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The Strong Families Program: Differential Impacts of Resilience and Parent Management Training

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THE STRONG FAMILIES PROGRAM: DIFFERENTIAL IMPACTS OF RESILIENCE AND
PARENT MANAGEMENT TRAINING

by

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ABSTRACT

Childhood behavior problems are pervasive with 50% of non-referred families citing noncompliance and behavior problems as an issue (Achenbach & Edelbrock, 1981). Many behavioral parent trainings (BPTs) treat these behaviors at an early age. Recently, adaptions to BPTs include group formats increasing accessibility and decreasing cost, especially for rural families with limited resources (Niec, Barnett, Prewett, & Stanley Chatham, 2016). Beyond BPTs, Alvord, Zucker, and Johnson Grados (2011) developed the Resilience Builder Program to enhance children's social, emotional, and behavioral skills through a cognitive behavioral framework. The Resilience Builder Program improves anxious and depressive symptoms and reduces behavior problems in children (Watson, Rich, Sanchez, O'Brien, & Alvord, 2013). Although researchers (Borden, Schultz, Herman, & Brooks, 2010) theorized about the suitability for combining BPTs and resilience training, no such study examining the combination of these interventions exists to date. The current study sought to examine the effectiveness of a group treatment combining BPT and resilience training on reducing parental stress and child externalizing behaviors and increasing children's resilience. A six-week group treatment format consisting of a parent training only group (e.g., Standard Group) and a parent training plus resilience group (e.g., Resilience Group) was utilized to determine the change in child externalizing behaviors, parental stress, and resilience. Multiple 2 (Group Type: Standard; Resilience) X 3 (Time: pre-; mid-; post) factorial ANOVAs were used to analyze the data. Results demonstrated no significant interactions between Group Type (Standard; Resilience) X Time (pre-; mid-; post) for parent stress, children's resilience, or children's externalizing behaviors. Significant main effects of Time were found across groups demonstrating a significant decrease in parental stress and children's externalizing behaviors, and a significant increase in children's resilience. However, when child age was included as a covariate, these effects did not hold. While there are limitations based on sample size ($N = 15$) and a lack of control group, there appears to be promising support for using shortened, group-based interventions in the treatment of externalizing behaviors among children. These results indicate BPT alone may be effective in increasing childhood resilience. Future research should aim to address limitations.

INDEX WORDS: Behavioral parent training; Resiliency; Rurality; Child behavior problems

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CHAPTER 1

INTRODUCTION

Statement of Problem

Childhood behavior problems (i.e., noncompliance) are a concern for approximately 50% of non-referred families with children aged four to seven years (Achenbach & Edelbrock, 1981). While no child complies 100% of the time, noncompliance in children can escalate into diagnosable conditions (e.g., Oppositional Defiance Disorder, Conduct Disorder). Beyond clinical diagnoses, research demonstrates noncompliance as an early starter pathway of lifetime conduct problems (Patterson, Campbell, & Bank, 1991). This pathway begins with noncompliance in childhood and, if untreated, may progress to more serious conduct problems such as stealing, fighting, and substance abuse. Additionally, as the individual's behavior problems escalate, the environmental range of where these behavior problems occur widens from home to school to the community at large.

Frequent noncompliance can result in children who are not socially or behaviorally prepared for school. One study demonstrated kindergarteners who displayed low levels of social and behavioral school-readiness were more likely to be held back a grade, require further services through an Individualized Education Plan (IEP), and be suspended and expelled compared to kindergarteners with higher levels of social and behavioral school-readiness (Bettencourt, Gross, & Ho, 2016). Concurrently, peer groups developed at school are more likely to maintain these deviant behaviors and escalate conduct problems throughout adolescence (Dishion, Patterson, Stoolmiller, & Skinner, 1991). Conduct problems have high comorbidity with depression and boys with both conduct problems and depressive symptoms display higher levels of suicidal ideation and substance use than those with only depression (Capaldi, 1991).

Later in life, individuals with conduct problems are at risk for developing various psychological diagnoses, including anti-social personality disorder, and having poor occupational adjustment (Farrington, 2003; Kratzer & Hodgins, 1997). Thus, untreated noncompliance in childhood will likely continue into adolescence which is associated with a wide variety of negative outcomes in mental, physical, social, and educational domains.

While children who engage in noncompliant behavior are at higher risk for a wide array of issues, parents of these children also experience increased distress. Specifically, parents of children with behavior problems experience increased parental stress compared with parents of children who do not present with behavior problems (Dumas, Wolf, Fisman, & Culligan, 1991). Paradoxically, parents' behaviors may inadvertently play a role in the development of child behavior problems through the coercive process. Patterson (1982) developed a coercion theory to explain how child behavior problems develop and are maintained through inadvertent parental reinforcement (e.g., negative attention and escape from demands following child misbehavior or noncompliance). This coercive process reinforces child noncompliance which then causes parents to escalate their demands at which point the child is forced to comply, reinforcing the parents' escalation of demands. Therefore, there are numerous consequences to childhood behavior problems for both the child and the parent which are often developed and maintained through a coercive process of demands and reinforcement.

Fortunately, many treatment options exist to ameliorate childhood behavior problems with early intervention demonstrating the best prognosis. Specifically, behavioral parent training (BPTs) implementing social learning, attachment theory, and behavioral principles are effective in improving child behavior problems (McMahon & Forehand, 2005). These BPT programs are designed to intervene with children at a young age to minimize noncompliant behaviors and

maximize the parent-child relationship. Evidence-based BPTs include Parent-Child Interaction Therapy (McNeil & Hembree-Kigin, 2010), The Incredible Years (Webster-Stratton, 2005), Helping the Noncompliant Child (McMahon & Forehand, 2003), and Triple P Positive Parenting Program (Sanders, 1999).

Based on the work of Diana Baumrind (1966, 1967) many BPT programs combine social learning theories and attachment theories to achieve authoritative parenting. For example, BPTs emphasize the use of play therapy skills including praise, reflection, imitation, description, and enthusiasm (i.e., PRIDE skills; McNeil & Hembree-Kigin, 2010) to develop the parent-child relationship. Social learning theory, particularly coercion theory, dictates the importance of limit setting and follow through to reverse the learned contingency of escalation between parents and children. Thus, through the combination of social learning theory and attachment theory BPTs aim to develop authoritative parenting styles. Moreover, Baumrind's (1966, 1967) research demonstrated authoritative parenting is associated with the most positive childhood outcomes and teaching parents skills based on social learning theory and attachment theory is an effective way to develop authoritative parenting styles.

In combination with attachment and social learning theory skills proposed by Baumrind, effective BPTs integrate the use of differential reinforcement as outlined by Constance Hanf (1969). Hanf emphasized behavioral principles to achieve compliance. Common features of BPTs include teaching parents the importance and application of differential reinforcement, giving good instructions, consistent consequences (i.e., time out) for noncompliance, and consistent rewards for compliance. Overall, the combination of attachment theory, social learning theory, and behavioral principles are effective in the treatment of noncompliant

behaviors, oppositional defiant disorder, and conduct disorder (McMahon & Forehand, 2005; McNeil & Hembree-Kigin, 2010; Webster-Stratton, 1990).

