has been misclassified, and is quite different from the majority of parents who maltreat their children, or she completed all instruments in such a way as not to reveal her actual feelings and beliefs. She is atypical of her peer group, and the general literature on parents who maltreat their child, in that she does not have any of the problems that the measures were designed to gauge.

From anecdotal observations and interaction with Participant 04, it is most likely that she filled out the assessment battery in a misleading way. Of particular note is her exit interview, in which she admitted to having an ongoing alcohol problem, a gambling addiction, and a history of sexual abuse and domestic violence. She also admitted to having had long-term depression and having started taking an anti-depression medication within the last two weeks of training.

In addition to the above measurement issues, there were a number of experimental design issues that were problematic. The initial recruitment drive resulted in a low number of referrals and, while the aim of the study was to have 12 participants in each group, the actual number referred was just over half of that number. Given contractual obligations, both the Methodist Mission and the Home & Family Society were under considerable time pressure, and the project had to be started. This meant that to achieve a between group comparison, virtually all participants had to be retained. While great effort was made to retain all subjects, this proved to be an impossible task.

An obvious additional problem was the varying levels of participants' access to their children during the course of this study. Eight of the participants who completed the study actually saw a decrease in their access to their target child. Of these, two (Participants 08 and 09) had their access reduced to sporadic (once or twice a month) supervised access at an access centre, another two (Participants 05 and 06) had not seen their child for over a month just prior to the post-training measure, and another two (Participants 01 and 02) had not seen their child for over month during training and had then had their access limited to sporadic (once or twice a month) supervised access at an access centre. This meant that these parents had limited opportunities to practise what they were learning in the course. It also meant that their self-report data may have based more on recall than recent experience.

Two further limitations of the study were the lack of clear referrals, and dropouts. The majority of referral forms provided little or no information surrounding care and protection issues and, consequently, most of this information about the participants' background was gleaned from participants and their Social Workers through the course of this study. The participants varied with respect to the difficulties which had resulted in their loss of custody. This information, however, was confidential data which was unavailable to the trainers and hence could not be used to tailor training to the needs of individual participants.

Nor could differences in the history of the subjects be used to explain differences in their responses to the training programme. It has been suggested in literature (Oates & Bross, 1995; Jones, 1987) that different types of maltreatment may benefit from different interventions. While the study was only providing one standardised intervention, clearer information surrounding participants' care and protection issues would have helped indicate who in particular this programme is most effective with. Instead only a *blanket statement* that this programme appears to have been "generally ineffective with this group of maltreating parents" could be made. It is possible, for example that the differences noted at baseline, between those participants who dropped out of the programme and those who went on to complete it, may have identified a distinct subgroup of maltreating parents.

The small sample size of this study is also a limitation, in that the power to detect differences between the groups is reduced, and therefore tends to hide what may otherwise have been significant results (Cohen, 1990). Conversely, the number of comparisons in this study also meant that the odds of having a significant result through chance alone were much higher.

While the *t*-test tests for statistically significant differences between the groups over time, it is important to note that it does not detect clinical differences. Although variations might be small between the baseline and post-training phases, they may have resulted in a move from the clinically elevated level on an instrument to within the normal range. Conversely a larger and statistically significant shift may stay within the clinically significant (or normal range) and, as such, not represent any clinically significant change in the group's psychopathology.

Herein lies the problem with the three $p > 0.05$ results found in the baseline and post-training analysis: CAPI Random subscale ($p = 0.031$), PACBM Blame and Intentional attributions in the *Ambiguous* ($p = 0.030$) and Internal attributions in the *Intentional* situation

($p = 0.028$). These results all indicate a statistically significant difference between the groups, but they did not represent any meaningful shift in the group's cognitions. The CAPI result does not represent any change in abuse potential but rather a minor shift in participant's random response to validity items built into the inventory. As the baseline score (3.60) for the random subscale was low to start with (elevated >6), this shift was of even less concern. Both the PACBM subscales score also fell below a level of clinical concern (>3.5) at baseline and their shifts can be seen as representing moves within the disagree spectrum of this scale. Though the Blame and Intentional attribution score, for the Ambiguous situation (3.43), was approaching a level of concern it was nonetheless marginal and did not represent a clear tendency by the group to actually *agree* (≥5) with this attribution.

Although the between group design with single assessment batteries administered was not a limitation of the study, the collapse of the groups meant that the data analysis was problematic. The fact that only single administrations of assessment batteries were taken and the consistency of parents' responses were variable on a day to day basis meant that the results were unable to be analysed on a case by case basis.

Finally, it is important to consider the issues of the programme delivery and trainer differences in this study (Tan, 2002). While the programme was detailed in manuals, the unique issues and needs associated with this parent group, such as learning difficulties and the need for simplification or repetition of materials, meant that it was often difficult to get through each session in the time allocated. Trainers, at times, had to use discretion as to how to condense sessions in order to cover everything necessary. There were also some notable differences in the experience and backgrounds of the trainers for each of the groups, which might have affected their interactions with the group and the presentation of the course material. These variables have implications when the participants' results were placed in a single group for analysis. Nonetheless the researchers felt that the programmes were similar

enough, and that all participants received essentially the same information in the end to justify this decision.

Interpretation of the Results and Exit Interviews findings.

The findings of this study should be viewed tentatively, given issues relating to the limitations of self-report measures, the sample size, statistical validity, and the collapse of the group experimental design. Nevertheless, the results indicated that few changes occurred in either the participants' beliefs or their behaviour (Stebbing, 2003) towards their child during the course of the present study. There are three possible reasons for this:

1. The intervention was effective and resulted in improvement, but these changes were not detected by the procedures used in the present study.
2. The intervention resulted in a stabilising effect rather than an improvement.
3. The intervention had little or no effect on either the beliefs or the behaviour of the participants.

The first possibility seems unlikely. It is true that the sample size was small and that the t-test was lacking in power. However, the differences between the means was so small on many of the measures that it seems unlikely that the training programme had much of an effect.

In addition the effectiveness of the intervention may have been masked by participant factors. Again as indicated in the limitations section it could be argued that this participant population is well versed in impression management. Given this, the participants may have actually significantly improved but, at the same time, become more accurate in their self-reporting due to increased levels of trust and openness with the researchers. From the experience of both researchers, it is possible that this happened to some degree. However, the

validity index indicated that the vast majority of participants were still *faking good* at post-training, which suggests that this was not the key reason for the results.

The intervention may have been effective for some participants and not for others. If one looks at the results on a case-by-case basis, there is some indication that this may have happened. However, as noted earlier, the experimental design and volatile lifestyle of the participants rules out any analysis at the individual level.

The second possible reason for few changes in the results of this study may be that the intervention prevented any further deterioration of the parenting situation. It has been argued that, with high-risk families, a lack of improvement following an intervention may not be a failure but could indicate a stabilising effect for families whose functioning may have otherwise declined further (Ayoub et al., 1992). In fact it is not uncommon for high-risk families to get worse despite treatment (Ayoub, et al., 1992). However, this possibility could only have been examined if a no-treatment control group had been included in the design and this seems unlikely given that eight of the 10 participants actually had access to their child reduced during the course of the present study. This result would seem to imply that as far as CYFS are concerned, the care and protection issues with these participants did not improve and in some cases may have worsened.

The third possibility is that for this specific group of participants, this particular programme was not effective. Given the overall pattern of results, this is the conclusion which has been reached as far as the present study is concerned. This conclusion is consistent with the research literature in this area, which has tended to find that short term treatments for abusive parents have little effect on the parenting behaviour of such parents (Dumas & Albin, 1986; Chalk & King, 1998; Oates & Bross,1995; Ayoub et al., 1992).