Purpose

The purpose of the current study was to examine the efficacy of parent management training in a shortened group format. If a short-term group delivery effectively reduces child noncompliance, beneficial treatment options could be more readily available for individuals from rural or lower income communities. A shortened group treatment offers a more cost-effective option than traditional individual treatment or longer group treatment formats. Additionally, the current study examined the effects of adding a resilience training component on child behavior problems, parental stress, and resilience (i.e., Resilience Group, see Method) versus the effects of a parent management only group (i.e., Standard Group, see Method). We expected child behavior problems and parental stress would decrease in both the Standard Group and the Resilience Group. However, we expected greater decreases in Externalizing behavior in the Resilience group with exploratory analyses being conducted regarding resilience interventions and parental stress. Additionally, we expected measures of resilience to increase in the Resilience group and remain stable in the Standard group.

Definition of Terms

Noncompliant Behaviors. Child behavior problems are commonly divided into two categories: noncompliant behaviors and disruptive behaviors. Disruptive behaviors involve children doing what they are told *not* to do and noncompliant behaviors involve children not doing what they are told *to* do (McNeil and Hembree-Kigin, 2010). Operationally, compliance can be defined as the "appropriate following of an instruction to perform a specific response within a reasonable and/or designated time" (Schoen, 1983, p. 493 as cited in McMahon and

Forehand, 2005). Behaviors are deemed noncompliant if the child does not comply within five seconds of an instruction. In this way, disruptive behaviors can also be viewed as noncompliant as children are violating an instruction (e.g., do not hit). Therefore, the current study referred to all child behavior problems as "noncompliant behaviors" to avoid confusion.

Resilience. Resilience is often theorized as a trait which only occurs after a trauma. However, researchers recently shifted the focus on resilience toward a skill which can be learned and strengthened through internal and external factors (Abramson, Park, Stehling-Ariza, & Redlener, 2010; Masten & Monn, 2015; Ungar, 2013). For the purpose of the current study, resilience was defined as "a set of skills and characteristics that allows individuals to adjust and cope effectively with life's challenges" (Alvord, Zucker, & Grados, 2011, p. 1). The current study focused on the following components of resilience: optimistic thinking, stress management, self-regulation, self-esteem, and empathy.

CHAPTER 2

LITERATURE REVIEW

Rationale for Parent Training

Disruptive behavior in childhood is one of the most common mental health referrals (Kazdin et al., 1995) and is linked with lifelong negative consequences including physical aggression and criminality (Broidy et al., 2003; Farrington, 2003). The Diagnostic and Statistical Manual, Fifth Edition (DSM-5) denotes two main categories of behavior problems in which noncompliance is the major concern: Oppositional Defiant Disorder and Conduct Disorder. Beyond these diagnoses, parents of children diagnosed with Attention Deficit/Hyperactivity Disorder (ADHD) and Autism Spectrum Disorder often report concerns regarding noncompliance. The prevalence rate for these disorders using DSM-IV criteria are: ADHD – 5%, Conduct Disorder – 2 to 10%, and Oppositional Defiant Disorder – 1 to 11% (American Psychiatric Association, 2013).

Regardless of diagnosis, caregivers often experience increased stress as a result of their children's noncompliant behaviors (Capaldi et al., 2002). Fortunately, parental behavior (e.g., discipline strategies) is suggested as a mediating factor in the relationship between child behavior problems and parental stress (Forgatch, Patterson, & Skinner, 1988). Therefore, parents can and should seek intervention in developing their behavior management skills when faced with noncompliant behaviors from their children. In addition to diagnosable conditions, many children display sub-clinical non-compliance concerns which also create caregiver stress and are amenable to treatment with similar techniques as those used for children experiencing clinically significant levels of noncompliant behaviors (McMahon & Forehand, 2005).

There are numerous methods for clinicians and caregivers to use to treat childhood behavior problems. However, the interventions with the most empirical support for childhood behavior problems (e.g., Parent-Child Interaction Therapy, The Incredible Years, Helping the Non-compliant Child) stem from the work of Constance Hanf at the Oregon Social Learning Center (Hanf, 1969; McMahon & Forehand, 2005). The Hanf model combines attachment, social learning, and behavioral theories to focus treatment strategies on increasing the quality of the caregiver-child relationship followed by implementing strict, consistent discipline. These discipline strategies are utilized through differential reinforcement strategies for compliance versus noncompliance (Hanf, 1969). Additionally, caregivers are taught these skills for use in the child's environment for maximum generalization. Caregiver involvement in treatment differs from individual therapy with the child, which may not generalize to the caregiver or other settings.

Although caregiver involvement varies by treatment modality, all evidenced-based BPTs are grounded in similar theories. Attachment theory, social learning theory, and behavioral principles all provide important influences in developing a strong parent-child relationship in combination with an effective discipline program. Bowlby's attachment theory (2005) highlights the importance of parental warmth and responsiveness to the child's needs which is facilitated through the use of play therapy skills (e.g., PRIDE skills, "catch them being good," attending skills) to develop a secure attachment (McNeil & Hembree-Kigin, 2010). The grounding of BPTs in attachment theory is supplemented by social learning theory principles.

Bandura (1977) proposed a theoretical shift from pure behaviorism to social learning theory in which individuals learn from others through imitation, modeling, and observation. Additionally, social learning theory highlights the importance of reinforcement and punishment

on changing behavior. One key component of social learning theory as it relates to BPT revolves around Patterson's (1982) coercion theory. Developed in an attempt to explain negative escalations in parent-child interactions, coercion theory posits children and parents negatively reinforce the escalation of the other party. For example, children's noncompliance is negatively reinforced when parents withdraw demands to comply and the child escapes the demand. However, as the child's negative behaviors escalate, parents become more frustrated until they achieve compliance through negative means (e.g., spanking, yelling) at which point their escalation is negatively reinforced as the child complies. Many BPT programs combine attachment and social learning theories in an attempt to teach authoritative parenting.

Diana Baumrind (1966, 1967) highlighted the importance of integrating attachment theory and social learning theory to achieve the nurturance and limit setting required by authoritative parenting. Achieving authoritative parenting is an important treatment goal as authoritative parenting is associated with improved outcomes in adolescence including better grades and increased self-reliance as well as lower levels of anxiety, depression, and externalizing behaviors (Steinberg, Mounts, Lamborn, & Dornbusch, 1991). In addition to the theoretical groundwork provided by attachment theory and social learning theory, BPT relies heavily on the principles of behaviorism with an emphasis on differential reinforcement as outlined by Constance Hanf (1969). Specifically, BPT programs teach parents to reward compliance and use the consistent implementation of discipline procedures (i.e., time out) to achieve compliance.