Repeatedly the literature has reported no positive treatment outcomes for a small group of parents, which include families with marital problems, low income, high levels of

stress, and depression or other psychopathology, parental substance abuse problems and limited social contact or support (Dadds, 1997; Sander, Markie-Dadds, Tully, & Bor, 2000: Griest et al., 1982; Assemany & McIntosh, 2002). These variables are similar to those associated with risk factors for child maltreatment.

The twelve-week intervention used in this study appears to have underestimated the effects of these variables. In fact, research by Dumas and Albin (1986) argues that SES is a stronger predictor of outcome than attendance in a BPT programme. Dumas and Albin (1986) goes as far as to conclude that "time-limited parent training interventions are likely to fail as long as enduring adverse setting events influence family functioning, no matter how actively parents participate in treatment." (Dumas & Albin, 1986, p.230).

Even if one does view parental skills deficits as a core feature of child maltreatment the implications are far more complex than the simple acquisition of skills. Parenting skills are typically learnt over a lifetime of socialisation, while a short-term parent training programme is an attempt to teach these skills over a few weeks (Tan, 2002). However, with maltreating parents, not only do new skills have to be learnt, but olds ones have to be unlearnt. These maladaptive approaches to parenting are often well embedded in the parent's own history of maltreatment. As such, the parent has psychological issues and needs that need to be dealt with before they can start to unlearn these old values (Mortley, 1998) Given this, one can start to appreciate the futility of attempting to reprogramme a lifetime of maladaptive learning in just a few weeks. As Oates and Bross (1995) succinctly state "when one realise that abusive behaviour has often been learned by parents over several years in their childhood, it becomes clear that treatment ... most likely will have to take place over several years as well" (p.471). Surprisingly, in the exit interviews, the majority of participants saw limitations in the brevity of the intervention. They commented that there was a lot of new information to digest and that the intervention was "too rushed"

Although the use of BPT can be justified given the power of this intervention (Serketich & Dumas, 1996), the advocation of long-term multi-faceted interventions that work with the family's multiple problems with maltreating parents seems more strongly supported in the literature (Ayoub, et al., 1992; Brunk, Henggeler, & Whelan, 1987; Tomison, 1998; Jones, 1987; Land, 1986). Components that have been suggested include treatment of depression, child focussed interventions, therapy regarding abuse triggers, and a focus on treatment barriers.

The training schedule for maltreating parents itself would benefit with changes in the sequence and delivery mode. It has been suggested that the initial approach to an intervention programme with maltreating parents is to improve their mood state and decrease their stress levels and only introduce more materials after they have mastered these skills in emotional regulation (Azar et al., 1998). In addition, difficulties such as resistance to advice, attendance, and compliance issues should be addressed early on in a programme, and problem-solving skills taught to help parents work out strategies to overcome difficulties. No remuneration was offered to any of the parents for attending the initial meeting, subsequent training sessions, or assessment in this study and BPT. Nor did they receive any assistance in the form of childcare or transport expenses. If parents were paid to participate in programmes, this may increase their levels of attendance as well as meeting their real need for more money (Dumas & Albin, 1986).

This group of parents also have a high level of learning difficulties (Tan, 2002). It has been noted that they are less likely to learn from observations and hypothetical discussions, and are more likely to need skills demonstrated in real time with a lot of repetition and information demonstrated in small units.

There also appears to be evidence suggesting the increased efficacy of treatment interventions that include a child focussed component (Tan, 2002). Hect and Hansen (2001)

have recommended that given maltreatment and its associated risk factors for the parent-child relationship it would seem self evident to provide the child with treatment as well as the parents. These authors recommend the necessity for both family therapy to work with relationship problems, and environmental issues, as well as individual treatment to address the issues of psychopathology, and concentrated work with foster parents.

A key concept in working with these parents is the use of a group process. While the group format is used because it is cost effective, its use with maltreating parents is advocated due to the issues of social isolation (Azar et al., 1998). As mentioned earlier, social isolation is a risk factor for maltreatment and has also been identified as a key predictor of the recurrence of maltreatment (Kaplan et al., 1999). This was a notable point in the exit interviews as a positive aspect of the intervention. The benefits of this format include, providing participants with an opportunity to share views and ideas, providing them with support and networks, and help in the development of self-confidence and self esteem. This in turn leads to heightened levels of engagement and increased learning benefits (Tan, 2002). These benefits of the group process were repeatedly echoed by the participants of the current study throughout the exit interview findings. Comments such as "it was great meeting other parents" indicate the importance of the social value to these participants of the group format. Perhaps more significantly, comments such as "it was helpful finding out that I was not the only one" indicate the potential therapeutic benefit of this approach.

Nevertheless it is important to note that Azar et al. (1998) also cautions the need to be careful, given the risk of negative behaviours being modelled to other group members, and general deficits in their social skills affecting the group process. It is also important to note that from the experience of those involved in the administration of this study, it has become clear that while the parents who have had their children removed from them represent a distinct group of parents with their own unique needs and challenges, they also represent an

extremely heterogeneous group with different histories, stressors, and problems that may be quite independent of their current situation.

This has two implications. One, as already mentioned, is the need for a clearer referral and screening process to ascertain which interventions work for whom. The second is the need to ascertain individual intervention needs. Of note is the use in some parent training programmes of a mixture of individual and group formats which would appear to be recommended in this situation (Azar et al., 1998). For although the participants noted the advantages of the group process for them, there was very little benefit seen when it came to cognitive shifts or the application of the skills they learnt to the real world setting. Given the diverse plethora of problems with which each participant presented, combined with their diverse learning impairments, more intensive individualised work would seem to be a sensible adjunct.

The information from the referrals and DASS would tend to suggest that individual therapeutic components that focus on alcohol and drug issues and depression may be of particular benefit. Both of these issues have been implicated as risk factors for maltreatment and for a lack of treatment outcomes (Kinard, 1982; Black et al., 2001; Mammen, et al., 2002; Ayoub et al.,1992). In particular individual therapy may be beneficial if it focussed on the triggers for maltreatment of the child (Azar et al., 1998).

As denial was an additional problem found in this study, it may be that even with a long-term comprehensive approach, these parents may not benefit. Not only are maltreating parents operating in a certain way that needs to be retrained, but many are also denying that they are acting in a certain way, i.e. abusive towards their children. (Scott, 1998; Jones, 1987). As noted in the limitations, many participants spent a lot of time shifting the responsibility for their situation on to someone else (typically CYFS). The consequence of this is the perception that they (maltreating parents) do not need parent training because it is not their problem.

Jones(1987) and Azar et al. (1998) suggest that denial represents a significant roadblock to any intervention, and as such must be overcome first. It could be argued here that the benefits of the group process previously noted could be used as a therapeutic process. That is, it could be beneficial to first provide maltreating parents with a programme of a similar nature to those used for sexual abusers, which would confront these issues.

Having overcome all of these variables, it is possible that due to the multiple needs of maltreating parents and the complex nature of issues surrounding this clinical sub-group, they may need permanent ongoing-care as opposed to specific short-term treatments. This is an approach that has become increasingly vocalised in the literature surrounding severe anti-social behaviour in older adolescents (Kazdin, 1997; Chamberlain & Friman, 1997).

It needs to be remembered that over half of the participants initially selected for this study had already experienced some kind of parent training. This statistic is indicative of the high level of intervention these parents have already had, with little or no success. For example, at least three participants that the researcher is aware of at least three participants who have had intensive individualised parent training. This is not to mention the multitude of other interventions participants in this study have had, including alcohol and drug counselling, gambling addiction counselling, anger management, treatment for depression, relationship counselling, and sexual abuse counselling.

Unfortunately, some parents who have maltreated their children may never regain full custody of their children. Despite repeated and intensive interventions they do not demonstrate any long-term change. Many of the participants who were referred to this study were, by all accounts, already considered by many to be beyond help. They were referred to the training course because the two agencies had requested participants and their Social Workers to attend, and had often excluded all other options.

Although not a view held by the present researcher, it is important to note that some researchers have suggested that there are parents who simply will not benefit from intervention (Jones, 1987; Cohn & Daro, 1987). Jones notes that there may be different reasons why parents do not respond to treatment, ranging from a lack of motivation to change to an inability to change despite their best intentions. This includes parents who are in consistent denial, through to parents who are changing, but too slowly. Even with intensive long-term interventions, up to 50% or more of parents continue to maltreat their children (Cohn & Daro, 1987; Azar et al., 1998). These results have led some writers to the conclusion that it may be best to place resources into "helping the parent understand that it is not safe for their child to live with them" (Jones, 1987, p.410), and that resources would be better spent on preventative interventions that target at risk families much earlier (Cohn & Daro, 1987; Tomison, 1998).

Nevertheless, while it is important to take a preventive approach, problems with current maltreating parents still exist and it is important not to give up hope. Given that New Zealand has a statutory protection agency to prevent parents from causing any further harm to the child, continued attempts should be made to find effective interventions for these parents.

REFERENCES

Abramson, L. Y., Seligman, M. E. P. & Teasdale, J. (1978). Learned helplessness in humans: Critique and reformulation. *Journal of Abnormal Psychology, 87,* 49-74.

Antony, M.M., Bieling, P.J., Cox, B.J., Enns, M.W., & Swinson, R.P. (1998). Psychometric properties of the 42-item and 21-item versions of the Depression Anxiety Stress Scales in clinical groups and a community sample. *Psychological Assessment, 10,* 176-181.

Assemany, A.E., & McIntosh, D.E. (2002). Negative treatment outcomes of behavioral parent training programs. *Psychology in the Schools, 39,* 209-219.

Ayoub, C.C., & Willett, J.B., Robinson, D.S. (1992). Families at risk of child maltreatment: Entry-level characteristics and growth in family functioning during treatment. *Child Abuse & Neglect, 16,* 495-511.

Azar, S.T., Ferraro, M.H., & Breton, S.J. (1998). Intrafamilial child maltreatment. In T.H. Ollendick & M. Hersen (Eds.), *Handbook of child psychopathology* 3rd ed., (pp. 483-504). New York: Plenum Press.

Barnett, D., Manly, J.T., & Cicchetti, D. (1993). Defining child maltreatment: The interface between policy and research. In D. Cicchetti & S.L. Toth (Eds.). (pp. 7-73). Norweed, NJ:Ablex.

Bauer, W. D., & Twentyman, C. T. (1985). Abusing, neglectful, and comparison mothers' response to child-related and non-child-related stressors. *Journal of Consulting and Clinical Psychology, 53,* 335-343.

Black, D.A., Heyman, R.E., & Slep, A.M.S. (2001). Risk factors for child physical abuse. *Aggression and Violent Behavior, 6,* 121-188.

Blinn-Pike, L., & Mingus, S. (2000). The internal consistency of the Child Abuse Potential Inventory with adolescent mothers. *Journal of Adolescence, 23,* 107-111.

Boggs, S.R., Eyberg, S., & Reynolds, L.A. (1990). Concurrent validity of the Eyberg Child Behavior Inventory. *Journal of Clinical Child Psychology, 19,* 75-78.

Brestan, E.V., & Eyberg, S.M. (1998). Effective psychosocial treatments of conduct-disordered children and adolescents: 29 years, 82 studies, and 5,272 kids. *Journal of Clinical Child Psychology, 27,* 180-189.

Bronfenbrenner, U. (1989). Ecological systems theory. In R. Vasta (Ed.), *Annals of Child Development Vol. 6* (pp. 187-249). Greenwich, CT: JAI Press.

Brown, T.A., Chorpita, B.F., Korotitsch, W., & Barlow, D.H. (1997). Psychometric properties of the Depression Anxiety Stress Scales (DASS) in clinical samples. *Behaviour Research and Therapy, 35,* 79-89.

Brunk, M., Henggeler, S.W., & Whelan, J.P. (1987). Comparison of Multisystemic Therapy and parent training in the brief treatment of child abuse and neglect. *Journal of Consulting and Clinical Psychology, 55*, 171-178.

Bugental, D.B., Blue, J., & Cruzcosa, M. (1989). Perceived control over caregiving outcomes: Implications for child abuse. *Developmental Psychology, 25,* 532-539.

Bugental, D.B., & Johnston, C. (2000). Parental and child cognitions in the context of the family. *Annual Review of Psychology, 51,* 315-344.

Bugental, D.B., Mantyla, S.M. & Lewis, J. (1989). Parental attributions as moderators of affective communication to children at risk for physical abuse. In D. Cicchetti & V. Carlson (Eds.), *Child maltreatment: Theory and research on the causes and consequences of child abuse and neglect.* New York: Cambridge University Press.

Chalk, R. & King, P.A (Eds.) (1998*). Violence in families: Assessing prevention and treatment programs.* National Academy Press: Washington DC.

Chamberlain, P., & Friman, P. C. (1997). Residential programs for antisocial children and adolescents. In D. M. Stoff, J. Breiling, & J. D. Maser (Eds.), *Handbook of antisocial behaviour* (pp. 416-424). New York: John Wiley & Sons.

Children, Young Persons, and their Families Act (1989). Retrieved October 23, 2002, from http://www.rangi.knowledge-basket.co.nz/gpacts/public/text/1989/an/024.html.

Cohen, J. (1990). Things I have learnt so far. *American Psychologist, 45*, 1304-1312.

Cohn, A.H., & Daro, D. (1987). Is treatment too late: What ten years of evaluative research tell us. *Child Abuse & Neglect, 11*, 433-442.

Dadds, M.R. (1997). Conduct disorder. In R.T. Ammerman & M. Harsens (Eds.), *Handbook of prevention and treatment with children and adolescents: Intervention in the real world context* (pp. 521-550). New York: John Wiley & Sons.

Department of Child, Youth and Family Services. (2003). *Personal communication with Garth Young, CYFS, 6 February, 2002.* Unpublished client statistic.

Dix, T. (1991). The affective organization of parenting: Adaptive and maladaptive processes. *Psychological Bulletin, 110*, 3-25.

Dix, T. (1993). Attributing dispositions to children: An interactional analysis of attributions in socialization. *Personality & Social Psychology Bulletin, 19*, 633-643.

Dix, T., & Grusec, J. (1985). Parent attribution processes in the socialization of children. In I. E. Sigel (Ed.), *Parental belief systems* (pp, 201-233). Hillsdale, NJ: Erlbaum.

Dumas, J.E., & Albin, J.B. (1986). Parent training outcome: Does active parental involvement matter? *Behaviour Research & Therapy, 24*, 227-230.

Elley, W. B., & Irving, J.C. (in press). The Elley-Irving socio-economic index: 2001 census revision. *New Zealand Journal of Educational Studies.*

Eyberg, S. M., & Pincus, D. (1999). *Eyberg Child Behavior Inventory and Sutter-Eyberg Student Behavior Inventory revised: Professional manual.* Odessa, FL: Psychological Assessment Resources.

Griest, D.L., Forehand, R., Rogers, T., Breiner, J., Furey, W., & Williams, C.A. (1982). Effects of parent enhancement therapy on the treatment outcome and generalization of parent training program. *Behaviour, Research, & Therapy, 20,* 429-436.

Hansen, D.J., Sedlar, G., & DeRoma, V. (1998). *Manual for the PAI: The Parental Anger Inventory.* Lincoln, NB: CPTP.

Hecht, D.B., & Hansen, D.J. (2001). The environment of child maltreatment contextual factors and the development of psychopathology. *Aggression and Violent Behavior, 6,* 443-157.

Heider, F. (1958). *The psychology of interpersonal relations.* New York: Wiley.

Iwaniec, D. (1997). Evaluating parent training for emotionally abusive and neglectful parents: Comparing individual versus individual and group intervention. *Research on Social Work Practice, 7,* 329-349.