Many caregiver training programs are only offered in an individual treatment format, with the exception of Webster-Stratton's The Incredible Years program. However, the efficacy of Parent-Child Interaction Therapy (PCIT) was recently examined in a group format with

promising results (Lyon & Budd, 2010; Niec, Barnett, Prewett, & Chatham, 2016). A randomized clinical trial of group PCIT suggests delivering PCIT in a group format is similarly efficacious to the individual treatment format (Niec et al., 2016). These results are promising as delivering PCIT in a group format offers more practical, cost-effective treatment opportunities for individuals from rural communities or low socioeconomic status backgrounds. In addition, a group format is useful in any area with a dearth of qualified therapists trained in the implementation of these interventions as a group treatment reaches more individuals in the same amount of time.

Offering behavior management programs in a group format offers solutions for many individuals who struggle with obtaining services. For example, there is a shortage of trained mental health professionals offering these interventions and families often drop out of individual treatment. Scarcity of resources and high attrition rates result in approximately 67% of children who would benefit from these programs not receiving the appropriate treatment services (Kazdin, 2008; Satcher, 2000). Individuals within rural communities may have even less access to resources and may be forced to travel long distances to receive these specialized treatments (Smalley, Warren, & Rainer, 2012; Arcury, Preisser, Gesler, & Powers, 2005). Cost is also another barrier for low income families who may be unable to afford individual psychotherapy. Offering behavior management programs in a group format offers solutions for many of these barriers as efficacious treatments can be disseminated to multiple families at once while dividing the cost among families. Additionally, families may receive positive support from one another leading to decreased attrition rates. Therefore, the numerous potential benefits of a group BPT program should continue to be explored.

The randomized clinical trials for group format PCIT utilized the manualized standards for individual PCIT as well as the same 14-session format. However, both studies reported high attrition rates with the mean number of sessions completed in the trials as six (Lyon & Budd, 2010; Niec et al., 2016). The literature demonstrates group PCIT is an efficacious option to maximize opportunities for a more diverse population of clientele. However, it is unclear if using a shorter term for the group format is as efficacious as the 14-week format. A shorter format, if similarly effective, would further expand the availability of evidenced based treatment for families who are unable to commit to the longer format. Thus, in an attempt to minimize attrition and maximize treatment gains, the current study used a six-session design similar to Forehand and Long's (2010) abbreviated program used for individual families.

For the purpose of this study, we followed the Hanf model (1969) and focused on improving the caregiver-child relationship followed by the implementation of strict, consistent discipline. In Phase One of treatment, caregivers were taught play therapy skills (e.g., PRIDE skills, "catch them being good," attending skills) to increase positive interactions with their children. Concurrently, selective attention and modeling strategies were used to combine behavioral and social learning techniques to provide positive attention for behaviors parents want to increase. Further, caregivers were taught to ignore undesirable behaviors in line with differential reinforcement procedures. During Phase Two, caregivers were taught strict, consistent discipline strategies consisting of family rules, giving effective instructions, and time-out procedures.

Resilience

Resilience has been a topic of interest and debate within the psychological community as disagreement exists about the necessity of a traumatic event to demonstrate resilience. For

example, some researchers consider resilience to be a trait only realized after a trauma (e.g.,

Ungar, 2013). However, other researchers focus instead on the concept of resilience as

adaptation and thriving regardless of the presence of trauma (Donnon & Hammond, 2007;

Masten, 2001; Masten et al., 1990). Additionally, resilience can be influenced by external and

internal factors (Brownlee et al., 2013). External resilience factors represent any outside

influences on a child (e.g., parents, peers, school) while internal factors are comprised of

individual characteristics such as self-esteem. For the purpose of this study, resilience was

defined without regard to trauma and focused on internal, personal qualities and strengths which

can be developed such as optimistic thinking, stress management, empathy, self-esteem, and self-

regulation. However, as the current study was conducted with small children, parents were

concurrently taught the information as a means to facilitate the use of external influences as well.

The concept of resilience denotes a shift from determining progress through the absence

of symptoms and in turn promotes adaptive growth through positivistic and strength-based

measurements such as well-being and flourishing (Masten, 2014). Resilience is recognized as a

protective factor and refers to the ability to adapt successfully to challenges (Masten & Monn,

2015). Stemming from Bronfenbrenner's (1986) ecological model of child development, Masten

and Monn (2015) argue for the conceptualization of resilience on both the individual and family

level demonstrating the importance of examining the holistic impact of the environment on

resilience. Moreover, a child's family, school, and community accounts for more variance in

childhood resilience than individual characteristics (Abramson, Park, Stehling-Ariza, &

Redlener, 2010; Ungar, 2013; Ungar, 2015). Furthermore, even when accounting for individual

differences, environments which are conducive to the development of resilience can facilitate

changes in developmental pathways (Ungar, 2013). Given the importance of these systems on a

child's development, there is an opportunity for these same systems to promote resilience and well-being and prevent negative outcomes. Therefore, by educating parents about ways to increase resilient traits in their children and provide environments conducive to the development of resilience, the likelihood of positively influencing the developmental trajectory of children can be increased.

Although childhood resilience is increasing in recognition, defining resilience in childhood remains difficult due to the larger debate of how to define resilience generally. However, McCormick, Kuo, and Masten (2011) identified resilience in childhood as the adaptation to challenges with a focus on positive development in accordance with developmental milestones. Building from this definition of resilience, Alford, Zucker, and Johnson-Grados (2011) developed the Resilience Builder Program for Children and Adolescents to develop resilience skills and increase protective factors among children and teens. Specifically, the program addresses self-regulation (affective and behavioral), social skills and problem solving, flexibility, and proactive orientation as well as other resilience skills in a group format. The Resilience Builder Program has been effective in decreasing anxious and depressive symptoms as well as improving social, emotional, and overall family functioning (Watson, Rich, Sanchez, O'Brien, & Alvord, 2013). The Watson et al. (2013) study also found an improvement in problem behaviors reported by teachers and parents. Borden, Shultz, Herman, and Brooks (2010) discussed the suitability of the Incredible Years program, a specific behavioral parent training program, as a model for incorporating resilience into its preventive group format as improving parenting skills and the parent-child relationship can serve as an asset in enhancing resilience. However, no such study had examined the effectiveness of combining resilience training and behavioral parent management training into one treatment. As such, the current study utilized the

Resilience Builder Program to determine if incorporating resilience training through psychoeducation as part of a parent behavior management treatment would increase resilience and contribute to diminished externalizing behavior concerns among children.

Current Study

  Hypotheses. The current study examined treatment changes following a 6-week caregiver behavior management program implemented in a group format. In addition, comparisons were made between a behavior management only group and a behavior management plus resilience training group. Please see the Method section and Appendix A for a description of the two programs. The current study had specific hypotheses related to changes in children's behaviors and parental stress. Additionally, while the current study did not directly compare a longer vs. shorter group format, it was hypothesized that information about behavior changes from the beginning to end of group treatment provides preliminary support for the usefulness of a shorter group format.