Jenson, C.E., Green, R.G., Singh, N.N., Best, A.M., Ellis C.R. (1998). Parental attributions of the causes of their children's behavior. *Journal of Child and Family Studies, 7,* 205-215.

Joiner, T.E., & Wagner, K.D. (1996). Parental, child-centred attributions and outcome: A meta-analytic Review with conceptual and methodological implications. *Journal of Abnormal Child Psychology, 24,* 37-52.

Jones, D. P. H. (1987). The untreatable family. *Child Abuse & Neglect*, 11, 409-420.

Kaplan, S.J., Pelcovitz, D., & Labruna, V. (1999). Child and adolescent abuse and neglect research: A review of the past 10 years. Part 1: Physical and emotional abuse and neglect. *Journal of the American Academy of Child and Adolescent Psychiatry, 38,* 1214-1222.

Kaufman, J., & Zigler, E. (1989). The intergenerational transmission of child abuse. In D. Cicchetti & V. Carlson (Eds.), *Child maltreatment: Theory and research on the causes and consequences of child abuse and neglect* (pp. 129-150). New York: Cambridge University Press.

Kazdin, A. E. (1997). Parent management training: Evidence, outcomes, and issues. *Journal of the American Academy of Child and Adolescent Psychiatry, 36,* 1349-1356.

Kinard, E.M. (1982). Child abuse and depression: Cause or consequence? *Child Welfare, 61,* 403-413.

Land, H.M. (1986). Child abuse: Differential diagnosis, differential treatment. *Child Welfare, 65,* 33-44.

Lovibond, S.H., & Lovibond, P.F. (1995). *Manual for the depression anxiety stress scales* (2nd ed.). Sydney: Psychology Foundation of Australia.

McMahon, R.J. (1999). Parent Training. In S.W. Russ & T. Ollendick (Eds.), *Handbook of Psychotherapies with children and families* (pp. 153-180). New York: Plenum Press.

McMahon, R.J., & Forehand, R. (1988). Conduct disorders. In E. J. Mash & L.G. Terdal (Eds.), *Behavioral assessment of childhood disorders* (2nd ed., pp. 105-153). New York: Guildford Press.

Mammen, O.K., Kolko, D.J., & Pilkonis, P.A. (2002). Negative affect and parental aggression in child physical abuse. *Child Abuse & Neglect, 26,* 407-424.

Miller, S.A. (1995). Parents' attributions for their children's behavior. *Child Development, 66,* 1557-1584.

Milner, J.S. (1986). *The Child Abuse Potential Inventory: Manual.* (2nd ed.). DeKalb, IL: Psytec Inc.

Milner, J.S. (1994). Assessing physical child abuse risk: The child abuse potential inventory. *Clinical Psychology Review, 14,* 547-583.

Mortley, E. (1998). "Good enough" parenting: The role of parenting education. *Monograph No 170,* Norwich: Social Work Monographs.

Oates, R.K., & Bross, D.C. (1995). What have we learned about treating child physical abuse? A literature review of the last decade. *Child Abuse & Neglect, 19,* 463-473.

Patterson, G.R. (1982). Coercive family processes. Eugene, Oregon: Castalia Press.

Patterson, G .R., Reid, J. B., & Dishion, T. J. (1992). *A social learning approach. Vol. 4. Antisocial boys.* Eugene, Oregon: Castalia Press.

Peterson, L., Gable, S., Doyle, C., & Ewigman, B. (1997). Beyond parenting skills: Battling barriers and building bonds to prevent child abuse and neglect. *Cognitive and Behavioural Practice, 4,* 53-74.

Reid, J.B. (1993). Prevention of conduct disorder before and after school entry: Relating interventions to developmental findings. *Development and Psychopathology,* 5, 243-262.

Reid, J. B., Baldwin, D. V., Patterson, G. R, & Dishion, T. (1987). Some problems relating to the assessment of childhood disorders: a role for observational data. In M. Rutter, H. Tums, and I. Lann (Eds.), *Assessment and Diagnosis in Child and Adolescent Psychopathology* (pp. 156-195). New York: Guilford Press.

Rodriguez, C.M., & Green, A.J. (1997). Parenting stress and anger expression as predictors of child abuse potential. *Child Abuse & Neglect, 21,* 367-377.

Rogosch, F.A., Cicchetti, D., Shields, A., & Toth, S.L. (1995). Parenting dysfunction in child maltreatment. In M.H. Bornstein (Ed). *Handbook of parenting: Vol. 4. Applied and practical parenting* (pp. 127-159). Mahwah, NJ: Lawrence Erlbaum Associates.

Rosenberg, S.D., & Reppucci, N. D. (1983). Abusive mothers: Perceptions of their own and their children's behavior. *Journal of Consulting and Clinical Psychology, 51,* 674-682.

Sanders, M.R. (1999). Triple P - Positive Parenting Programme: Towards an empirically validated multilevel parenting and family support strategy for the prevention of behavior and emotional problems in children. *Clinical Child and Family Psychology Review, 2,* 71-90.

Sanders, M.R., & Cann, W. (2002). Promoting positive parenting as an abuse prevention strategy. In K. Browne, H. Hanks, P. Stratton, & C. Hamilton (Eds.). *Early prediction and prevention of child abuse.* (pp. 145-163). London: Wiley & Sons.

Sanders, M.R., Gravestock, F., Pidgeon, A., Connors, M.D. & Brown, S. (2002). *Does parental attributional retraining and anger management enhance the effects of the Triple P - Positive Parenting Program with parents at-risk of child maltreatment?* Manuscript submitted for publication.

Sanders, M.R., Markie-Dadds, C., Tully, L.A., & Bor, W. (2000). The Tripe P - Positive Parenting Program: A comparison of enhanced, standard, and self-directed behavioural family interventions for parents of children with early onset conduct problems. *Journal of Consulting and Clinical Psychology, 68,* 624-640.

Schumacher, J.A., Slep, A.M.S., & Heyman, R.E. (2001). Risk factors for child neglect. *Aggression and Violent Behavior, 6,* 231-254.

Schwarz, N. (1999). Self-reports: How the questions shape the answers. *American Psychologist, 54,* 93-105.

Scott, S. (1998). Intensive interventions to improve parenting. *Archives of Diseases in Childhood, 79,* 90-93.

Sedlar, G., & Hansen, D.J. (2001). Anger, child behavior, and family distress: Further evaluation of the parental anger inventory. *Journal of Family Violence, 16,* 361-373.

Serketich, W.J., & Dumas, J. E. (1996). The effectiveness of Behavioral Parent Training to modify antisocial behaviour in children: A meta-analysis. *Behavior Therapy, 27,*171-186. Southam-Greow, M.A., & Kendall, P.C. (2002). Emotion regulation and understanding implications for child psychopathology and therapy. *Clinical Psychology Review, 22,* 189-222.

Stebbing, D. (2003). *Parent training for high-risk parents: A behavioural evaluation of the Triple P Pathways programme.* Unpublished master's dissertation, University of Canterbury, Christchurch, New Zealand.

Tan, R. (2002). *A literature review of parenting programmes.* Manuscript submitted for publication.

Taylor, T.K., & Biglan, A. (1998). Behavioral family interventions for improving child-rearing: A review of the literature for clinicians and policy makers. *Clinical Child and Family Psychology, 1,* 41-61.

Tomison, A.M. (1998). Valuing parent education: A cornerstone of child abuse prevention. *Issues in Child Abuse Prevention,* (Number 10). Melbourne: Australian Institute of Family Studies.

Twentyman, C.T., & Plotkin, R.C. (1982). Unrealistic expectations of parents who maltreat their children: An educational deficit that pertains to child development. *Journal of Clinical Psychology, 38,* 497-503.

Weiner , B. (1985). An attributional theory of achievement motivation and emotion. *Psychological Review, 92,* 548-573.

Whipple, E.E., & Wilson, S.R. (1996). Evaluation of a parent education and support program for families at risk of physical child abuse. *Families in society: The Journal of Contemporary Human Services, 4,* 227-239.

APPENDIX 1

REFERRAL LETTER

Name of Project: Parent Works: Evaluation study

Name of Researchers: David Stebbing & Shane Stevenson

Dear

Thank you for agreeing to take part in this research project. It is really important to us that you understand the purpose of this study, and fully appreciate the value we place on your involvement. We hope this letter will go someway to answering any questions you may have regarding the project, and also your involvement in it.

ABOUT THE PROJECT

The aim of this study is to help us better understand how we can successfully assist parents to enhance and develop their parenting skills. You have been given the opportunity to experience this first hand through the parenting courses that will be run for you. For the parenting programme, parents will be put into one of two groups. Each group will be taught a variety of important skills that will help them to improve their parenting practices. **Each group will receive the same skills training, but the order in which you will be taught will vary between the two groups.** The reason for this is to enable us to see which parts of each programme are most helpful for parents. At the end of the programme, parents in each group will have completed the same training but in a different order.

WHAT IS EXPECTED OF YOU?

To allow us to understand how the project is working out for everyone, we will be meeting with you on a number of different occasions.

- Initially we will arrange a group meeting with you and the other parents before the programme starts. **You have the choice of two dates to attend this first meeting; either Monday the 29nd of April between 12:30 and 2:30pm, or Wednesday the 1st of May between 4:00 and 6:00pm.** We will be contacting you by phone over the next few days to confirm when you will be attending.
- In this meeting we will run through a questionnaire, talk with you about what you hope to get out of the programme, give you an opportunity to ask any questions, and confirm a time to meet with you at your home to observe you and your child during a meal time.
- The questionnaire will involve you letting us know what your child is currently like (e.g. Do they yell or fight lots?). It will also involve questions about why you think your child might behave in certain ways in various situations (e.g. Possible reasons why your child may refuse to come inside when asked). These questions don't involve you having to write anything, you only have to circle a box indicating how much you agree or disagree with the statement, or alternatively circle a box indicating how often a certain behaviour occurs.
- The observation will involve us providing you with a set of basic guidelines to follow that centre around typical meal time activities. This will involve encouraging your child to assist in setting the table before the meal, remaining seated during the meal and helping clean up after the meal. The guidelines that will be provided for you will depend on the age of your child (e.g. simple for younger children and more complex for older children). This session will be video taped so we can record your progress.

- After 8, and then 12 weeks of training, we will give you another questionnaire and visit you and your child at home as before. During the last meeting we will talk with you about what you thought of the programme.
- It is important to us that you do not find the experience of being video taped and/or completing the questionnaires stressful. If you find taking part in either of these activities raises issues for you we are available to discuss your concerns.
- It is important that you are available for all 3 questionnaire sessions and all 3 home visits. This means a total time commitment for you of approximately 6 hours over the entire length of the study.

WHAT WILL HAPPEN TO THE INFORMATION YOU GIVE US?

We want you to understand that we are not employed by Child Youth and Family Services (CYFS), Home and Family Service, or by Methodist Mission Child Wise. We are students from the University of Canterbury working with the Methodist Mission Child Wise, and Home and Family Service to find out how helpful the parenting programme is. The information you give us will be used for two purposes. Firstly, it will be used by the programme directors to assess the progress that you have made following the completion of sections of the training programme. Secondly, the information that you provide will enable an overall evaluation to be done of the programme.

All the information that we collect from you during this study will be treated with the utmost respect and confidentiality. All questionnaires and videotapes will be locked away, and viewed only by us and our university supervisors. Once the information we need has been gathered, your videotapes and questionnaires will be destroyed. At the end of this study there will be no way to identify you or your child as an individual in our thesis or any other reports that may be published.

If you have any immediate problems or concerns, we are able to be contacted by you leaving a message with the receptionist at the Methodist Mission (366-6745).

Sincerely yours,

David Stebbing
Postgraduate Student
Education Department
University of Canterbury

Shane Stevenson
Postgraduate Student
Education Department
University of Canterbury

APPENDIX 2

PACBM INSTRUMENTS

Directions:
Please read the situation below. Imagine your child performing each behaviour, and then take some time to think about what would cause your child to behave in the way described. Next read the statements that follow each situation. Please circle the number on each scale that indicates how strongly you disagree or agree with each statement.

Situation 1- Imagine your child is playing with his/her friend in the next room and you think you hear them fighting. You ask your child what's going on but there is no reply. You go into the room to check, and at that moment your child hits their friend.

	disagree strongly	disagree	disagree	agree somewhat	agree	agree strongly
1. My child's behaviour is due to something about my child; for example, because that's the way she or he is.	1	2	3	4	5	6
2. The reason my child hit their friend is because my child was thinking only of herself or himself.	1	2	3	4	5	6
3. The reason for my child behaving this way also affects other areas of my relationship with my child: for example, other things I could say or do to my child.	1	2	3	4	5	6
4. My child intended to hit their friend on purpose.	1	2	3	4	5	6
5. My child's behaviour is due to the circumstances of the situation; for example, who was there, where it happened, and when it happened.	1	2	3	4	5	6
6. My child deserves to be blamed for hitting their friend.	1	2	3	4	5	6
7. My child's behaviour is due to something about me for example, the way I manage my child's behaviour.	1	2	3	4	5	6
8. The reason my child hit their friend is unlikely to change	1	2	3	4	5	6

Situation 2- Imagine shortly after you punish your child, you tell her/him to play quietly with his/her toys. Very soon after this instruction your child stands up, looks you in the eye, throws a toy at an expensive ornament breaks it, and then runs away.

	disagree strongly	disagree	disagree	agree somewhat	agree	agree strongly
1. My child's behaviour is due to something about my child for example; because that's the way she or he is.	1	2	3	4	5	6
2. The reason for my child's behaviour is because my child was thinking only of herself or himself.	1	2	3	4	5	6
3. The reason for my child behaving this way also affects other areas of my relationship with my child: for example; other things I could say or do to my child.	1	2	3	4	5	6
4. My child intended to behave this way on purpose.	1	2	3	4	5	6
5. My child's behaviour is due to the circumstances of the situation; for example; who was there; where it happened and when it happened.	1	2	3	4	5	6
6. My child deserves to be blamed for their behaviour.	1	2	3	4	5	6
7. My child's behaviour is due to something about me: for example the way I manage my child's behaviour.	1	2	3	4	5	6
8. The reason my child behaved this way is unlikely to change.	1	2	3	4	5	6

Situation 3- Imagine you are in the supermarket and your child asks you for a ride on the merry-go-round. You say "No, I have not got any money for rides today". Your child reacts by hitting you.

	disagree strongly	disagree	disagree	agree somewhat	agree	agree strongly
1. My child's behaviour is due to something about my child; for example because that's the way she or he is.	1	2	3	4	5	6
2. The reason my child hit me is because my child was thinking only of herself or himself.	1	2	3	4	5	6
3. The reason for my child behaving in this way also affects other areas of my relationship with my child: for example, other things I could say or do to my child.	1	2	3	4	5	6
4. My child intended to hit me on purpose.	1	2	3	4	5	6
5. My child's behaviour is due to the circumstances of the situation: for example, who was there, where it happened; and when it happened.	1	2	3	4	5	6
6. My child deserves to be blamed for hitting me.	1	2	3	4	5	6
7. My child's behaviour is due to something about me; for example, the way I manage my child's behaviour.	1	2	3	4	5	6
8. The reason my child hit me is unlikely to change.	1	2	3	4	5	6

Situation 4- Imagine after being told to come inside twice, your child responds angrily "No, I'm not coming, I don't have to".