  Hypothesis 1: Child externalizing behaviors would decrease from baseline to mid-treatment and post-treatment assessments for both clinical groups [i.e., Standard Parent Management Training Group ("Standard" Group) or Resilience Parent Management Training Group ("Resilience" Group)], consistent with previous research on the efficacy of behavior management programs presented in group format (Lyon & Budd, 2010; Niec et al., 2016). As both groups received effective behavior management training, child behavior problems were expected to decrease over the course of treatment. It was predicted that children in the Resilience Group would experience a greater decrease in externalizing behaviors compared to those in the Standard Group as the Resilience Builder Program was shown to decrease behavior problems (Watson et al., 2013).

Hypothesis 2: Caregiver stress would decrease from baseline to mid-treatment and post-treatment assessments for both clinical groups (i.e., Standard and Resilience Groups) consistent with previous research on the impact of behavior management programs on caregiver stress (Pisterman et al., 1992). Exploratory analyses were conducted as it was unknown if resilience interventions would decrease parental stress beyond the decreases expected as a result of the parent management training.

Hypothesis 3: Resilience would increase more for those in the Resilience Group compared to the Standard Group. Resilience ratings were expected to increase in the Resilience Group at mid-treatment and post-treatment assessments while the Standard Group's scores were expected to remain stable across time.

CHAPTER 3

METHOD

The current study utilized a mixed model design to compare treatment changes across time between the Standard Group and the Resilience Group. Group differences in parental stress as well as parent-rated measures of resilience and overall child behavior problems were examined. The study was conducted in a brief group format (e.g., six weeks) designed to determine if short-term parent management training could serve as an accessible option for rural families who may not have access to long-term treatment options.

Participants

Data were collected from families in or near a rural, southeastern city. Participants were recruited from the community (e.g., pediatrician's offices, child care centers, HeadStart office, Boys and Girls clubs) via advertisements. Inclusion criteria for parent behavior management psychoeducational groups, as outlined by Neiter, Thornberry, and Brestan-Knight (2012), required families to have a child between the ages of two and eight, be primarily English speakers, have legal custody of the child, and be seeking services independently. Following recruitment, 22 families initially signed up to participate. Most of these families (15) attended and completed at least one session, with eight families attending all six sessions. Seven families attended five sessions, one family attended four sessions, two families attended three sessions, and four families only attended the first session. One family who attended only the first session did not fully complete the measures which yielded invalid results and they were excluded from the analyses.

Initially, 11 families were assigned to each group type (i.e., Standard or Resilience), with seven families completing the program in the Standard group and eight families completing the

program in the Resilience group. Generally, the child's mother attended groups and completed

the self-report measures ($n = 20$) about their child and their family. For two families, the child's

grandmother attended groups and completed the measures. Nine families reported an annual

household income below $40,000 and ten families reported an annual household income between

$40,000 and $80,000 annually; three families did not report their annual income. Most families

($n = 13$) reported current head of family employment, with eight families reporting current

unemployment; one family did not report their current employment status. Additionally, six of

the parents completing measures were high school graduates, ten were college graduates, and

five reported some higher educational experience. Parents reported identifying with the

following ethnicities: Caucasian ($n = 12$), African-American ($n = 5$), Asian ($n = 2$), or Other

Ethnic Group ($n = 1$). Children who participated in the study were primarily male ($n = 14$) and

the average age was 5.5 years ($SD = 1.72$).

This study consisted of four six-week treatment groups. Two groups occurred

concurrently on different weeknights, one for each condition, over 3 rounds. At pre-treatment,

mid-treatment, and post-treatment, participants completed the Parenting Stress Index (PSI) and

the Behavior Assessment System for Children, Third Edition (BASC-3). In addition, at pre-

treatment, families completed demographic information (see Appendix B) and at post-treatment

they completed a program evaluation (see Appendix C). Family dyads received $15 for the

completion of measures at each assessment period. These funds were provided from a Georgia

Southern University Graduate Student Organization (GSO) research grant.

Procedure

Due to limited availability in the evenings, families self-selected the night they would

attend the group but were blind to their group's condition (e.g., Standard or Resilience) and the

night each group type was held was rotated to minimize self-selection bias. For example, the Resilience group was held on Mondays and the Standard group was held on Wednesdays during round one with the order being reversed in round two. Each group met once a week for six weeks; however, due to school holidays, each group took a one week break during treatment. Doctoral students in the clinical psychology program, supervised by a licensed psychologist, were the direct providers for the psychoeducational groups and were counterbalanced across the three rounds of group treatments. The Standard Group met for approximately 90 minutes and the Resilience Group met for 120 minutes each week, which allowed for the addition of resilience training. Measures were completed at pre-treatment, mid-treatment, and post-treatment. Each session in both the Standard and Resilience Groups consisted of psychoeducation on behavior management skills, time for practicing these skills, and (for certain sessions) coaching of these skills. In addition, the Resilience group also included psychoeducation on a resilience skill.

Each family dyad had 20 minutes of individual coaching with one of the two co-therapists in sessions where coaching was planned. During coaching sessions, families who were waiting for their coaching time remained together practicing their skills with trained research assistants. These research assistants consisted of doctoral, masters, and undergraduate students who were trained in the implementation of PRIDE skills. These assistants helped facilitate families' practice by modeling PRIDE skills and providing limited feedback on a rotating basis. However, research assistants were instructed to refrain from providing extended feedback to ensure families only received 20 minutes of direct coaching per week. At the end of each coaching session, parents were given individualized feedback on skills performed well as well as areas for improvement. At the final group, participants were debriefed and were provided with individual recommendations for continued behavioral gains and, if needed, references for

continued treatment. Please see Appendix A for a session-by-session guide for each group. All study interventions were conducted under the supervision of a licensed psychologist who has extensive training in delivering the treatment techniques.

Measures

  Behavior Assessment System for Children, Third Edition (BASC-3; Reynolds & Kamphaus, 2015). The BASC-3 is designed for use with individuals ages 2 to 25 and includes self-report, parent-rating, and teacher-rating scales. The Parent Rating Scales (PRS) was used as a measure of Externalizing Problems (Aggression, Conduct Problems, and Hyperactivity subscales) as well as child resilience (Resilience and Emotional Self-Control subscales). The Aggression subscale is comprised of 9 items, the Hyperactivity subscale contains 11 items, and the Conduct Problems 10 subscale has items. The Resilience and Emotional Self-Control subscales are on the Content Scales section and are made up of 9 and 10 items, respectively. Subscale and composite scores are based on a normative population that can be separated by gender, age, or clinical status; the normative data for a non-clinical, combined sample of girls and boys was utilized for this study. The PRS items are presented on a 4-point Likert scale ranging from *Never* to *Almost Always*; however, the number of items vary based on the form used. For example, the PRS-Preschool form has 139 total items while the PRS-Child form is comprised of 175 total items. The PRS shows strong internal consistency (Cronbach alpha ~ .90) and test-retest reliability (Cronbach alpha .78 to .92), as well as convergent, divergent, and concurrent validity.

  Parenting Stress Index, Fourth Edition – Short Form (PSI-4-SF; Abidin, 2012). The PSI-4-SF is a 36-item self-report inventory with items rated on a 5 point Likert scale (1 = *Strongly Agree* and 5 = *Strongly Disagree*). The PSI-4-SF underwent minor changes to improve

the cultural sensitivity of the language used as well revise any items based on demonstrable psychometric or conceptual improvement (Abidin, 2012). The PSI-SF has adequate test-retest reliability ($\alpha = .76$) and internality consistency ($\alpha = .85$), as well as adequate construct and content validity with trauma populations (Larson, 2004; Timmer, Sedlar, & Urquiza, 2004) as well as with diverse populations varying on race/ethnicity, income, and child's diagnosis (Button, Pianta, & Marvin, 2001; Smith, Oliver, & Innocenti, 2001; Tomanik, Harris, & Hawkins, 2004; Waisbren et al., 2004). Additionally, the PSI-SF is psychometrically valid with a low-income, minority population and the three-factor model examining the parental distress, difficult child, and parent-child dysfunctional interaction subscales was supported (Reitman, Currier, & Stickle, 2002). Due to the extensive research on the reliability and validity of the Parenting Stress Index and the Parenting Stress Index-Short Form, the PSI's authors did not conduct additional studies with the PSI-4-SF (Abidin, 2012).

Demographics. Parents provided demographic information about who lives in the home as well as ages, race/ethnicity, and relationship to the identified child for treatment. Parents were also asked to complete information regarding their income and educational level as well as their mental health history and any current mental health diagnoses, services, or concerns for their child. Please see Appendix B.

Program Evaluation. At the end of treatment, parents were asked to complete a program evaluation developed by the author. Questions were designed to gauge participant opinions regarding therapist characteristics, the session length and number of sessions, relevancy and engagement in group topics, as well as an overall evaluation of perceived impact on the parents, child, and family. Please see Appendix C.

CHAPTER FOUR

RESULTS

Preliminary Analyses

Due to the inability to randomly assign participants to condition, preliminary analyses were conducted to ensure the Standard and Resilience groups were equivalent on measures of Externalizing behaviors, Parental Stress, and Resilience prior to the beginning of treatment. Three independent sample t-tests were used to analyze the data. No group differences were found at pre-treatment for Resilience ($t(19) = .68$, $p = .50$), Externalizing behavior ($t(19) = .35$, $p = .73$), or Parental Stress ($t(19) = .26$, $p = .80$). Specifically, the Standard Group ($M = 38.3$, $SD = 10.20$) and the Resilience group ($M = 35.73$, $SD = 6.92$) both showed deficits in Resilience at comparable levels, with both groups falling in the "at risk" range on the BASC-3. Similarly, Externalizing behaviors approached the clinically significant cutoff of 70 on the BASC-3 for both the Standard ($M = 67.8$, $SD = 14.48$) and Resilience ($M = 65.72$, $SD = 12.89$) groups. Finally, both groups scored in the clinically significant range on the PSI-4-SF indicating high levels of Parental Stress in both the Standard ($M = 99.4$, $SD = 26.4$) and Resilience ($M = 96.46$, $SD = 26.23$) groups.

Additionally, seven families did not complete the study, so analyses were completed to better understand the impact of attrition. A One Way Multivariate Analysis of Variance (MANOVA) was conducted to determine if there were any differences between families who completed the program versus those who did not in reported levels of Externalizing Behaviors, Parental Stress, and Resilience at the pre-treatment evaluation. The overall MANOVA was not significant, Wilks $\Lambda = .89$, $F(3, 17) = .70$, $p = .56$ indicating no significant difference in Externalizing Behaviors, Parental Stress, and Resilience at pretreatment between families who

completed the treatment and families who did not complete the treatment. Further Chi-Square Test of Independence analyses were conducted to determine if there were relationships between family demographics and completing the program. No significant relationships between program completion and race/ethnicity ($\chi^2(4) = 1.5$, $p = .83$), child age ($\chi^2(6) = 7.12$, $p = .31$), parental education level ($\chi^2(2) = 3.36$, $p = .19$), or household income ($\chi^2(6) = 4.39$, $p = .62$) were found. Collectively these results suggest there were no significant differences between families who completed the program and those who did not.

Hypothesis Testing

Hypothesis One. An interaction between Time and Group Type was hypothesized, such that Externalizing behaviors would decrease across time, with a greater decrease in those attending the Resilience group. A 2 (Group: Standard group; Resilience group) by 3 (Time: pre-; mid-; post-treatment) mixed model Analysis of Variance (ANOVA) was used to analyze the data and results did not support this hypothesis. There was a significant main effect of Time on Externalizing behaviors, $F(2,13) = 3.62$, $p = .04$, $\eta_p^2 = .22$, demonstrating a significant decrease in Externalizing behaviors across time. No main effect of Group Type on Externalizing behaviors was found, $F(2,13) = .04$, $p = .84$. Furthermore, there was no significant interaction for Group Type X Time, $F(2,13) = .14$, $p > .05$, $\eta_p^2 = .01$. Overall, results indicate that incorporating resilience interventions did not reduce Externalizing behaviors beyond the decreases observed in the Standard group, contrary to predictions. Additionally, while there was no observed interaction, there was a significant decrease in parent-reported Externalizing behaviors across time in both group formats. Please see Table 1 for means and standard deviations of Externalizing behaviors by condition.

Although there was no significant interaction, there appeared to be clinically meaningful differences in reported levels of Externalizing Behaviors, so post hoc related sample t-tests were used to better understand any behavior changes across time. There were no significant differences in the Standard Groups Externalizing Behaviors from pre-treatment to mid-treatment ($t(6) = 1.22$, $p = .27$) with Externalizing Behaviors decreasing slightly from pre-treatment ($M = 68.71$, $SD = 11.22$) to mid-treatment ($M = 64.86$, $SD = 10.29$). This trend continued from mid-treatment ($M = 64.86$, $SD = 10.29$) to post-treatment ($M = 63.43$, $SD = 9.68$), although this difference was not significant ($t(6) = .64$, $p = .54$). A slightly pattern of results was observed in the Resilience Group with an initial decrease in Externalizing Behaviors from pre-treatment ($M = 67.13$, $SD = 14.24$) to mid-treatment ($M = 63.00$, $SD = 12.96$). Alternatively, Externalizing Behaviors increased slightly from mid-treatment ($M = 63.00$, $SD = 12.96$) to post-treatment ($M = 63.38$, $SD = 12.15$). However, neither the pre- to mid-treatment change ($t(7) = 1.63$, $p = .15$) nor the mid- to post-treatment change ($t(7) = -.28$, $p = .79$) in Externalizing Behaviors for the Resilience Group were significant.