	disagree strongly	disagree	disagree	agree somewhat	agree	agree strongly
1. My child's behaviour is due to something about my child; for example because that's the way she or he is.	1	2	3	4	5	6
2. The reason my child behaved this way is because my child was thinking only of herself or himself;	1	2	3	4	5	6
3. The reason my child behaved this way also affects other areas of my relationship with my child; for example; other things I could say or do to my child.	1	2	3	4	5	6
4. My child intended to behave this way on purpose.	1	2	3	4	5	6
5. My child's behaviour is due to the circumstances of the situation; for example; who was there; where it happened; and when it happened.	1	2	3	4	5	6
6. My child deserves to be blamed for their behaviour.	1	2	3	4	5	6
7. My child's behaviour is due to something about me; for example; the way I manage my child's behaviour;	1	2	3	4	5	6
8. The reason my child behaved this way is unlikely to change.	1	2	3	4	5	6

Situation 5- Imagine your child is playing outside with a friend, you call out to your child to come inside but he/she doesn't respond.

		disagree strongly	disagree	disagree	agree somewhat	agree	agree strongly
1.	My child's behaviour is due to something about my child, for example, because that's the way she or he is.	1	2	3	4	5	6
2.	The reason my child behaved this way is because my child was thinking only of herself or himself.	1	2	3	4	5	6
3.	The reason for my child behaving in this way also affects other areas of my relationship with my child; for example, other things I could say or do to my child.	1	2	3	4	5	6
4.	My child intended to behave this way on purpose.	1	2	3	4	5	6
5.	My child's behaviour is due to the circumstances of the situation, for example who was there, where it happened, and when it happened.	1	2	3	4	5	6
6.	My child deserves to be blamed for their behaviour.	1	2	3	4	5	6
7.	My child's behaviour is due to something about me, for example, the way I manage my child's behaviour.	1	2	3	4	5	6
8.	The reason my child behaved this way is unlikely to change.	1	2	3	4	5	6

Situation 6- Imagine you leave your child and his/her friend in the next room to play for a while. After a few minutes you decide to check and see how things are going with the kids. At that moment you see your child throw a toy which breaks an expensive ornament.

		disagree strongly	disagree	disagree	agree somewhat	agree	agree strongly
1.	My child's behaviour is due to something about my child; for example, because that's the way she or he is.	1	2	3	4	5	6
2.	The reason my child threw a toy which broke an expensive ornament is because my child was thinking only of herself or himself.	1	2	3	4	5	6
3.	The reason my child threw a toy which broke an expensive ornament also affects other areas of my relationship with my child; for example like other things I could say or do to my child.	1	2	3	4	5	6
4.	My child intended to throw a toy, which broke an expensive ornament on purpose.	1	2	3	4	5	6
5.	My child's behaviour is due to the circumstances of the situation; for example, who was there, where it happened, and when it happened.	1	2	3	4	5	6
6.	My child deserves to be blamed for throwing a toy, which broke an expensive ornament.	1	2	3	4	5	6
7.	My child's behaviour is due to something about me; for example, the way I manage my child's behaviour.	1	2	3	4	5	6
8.	The reason my child threw a toy which broke an expensive ornament is unlikely to change.	1	2	3	4	5	6

APPENDIX 3

QUESTIONNAIRE RESULTS

	GROUP 1											
	P 01	P 02	P 03	P 04	P 05	P 06	P 07	Total Grp 1	Mean Grp1	STDEV Grp 1	Mean P01-10	STDEV P01-10
ECBI												
Intensity 1	153 *	134 *	110	56	131 *	103	112	799	114.14	30.86	119.60	31.61
Intensity 2	123	115	82	69	124 +	91	133 *	737	105.29	24.46	99.10	24.96
Intensity 3	136 *	125 +	109	72	124	124	144 *	834	119.14	23.48	117.60	30.17
Problem 1	17 *	21 *	10	0	27 *	19 *	15 *	109	15.57 *	8.64	14.70 +	8.34
Problem 2	15 *	10	3	0	20 *	12	18 *	78	11.14	7.45	8.60	7.55
Problem 3	14 +	12	5	0	21 *	26 *	15 *	93	13.29	8.86	13.90	8.97
DASS												
Depression 1	42 e	16 m	22 s	6	4	4	8	102	14.57 m	13.84	17.80 m	13.93
Depression 2	36 e	14 m	10 m i	0	14 m	22 s	21 s	117	16.71	11.24	12.70 mi	11.39
Depression 3	34 e	10 mi	20 m	0	14 m	21 s	22 s	121	17.29 m	10.69	15.40 m	11.03
Anxiety 1	42 e	6	10 m	2	0	16 s	2	78	11.14 m	14.69	11.20 m	12.87
Anxiety 2	38 e	2	6	0	12 m	22 e	6	86	12.29	13.49	10.20 m	12.31
Anxiety 3	38 e	2	6	0	12 m	20 e	8 m i	86	12.29 m	13.14	11.00 m	11.40
Stress 1	42 e	16 mi	20 m	8	4	6	24 m	120	17.14 mi	13.26	17.40 mi	12.65
Stress 2	36 e	16 mi	14 +	0	16 m i	18 mi	28 s	128	18.29	11.34	15.00 mi	12.23
Stress 3	34 e	10	10	0	14 +	22 m	20 m	110	15.71 mi	10.86	16.00 mi	10.75
PAI												
Intensity 1	131	91	89	50	74	74	81	590	84.29	24.66	88.50	24.39
Intensity 2	97	100	98	50	98	160 *	97	700	100.00	31.95	93.20	28.30
Intensity 3	120	117	86	53	91	150 *	99	716	102.29	30.66	100.90	26.47
Problem 1	27	19	26	21	19	13	21	146	20.86	4.71	22.70	5.01
Problem 2	25	13	26	4	37	33	32	170	24.29	11.83	22.30	10.20
Problem 3	30	12	25	18	23	38	21	167	23.86	8.40	24.40	7.32
PACBM												
Stable												
Abmiguous 1	3 2/3 *	3	3	2	3	3	1 1/3	19	2.71	0.78	2.57	0.69
Abmiguous 2	2 2/3	3 2/3 *	2	1 1/3	3	3	2	17.7	2.52	0.79	2.30	0.74
Abmiguous 3	2 2/3	5 *	1 1/3	1	3	2 1/3	3	18.3	2.62	1.31	2.30	1.21
Intentional 1	2 2/3	2 1/3	5 *	2	3	3 1/3	1 2/3	20	2.86	1.10	2.83	0.92
Intentional 2	2 1/3	3	1 1/3	1	3	2 1/3	2	15	2.14	0.77	2.07	0.64
Intentional 3	2 1/3	5 *	2	1	3	3	2	18.3	2.62	1.25	2.30	1.17
Combined 1	3 1/6	2 5/6	4 *	2	3	3 1/6	1 1/2	19.7	2.81	0.82	2.67	0.73
Combined 2	2 1/2	3 1/3	1 2/3	1 1/6	3	2 2/3	2	16.3	2.33	0.76	2.18	0.67
Combined 3	2	5	1 2/3	1	3	2 2/3	2 1/2	17.8	2.55	1.27	2.25	1.17
Blame/Intent												
Abmiguous 1	4 *	3	3 2/3 *	2 2/3	3	4 *	4 1/3 *	24.7	3.52 *	0.63	3.43 +	0.77
Abmiguous 2	3 2/3 *	3	3	5 *	3	3	3 1/3	24	3.43 +	0.74	3.17	0.86
Abmiguous 3	3 2/3 *	2	1	2	3	3 1/3	2 1/3	17.3	2.48	0.92	2.53	1.12
Intentional 1	5 *	2 1/6	3 1/3	2 1/3	3	3 1/3	4 1/3 *	23.5	3.36	1.02	3.35 +	0.89
Intentional 2	4 1/3 *	3 1/6	2 1/6	5 *	3	3	4 2/3 *	25.3	3.62 *	1.05	3.27	1.12
Intentional 3	4 1/6 *	2	2 1/3	5 *	3	3 2/3 *	3 1/3	23.5	3.36	1.04	3.05	1.00
Combined 1	4 2/3 *	2 4/9	3 4/9 +	2 4/9	3	3 5/9 *	4 1/3 *	23.9	3.41 +	0.86	3.38 +	0.79
Combined 2	4 1/9 *	3 1/9	2 4/9	5 *	3	3	4 1/6 *	24.8	3.55 *	0.90	3.23	1.00
Combined 3	4 *	2	1 8/9	4 *	3	3 5/9 *	3	21.4	3.06	0.87	2.88	0.87
Internal												
Abmiguous 1	4 2/3 *	3 1/3	3	2	3 1/3	1 1/3	1 1/3	19	2.71	1.23	2.66	1.04
Abmiguous 2	3 1/3	3	2	1	3	2	2 2/3	17	2.43	0.81	2.27	0.78
Abmiguous 3	3 2/3 *	2	3	1	3	2	2	16.7	2.38	0.89	2.30	0.84
Intentional 1	4 2/3 *	3 1/3	3	2	3 1/3	2 2/3	2	21	3.00	0.92	2.93	0.80
Intentional 2	4 1/3 *	3	1 2/3	1	3	3	3	19	2.71	1.08	2.47	1.02
Intentional 3	4 *	2	3	1	3	2 2/3	3	18.7	2.67	0.94	2.43	0.93
Combined 1	4 2/3 *	3 1/3	3	2	3 1/3	2	1 2/3	20	2.86	1.05	2.80	0.89
Combined 2	3 5/6 *	3	1 5/6	1	3	2 1/2	2 5/6	18	2.57	0.92	2.37	0.88
Combined 3	3 2/3 *	2	3	1	3	2 1/2	2 1/2	17.7	2.52	0.85	2.37	0.82