Due to the wide age range of children included in our sample, a 2 (Group: Standard; Resilience) by 3 (Time: pre-; mid-; post-treatment) mixed model Analysis of Covariance (ANCOVA) was conducted to determine the change in Externalizing behavior while controlling for child age. Results demonstrated no significant change in Externalizing Behaviors across time while controlling for child age ($F(2,13) = .07$, $p = .94$, $\eta_p^2 = .01$). Additionally, there was not a significant main effect of Group Type on Externalizing Behavior ($F(2,13) = .01$, $p = .92$, $\eta_p^2 = .001$) nor a significant Group Type X Time interaction ($F(2,13) = .18$, $p = .84$, $\eta_p^2 = .01$) when accounting for child age.

Hypothesis Two. The second hypothesis predicted a decrease in Parental Stress in both the Standard and Resilience group, with exploratory analysis conducted for assessing differential change by group type. A second mixed model 2 (Group: Standard; Resilience) by 3 (Time: pre-; mid-; post-treatment) ANOVA was conducted to determine the effect on Parental Stress. A significant main effect of Time on Parental Stress was found ($F(2,13) = 4.51$, $p = .02$, $\eta_p^2 = .26$) and demonstrated a decrease in Parental Stress across time for both group formats. No significant main effect of Group Type was found for Parental Stress, $F(2,13) = .04$, $p = .85$. A possible interaction between Group Type and Time on Parental Stress was not supported, $F(2,13) = 1.11$, $p > .05$, $\eta_p^2 = .08$. Overall, results indicated that Parental Stress significantly decreased over time, but resilience interventions did not appear to have an impact on Parental Stress. Please see Table 2 for group means and standard deviations.

Furthermore, an interesting pattern of behavior change was observed within each group, so related sample t-tests were used to further analyze the data. There were no significant differences in the Standard Group's Parental Stress from pre-treatment to mid-treatment ($t(6) = 1.08$, $p = .32$) with Parental Stress decreasing slightly from pre-treatment ($M = 101.86$, $SD = 13.73$) to mid-treatment ($M = 98.43$, $SD = 16.05$). This trend continued from mid-treatment ($M = 98.43$, $SD = 16.05$) to post-treatment ($M = 89.00$, $SD = 27.38$), although this difference was not significant ($t(6) = 1.09$, $p = .32$). Furthermore, the Resilience Group demonstrated a significant decrease in Parental Stress ($t(7) = 3.40$, $p = .01$) from pre-treatment ($M = 102.50$, $SD = 26.57$) to mid-treatment ($M = 89.51$, $SD = 22.46$). Conversely, Parental Stress did increase slightly from mid-treatment ($M = 89.51$, $SD = 22.46$) to post-treatment ($M = 91.38$, $SD = 20.35$). However, the mid- to post-treatment change in Parent Stress for the Resilience Group was not significant ($t(7) = -.47$, $p = .66$).

Additionally, to account for the role of child age in understanding Parental Stress, a 2 (Group: Standard; Resilience) by 3 (Time: pre-; mid-; post-treatment) mixed model ANCOVA was conducted with child age as a covariate in the analysis. Results demonstrated the main effect of Time on Parental Stress (F (2,13) = .187, p = .83, η_p^2 = .02) was no longer significant when controlling for child age. Similarly, the main effect of Group Type on Parental Stress was not significant (F(2,13) = .001, p = .98) and there was no significant interaction between Group Type and Time on Parental Stress (F(2,13) = 1.17, p = .33, η_p^2 = .09).

Hypothesis Three. Finally, an interaction between Group Type and Time on Resilience was hypothesized such that there would be no change in resilience in the Standard Group with an increase in Resilience in the Resilience Group. A third 2 (Group: Standard; Resilience) by 3 (Time: pre-; mid-; post-treatment) mixed model ANOVA was used to analyze the data. There was a significant main effect of Time for Resilience (F(2,13) = 3.71, p = .04, η_p^2 = .22) demonstrating an increase in Resilience over time regardless of Group Type. However, there was no significant main effect of Group Type for Resilience, F(2,13) = .00, p = .95. Furthermore, there was no significant interaction for Group Type by Time (F(2,13) = 1.69 p = .20, η_p^2 = .12) indicating the Resilience Group's scores were not significantly different from the Standard Group's scores on Resilience. Please see Table 3 for group means and standard deviations.

Although the hypothesized interaction was not significant, there appeared to be interesting changes within each group across time so further related sample t-tests were conducted to examine the changes in Resilience more closely. There were no significant differences in the Standard Group's Resilience scores from pre-treatment to mid-treatment (t(6) = -1.54, p = .17) with Resilience increasing slightly from pre-treatment (M = 36.86, SD = 9.28) to mid-treatment (M = 38.43, SD = 8.85). Again, this increase in Resilience continued from mid-

treatment (*M* = 38.43, *SD* = 8.85) to post-treatment (*M* = 41.00, *SD* = 10.41), although this

difference was not significant ($t(6)$ = -1.39, *p* = .21). The Resilience Group demonstrated larger

initial gains in Resilience from pre-treatment (*M* = 37.13, *SD* = 7.62) to mid-treatment (*M* =

40.88, *SD* = 7.88) which were significant ($t(7)$ = -3.91, *p* < .01). Contrary to predictions,

Resilience decreased from mid-treatment (*M* = 40.88, *SD* = 7.88) to post-treatment (*M* = 39.00,

SD = 5.10). However, the mid- to post-treatment increase in Resilience for the Resilience Group

was not significant ($t(7)$ = 1.06, *p* = .32).

Follow-up analyses were conducted to account for the role of child age in understanding

the relationship between Resilience, Time, and Group Type. A final 2 (Group: Standard;

Resilience) by 3 (Time: pre-; mid-; post-treatment) mixed model ANCOVA was used with child

age as the covariate. The main effect of Time on Resilience ($F(2,13)$ = 1.29, *p* = .30, η_p^2 = .10) as

well as the main effect of Group Type on Resilience ($F(2,13)$ = .03, *p* = .86) were non-significant

when child age was controlled. Furthermore, there was still no significant interaction between

Group Type by Time when accounting for child age ($F(2,13)$ = 2.55, *p* = .10, η_p^2 = .18).

However, it is important to note that the data violated the sphericity assumption, indicating the

data were not a good fit for this analysis due to low power (Mauchly's W = .421, *p* = .01).

Satisfaction Ratings

At the end of treatment, parents (*N* = 15) completed a survey regarding their satisfaction

with the Strong Families Program (see Appendix C). The majority of participants found their

therapists to be "extremely" supportive (*n* = 13), knowledgeable (*n* = 10), and prepared (*n* = 10).

The majority of participants (*n* =12) found six sessions to be "just the right amount" with three

families believing six sessions were "not quite enough." Parents were also asked to rate the

Strong Families Program's impact on themselves, their child, and their family. All participants

described themselves as better, with four families reporting they are "a little" better, six families reporting they are "much" better, and five families reporting they are "very much" better. Similar impacts were reported for the child, with two families reporting their child was "a little" better, 11 families reporting their child is "much" better, and two families reporting their child is "very much" better. Finally, all participants rated their family as "a little" better, *(n* = 3), "much" better *(n* = 10), or "very much" better (*n* = 2). Respondents were also invited to provide feedback on aspects of the program they did or did not like and provide recommendations for improvements. Parents generally found the group discussion and in-session coaching to be the most helpful aspects of the program and recommended follow-up maintenance sessions as well as in-home sessions as suggestions for improvement.

While all participants reported benefits from the program, chi-square analyses were conducted to determine if specific parental demographic factors were related to program support. One of the benefits of a short-term treatment program is the increased access for underserved families, so to promote generalizability it was important to understand if certain parental factors (e.g., race, education) related to reported benefits for the parent, their child, or their family. Chi Square Test of Independence analyses were used to analyze the data. The responding caregiver's answers for race/ethnicity, income, and education as well as the parent's report about their personal improvement, their child's improvement, and their family's improvement were used as variables in the analysis. No significant relationships were found between the parent's educational attainment and rating of their own ($\chi^2(4) = 2.16$, $p = .71$), their child's ($\chi^2(4) = 4.61$, $p = .33$), or their family's ($\chi^2(4) = 8.10$, $p = .09$) improvement. Household income was also examined and results indicated no significant relationships between their personal ($\chi^2(10) = 8.28$, $p = .41$), their child's ($\chi^2(10) = 7.89$, $p = .64$), or their family's ($\chi^2(8) = 11.56$, $p = .17$) well-

being and the family's reported income. Furthermore, there was no significant relationship between parent's race/ethnicity and their personal ($\chi^2(10) = 10.64$, $p = .39$), their child's ($\chi^2(8) = 9.63$, $p = .29$), or their family's ($\chi^2(10) = 12.32$, $p = .26$) well-being. These findings of no significant relationship between parental demographic factors and satisfaction indicates the program will likely generalize and be helpful for families from a wide variety of backgrounds including underserved, minority, or low SES families.

CHAPTER FIVE

DISCUSSION

The current study aimed to better understand the impact of a shortened group treatment program for behavioral parent training (BPT) and resilience training on child externalizing behaviors, parental stress, and child resilience. Two six-week group treatment programs were developed to examine reported behavior change based on a group format BPT (e.g., Standard Group) versus a group format BPT combined with resilience interventions (e.g., Resilience Group). Parent's rated their own, their families', and their child's behavior at pre, mid, and post-treatment to provide measures of child Externalizing behaviors, Parental Stress, and Resilience. We expected the Resilience Group to show greater decreases in Externalizing behavior and greater increases in Resilience than the Standard Group. Exploratory analyses were conducted to determine the effect of group type on Parental Stress.

Externalizing Behavior

Results demonstrated a non-significant interaction between Group Type and Time, contrary to predictions. However, there was a significant main effect of Time, indicating a significant reduction in parent-reported Externalizing Behaviors across time in both the Standard and Resilience Groups. However, there was an interesting pattern of behavior change with the main reductions of behavior occurring in the first three weeks of treatment for both the Resilience Group and the Standard Group. It is important to note the absence of a wait-list control group makes it impossible to determine if the intervention caused the reduction in behavior problems or if these behavior problems simply got better with time (e.g., regression to the mean). Furthermore, due to the wide age range of participating children, age was included in further analyses as a covariate and the main effect of time was no longer significant. Therefore,

while Externalizing Behaviors did significantly decrease across groups, it is important to recognize the possibility of other contributing factors (e.g., child age, regression to the mean) in impacting Externalizing Behavior beyond the current intervention.

Clinically, these results yield interesting implications as child behavior problems are pervasive in both clinical and non-clinical samples (Achenbach & Edelbrock, 1981). Specifically, while recent research demonstrates the effectiveness of a long-term group parenting program (Niec et al., 2016), these results indicate there may be clinically and statistically meaningful reductions in behavior problems after only six weeks of treatment. Furthermore, these findings suggest that clinicians need not add resilience interventions in efforts to reduce behavior problems with young children as BPTs alone are likely effective. This finding is consistent with previous research which found significant reductions in Externalizing Behaviors following BPT (McMahon & Forehand, 2005; McNeil & Hembree-Kigin, 2010; Sanders, 1999; Webster-Stratton, 2005). However, the lack of significant interaction indicates resilience interventions did not reduce behavior problems beyond what occurred in the BPT only group. This finding is contrary to previous research demonstrating the role of resilience interventions in reducing behavior problems (Calkins, Blandon, Williford, & Keane, 2007; Watson et al., 2013). It is possible resilience intervention effects were not observed in this study due to the small sample size and low power or it may be possible that these cognitive behavioral based interventions take longer than six weeks to change behavior.

Parental Stress

While previous research demonstrated the role of BPTs in reducing parental stress (Forgatch et al., 1989; Pisterman et al., 1992), no research to date has examined the role of resilience interventions in reducing parental stress. The current study conducted exploratory analyses to examine this relationship. Results demonstrated a non-significant interaction between

Group Type and Time on Parental Stress. However, Group Type explained 8% of the variance in Parental Stress, indicating resilience interventions may influence parental stress. Additionally, there was a significant main effect of Time demonstrating a significant reduction in Parental Stress across time, regardless of group. Interestingly, when child age was added to the analysis as a covariate, there was no significant main effect or interaction, but Group Type accounted for 9% of the variance in Parental Stress. Specifically, parents in the Standard Group reported slight decreases in stress from pre- to mid-treatment, with a much larger, but statistically non-significant, reduction in stress from mid- to post-treatment. Interestingly, the opposite pattern was observed in the Resilience Group with and initial statistically significant reduction in stress through mid-treatment followed by a slight increase in stress by post-treatment.

The current study was limited by sample size and power, hampering our ability to conduct meaningful exploratory analyses on the relationship between resilience interventions and parental stress. However, there was a significant overall reduction in parental stress regardless of group after six weeks of BPT, consistent with previous findings (Forgatch et al., 1989; Pisterman et al., 1992).

Resilience

Finally, the current study expected an interaction effect with increases in Resilience found only in the Resilience Group. Contrary to predictions, there was a non-significant interaction effect between Group Type and Time, but there was a significant main effect of Time for Resilience. Specifically, Resilience increased significantly across time for both groups; however, Group Type explained 12% of the variance in Resilience with the Standard Group showing higher gains in Resilience. Moreover, when child age was included as a covariate, Group Type explained 18% of the variance in Resilience indicating a moderate effect of Group Type on Resilience with higher gains in Resilience in the Standard Group.

This finding of higher Resilience gains in the Standard Group, although statistically non-significant, is important to deconstruct as it diverges from what was expected. One possible explanation for this finding may be that families in the Resilience Group were overwhelmed with too much work. For example, mean Resilience ratings increased significantly (e.g., approximately 3.5 points) from pre-treatment to mid-treatment in the Resilience Group while increasing only approximately 1.5 points in the Standard Group. However, these ratings decreased almost 2 points from mid-treatment to post-treatment in the Resilience Group while increasing 2.5 points in the Standard Group. Research suggests proactive parenting, or authoritative parenting, is a vital component in achieving child resilience, so it is possible simply improving parenting practices through BPT can help explain the increase in Resilience observed in the Standard Group (Alvord & Grados, 2005) but this does not explain the inconsistent pattern of Resilience found in the Resilience Group.