Note. For these tables the * symbol represents scores that are within the elevated or clinical range of the measure. The + symbol represents that the score is approaching this level.

	GROUP 1											
	P 01	P 02	P 03	P 04	P 05	P 06	P 07	Total Grp 1	Mean Grp1	STDEV Grp 1	Mean P01-10	STDEV P01-10
CAPI - Validity												
Lie 1	7 *	7 *	9 *	7 *	8 *	9 *	2	49	7.00 *	2.38	6.50 +	3.06
Lie 2	8 *	8 *	7 *	8 *	9 *	7 *	2	49	7.00 *	2.31	6.70 +	3.16
Lie 3	6 +	7 *	7 *	8 *	9 *	3	3	43	6.14	2.34	6.50 +	3.34
Random 1	4	5 +	2	3	2	5 +	1	22	3.14	1.57	3.60	2.22
Random 2	2	4	3	1	3	5 +	2	20	2.86	1.35	3.10	1.37
Random 3	0	5 +	1	1	3	1	1	12	1.71	1.70	2.00	1.56
Inconsistency 1	8 *	4	9 *	4	8 *	8 *	2	43	6.14 *	2.73	6.90 *	3.18
Inconsistency 2	5 +	0	5 +	7 *	10 *	6 *	8 *	41	5.86 -	3.13	6.20 *	2.90
Inconsistency 3	4	2	4	7 *	10 *	11 *	5 +	43	6.14 *	3.34	6.00 *	3.27
Validity Index												
Faking 1	-	Good	Good	Good	Good	Good	-					
Faking 2	Good	Good	Good	Good	Good	Good	-					
Faking 3	-	Good	Good	Good	Good	-	-					
CAPI - Abuse												
Abuse 1	151	132	190	63	289 *	354 *	167	1346	192.29	98.49	222.00 *	100.37
Abuse 2	281 *	31	305 *	58	323 *	298 *	209 +	1505	215.00 *	122.17	213.50	123.36
Abuse 3	316 *	35	384 *	61	287 *	307 *	119	1509	215.57 *	140.08	222.90 *	128.66
Ego 1	24	23	22	37	7	11	17	141	20.14	9.81	17.30	10.58
Ego 2	7	35	11	37	12	17	14	133	19.00	12.01	18.80	12.35
Ego 3	3	39	4	37	10	14	23	130	18.57	14.86	17.30	13.97
Loneliness 1	4	5	8	2	14	10	10	53	7.57	4.16	8.50	4.20
Loneliness 2	11	3	11	3	14	9	12	63	9.00	4.36	8.90	4.20
Loneliness 3	12	0	13	4	14	9	7	59	8.43	5.13	8.80	4.73
Factor Scores												
Distress 1	100	95	105	0	215 *	181 *	124	820	117.14	68.74	135.40	74.94
Distress 2	219 *	7	199 *	0	181 *	161 *	155 *	922	131.71 +	90.26	126.30	93.00
Distress 3	236 *	6	230 *	0	187 *	157 *	97	913	130.43 +	98.81	135.30	94.01
Rigidity 1	0	0	23	5	18	55 *	0	101	14.43	20.19	17.90	20.06
Rigidity 2	0	0	26	30 *	31 *	51 *	4	142	20.29	19.47	20.50	18.77
Rigidity 3	4	0	21	22	23	56 *	0	126	18.00	19.74	15.10	17.07
Unhappiness 1	11	19	28 *	8	22 +	37 *	16	141	20.14 +	9.99	22.90 *	9.46
Unhappiness 2	8	3	47 *	10	51 *	24 *	22 +	165	23.57 *	18.95	23.40	19.07
Unhappiness 3	35 *	19	62 *	8	24 *	19	14	181	25.86 *	18.01	25.30 *	15.68
Problems												
Child/Self 1	20 *	10 +	10 +	1	12 *	30 *	7	90	12.86 *	9.46	11.40 *	8.49
Child/Self 2	20 *	0	8	1	19 *	21 *	7	76	10.86 +	9.04	8.90	8.62
Child/Self 3	10 +	10 +	18 *	1	18 *	21 *	7	85	12.14 +	7.15	11.00 *	7.01
Family 1	7	0	1	38 *	6	37 *	0	89	12.71	17.16	16.40	16.12
Family 2	13	0	0	6	18 *	37 *	1	75	10.71	13.51	14.60	14.67
Family 3	19 *	0	32 *	19 *	12	38 *	1	121	17.29 +	14.40	21.60 *	14.60
Others 1	13	8	23 *	11	16	14	20 *	105	15.00	5.16	17.00	5.35
Others 2	21 *	21 *	21 *	11	23 *	4	22 *	123	17.57 +	7.21	19.10	6.38
Others 3	21 *	0	21 *	11	23 *	16	0	92	13.14	9.82	15.50	8.96

Note. For these tables the * symbol represents scores that are within the elevated or clinical range of the measure. The + symbol represents that the score is approaching this level.

	GROUP 2											
	P 08	P 09	P 10	P 11	P 12	P 13	Total P11-13	Mean P11-13	STDEV P11-13	Total Grp 2	Mean Grp2	STDEV Grp2
ECBI												
Intensity 1	161 *	92	144 *	159 *	232 *	162 *	553	184 *	41.31	950	158.33 *	44.84
Intensity 2	81	110	63							254	84.67	23.71
Intensity 3	165 *	110	67							342	114.00	49.12
Problem 1	23 *	7	8	16 *	34 *	24 *	74	24.7 *	9.02	112	18.67 *	10.39
Problem 2	0	7	1							8	2.67	3.79
Problem 3	27 *	14 +	5							46	15.33 *	11.06
DASS												
Depression 1	40 e	22 s	14 m	24 s	22 s	28 e	74	24.7 s	3.06	150	25.00 s	8.65
Depression 2	2	8	0							10	3.33	4.16
Depression 3	25 s	8	0							33	11.00 mi	12.77
Anxiety 1	18 s	16 s	0	10 m	10 m	12 m	32	10.7	1.15	66	11.00 m	6.29
Anxiety 2	0	16 s	0							16	5.33	9.24
Anxiety 3	12 m	12 m	0							24	8.00	6.93
Stress 1	26 s	26 s	2	20 m	26 s	18 mi	64	21.3 m	4.16	118	19.67 m	9.33
Stress 2	0	22 m	0							22	7.33	12.70
Stress 3	26 s	22 m	2							50	16.67 mi	12.86
PAI												
Intensity 1	113	113	69	119	230 *	162 *	511	170 *	55.97	806	134.33 +	55.37
Intensity 2	77	78	77							232	77.33	0.58
Intensity 3	118	88	87							293	97.67	17.62
Problem 1	26	30	25	19	45	28	92	30.7	13.20	173	28.83	8.75
Problem 2	18	16	19							53	17.67	1.53
Problem 3	27	20	30							77	25.67	5.13
PACBM												
Stable												
Abmiguous 1	2 1/3	2 1/3	2	3	5 1/3 *	3	11.3	3.78 *	1.35	18	3.00	1.21
Abmiguous 2	1 2/3	2	1 2/3							5.33	1.78	0.19
Abmiguous 3	1	1 2/3	2							4.67	1.56	0.51
Intentional 1	2 1/3	3	3	3 2/3 *	5 *	4 *	12.8	4.26 *	0.75	21.1	3.52 *	0.97
Intentional 2	2	2	1 2/3							5.67	1.89	0.19
Intentional 3	1	1 2/3	2							4.67	1.56	0.51
Combined 1	2 1/3	2 2/3	2	3 1/3	5 1/6 *	3 1/2 *	12	4 *	1.01	19	3.17	1.14
Combined 2	1 5/6	2	1 2/3							5.5	1.83	0.17
Combined 3	1	1 2/3	2							4.67	1.56	0.51
Blame/Intent												
Abmiguous 1	4 1/3 *	3 1/3	2	3 2/3 *	5 1/3 *	4 2/3 *	13.7	4.56 *	0.84	23.3	3.89 *	1.17
Abmiguous 2	3 2/3 *	2	2							7.67	2.56	0.96
Abmiguous 3	1 1/3	4 2/3 *	2							8	2.67	1.76
Intentional 1	3 1/3	4 *	2 2/3	3 1/3	5 1/3 *	5 1/6 *	13.8	4.61 *	1.11	23.8	3.97 *	1.08
Intentional 2	3 1/2 *	2 1/6	1 2/3							7.33	2.44	0.95
Intentional 3	2 1/6	2 5/6	2							7	2.33	0.44
Combined 1	3 2/3 *	3 7/9 *	2 4/9	3 4/9 +	5 1/3 *	5 *	13.8	4.59 *	1.01	23.7	3.94 *	1.06
Combined 2	3 5/9 *	2 1/9	1 7/9							7.44	2.48	0.94
Combined 3	1 8/9	3 4/9 +	2							7.33	2.44	0.87
Internal												
Abmiguous 1	2 2/3	3	2	4 2/3 *	6 *	2 1/3	13	4.33 *	1.86	20.7	3.44 +	1.56
Abmiguous 2	1 1/3	2 2/3	1 2/3							5.67	1.89	0.69
Abmiguous 3	1 1/3	3	2							6.33	2.11	0.84
Intentional 1	2 1/3	3 1/3	2 2/3	4 1/3 *	6 *	2	12.3	4.11 *	2.01	20.7	3.44 +	1.50
Intentional 2	1 1/3	2 2/3	1 2/3							5.67	1.89	0.69
Intentional 3	1	2 1/3	2 1/3							5.67	1.89	0.77
Combined 1	2 1/2	3 1/6	2 2/7	4 1/2 *	6 *	2 1/6	12.7	4.22 *	1.93	20.6	3.44 +	1.52
Combined 2	1 1/3	2 2/3	1 2/3							5.67	1.89	0.69
Combined 3	1 1/6	2 2/3	2 1/6							6	2.00	0.76

Note. For these tables the * symbol represents scores that are within the elevated or clinical range of the measure. The + symbol represents that the score is approaching this level.

	GROUP 2											
	P 08	P 09	P 10	P 11	P 12	P 13	Total P11-13	Mean P11-13	STDEV P11-13	Total Grp 2	Mean Grp2	STDEV Grp2
CAPI - Validity												
Lie 1	0	7 *	9 *	2	11 *	7 *	20	6.67 +	4.51	36	6.00 +	4.20
Lie 2	0	8 *	10 *							18	6.00 +	5.29
Lie 3	1	9 *	12 *							22	7.33 *	5.69
Random 1	1	8 *	5 +	2	2	4	8	2.67	1.15	22	3.67	2.58
Random 2	4	2	5 +							11	3.67	1.53
Random 3	2	2	4							8	2.67	1.15
Inconsistency 1	5 +	8 *	13 *	7 *	7 *	5 +	19	6.33 *	1.15	45	7.50 *	2.95
Inconsistency 2	4	8 *	9 *							21	7.00 *	2.65
Inconsistency 3	3	4	10 *							17	5.67 +	3.79
Validity Index												
Faking 1	-	Random	Good	-	Good	Good						
Faking 2	-	Good	Good									
Faking 3	-	Good	Good									
CAPI -Abuse												
Abuse 1	369 *	215 *	290 *	421 *	229 *	181	831	277 *	127.00	1705	284.17 *	94.26
Abuse 2	379 *	173	78							630	210.00 +	153.87
Abuse 3	356 *	252 *	112							720	240.00 *	122.44
Ego 1	0	22	10	2	19	20	41	13.7	10.12	73	12.17	9.60
Ego 2	0	27	28							55	18.33	15.89
Ego 3	0	15	28							43	14.33	14.01
Loneliness 1	14	6	12	13	10	8	31	10.3	2.52	63	10.50	3.08
Loneliness 2	14	7	5							26	8.67	4.73
Loneliness 3	14	10	5							29	9.67	4.51
Factor Scores												
Distress 1	249 *	84	201 *	260 *	117	67	444	148 +	100.16	978	163.00 *	84.64
Distress 2	249 *	66	26							341	113.67	118.90
Distress 3	249 *	144 +	47							440	146.67 +	101.03
Rigidity 1	18	50 *	10	55 *	33 *	14	102	34 *	20.52	180	30.00 *	19.15
Rigidity 2	13	45 *	5							63	21.00	21.17
Rigidity 3	4	16	5							25	8.33	6.66
Unhappiness 1	32 *	31 *	25 *	33 *	10	28 *	71	23.7 *	12.10	159	26.50 *	8.60
Unhappiness 2	50 *	13	6							69	23.00 *	23.64
Unhappiness 3	29 *	32 *	11							72	24.00 *	11.36
Problems												
Child/Self 1	9	2	13 *	30 *	15 *	11 *	56	18.7 *	10.02	80	13.33 *	9.31
Child/Self 2	1	0	12 *							13	4.33	6.66
Child/Self 3	13 *	0	12 *							25	8.33	7.23
Family 1	38 *	18 *	19 *	19 *	32 *	38 *	89	29.7 *	9.71	164	27.33 *	9.75
Family 2	38 *	26 *	7							71	23.67 *	15.63
Family 3	38 *	38 *	19 *							95	31.67 *	10.97
Others 1	23 *	20 *	22 *	24 *	22 *	23 *	69	23 *	1.00	134	22.33 *	1.37
Others 2	23 *	23 *	22 *							68	22.67 *	0.58
Others 3	23 *	22 *	18							63	21.00 *	2.65

Note. For these tables the * symbol represents scores that are within the elevated or clinical range of the measure. The + symbol represents that the score is approaching this level.