One possible explanation is that families in the Resilience Group became overwhelmed with trying to implement effective parenting skills (differential attention, consistent discipline, etc.) and resilience interventions. This is supported by the slight increases in Parental Stress and Externalizing Behaviors reported from mid-treatment to post-treatment in the Resilience Group. It is also possible the Resilience Group had children who struggled with the implementation of disciplinary procedures more so than the Standard Group. Further research is needed to better understand the inconsistent pattern of behavior change observed in the Standard and Resilience Groups. It is possible the Standard Group did not experience meaningful change until the implementation of effective discipline strategies in the last three weeks of treatment, whereas the Resilience Group experienced relief upon the initiation of treatment and became overwhelmed by the addition of effective discipline strategies in the last three weeks of treatment. To further examine the role of BPTs and resilience interventions, future research should collect more data

(e.g., number of time-outs, length of time-outs, beliefs regarding PRIDE skills) to help clarify the behavioral patterns observed in this study.

Limitations

The current study had several notable limitations including the lack of power due to limited sample size. Although a community sample of participants was used to increase generalizability, we were unable to recruit enough participants to reach a sufficient sample size to detect effects. Furthermore, we obtained a sample from one, rural town and most of our participants were Caucasian which limits the generalizability of our results to other geographic areas and ethnically and racially diverse families. These limitations can be improved in the future by using a multisite, representative sample to improve representation and generalizability.

Furthermore, the conclusions which can be drawn from the study's results are limited due to a lack of control group. Although originally designed with a wait-list control, the current study was unable to use this due to limited sample size. Without the wait-list control, we were unable to determine if the significant main effects observed in the current study were due to the treatment or other effects. As such, future research should implement a wait-list control procedure to better understand the effect of shortened, group BPTs on externalizing behavior, parental stress, and resilience.

Another limitation of the current study was the reliance on parent-report of child behavior. Research demonstrates inconsistent findings on the relationship between parent and teacher reports, but, generally, there appears to be low to moderate agreement between respondents with higher agreement found in families who have lower stress levels and are of a higher SES (Achenbach, McConaughy, & Howell, 1987; Kolko & Kazdin, 1993; Stone, Speltz, Collet, & Werler, 2013). Additionally, part of the coercive process outlined by Patterson (1982)

shows the negative interactional process existing between parents and children. This coercive

process may lead to increased parental stress and a general negative view of many child

behaviors and difficulty recognizing positive behaviors (McNeil & Hembree-Kigin, 2010). Thus,

it is likely parent's perception of their child's behaviors is not always accurate and future studies

should address this by adding a teacher report and, if possible, a clinician report of observable

behavior change.

Additional limitations were associated with practical concerns in the implementation of

the treatment, but are still noteworthy. For example, the current study did not utilize random

assignment which increased the possibility of self-selection bias, although counterbalancing was

used in an attempt to minimize this risk. Furthermore, only eight families attended all six

sessions, indicating concerns about having adequate time to engage in treatment. This lowered

attendance may result in limited treatment gains. Furthermore, groups were held from January to

July and it is possible families experienced different levels of stress, behavior problems, and

resilience based on the time of year they attended treatment. Finally, all groups had a week break

from the group due to school holidays. However, these breaks did not occur at the same time in

each group, which introduced additional sources of error into the study. It is also possible these

breaks halted treatment momentum and motivation.

Strengths

Although there were limitations to the current study, several strengths should be noted.

First, we used the same therapists across all three groups to maintain treatment integrity. More

specifically, the author of this study was the main therapist for all six groups with two other co-

therapists running one group per week. The co-therapists were counterbalanced across groups

and by using the same therapists we reduced additional variability introduced with new therapists.

Additionally, the rigorous assessment protocol and empirically supported treatments utilized were strengths. For example, we used three measurement periods which allowed us to examine the reported change in behavior more closely at several timepoints instead of just at pre-treatment and post-treatment. Additionally, we designed the Strong Families Program based on several empirically supported treatments. Our BPT protocol drew upon aspects of empirically supported parent-training programs including Parent-Child Interaction Therapy (McNeil & Hembree-Kigin, 2010) and Helping the Noncompliant Child (McMahon & Forehand, 2005). Furthermore, we used evidence-based resilience interventions drawn from the Resilience Builder Program (Alvord et al., 2011) which have been shown to reduce behavior problems, depression, and anxiety and increase resilience, social skills, and coping skills (Watson et al., 2013).

Another strength of the study was recruitment. Although we had a small, mainly Caucasian sample, our sample was recruited directly from the community (e.g., pediatrician offices, childcare centers). Participants were able to get sound, empirically supported treatment at no cost. These types of services are typically difficult to receive in the area where the study was conducted. In addition, overall results indicate children's externalizing behaviors and parental stress decreased from pre- to post-treatment assessment and children's resiliency increased.

Future Directions

Research should continue to examine the effectiveness of short-term, group BPT with underserved populations. The current study examined rural families, but future research should examine the effect of these short-term treatments with a variety of populations in need (e.g.,

urban, low SES), as shorter, group treatments are more cost effective and can reach more people.

One particular population which may benefit from these short-term interventions are foster

parents who need fast and effective ways to bond with foster children while maintaining

effective rules and discipline strategies (e.g., time out).

Furthermore, more research is needed to determine if the current findings hold with

larger, more representative samples. Follow up studies will also be important to better

understand if short-term treatment gains persist. It would beneficial to conduct future studies

examining treatment gains at three-month, six-month, and one-year follow ups to determine if

parents continue to follow through with these new parenting strategies and to examine the long-

term effects on child behavior.

Clinical Implications

While there are important issues to address is future studies, the current study offers

important clinical implications. First, it appears a shortened-group treatment model can reduce

parent-reported child behavior problems and parental stress. There also appears to be a

significant increase in parent-reported resilience with BPTs. By using shorter-group treatment

protocols clinicians can increase the number of patients receiving needed services. Furthermore,

clinicians can save valuable time by avoiding unhelpful treatment techniques. For example, the

current study found no significant influence of resilience interventions in reducing externalizing

behaviors and parental stress or increasing resilience. Thus, if clinicians can use only BPT to

achieve the same gains they can use their time in treatment more effectively by not using

resilience interventions.

Additionally, these findings have important implications for underserved populations. In

the world of managed-care, reducing treatment length to six sessions can increase treatment

access and reduce costs for rural and low SES families. For example, rural families who may experience limited resources as well as few qualified providers can benefit immensely from short-term group treatments to reduce child behavior problems and parental stress. Beyond specific populations, many long-term treatments suffer from high attrition rates which can be mitigated through short-term treatment.

Conclusion

The current study aimed to better understand the effectiveness of short-term group based BPT and resilience intervention in reducing child behavior problems and parental stress and increasing resilience. We developed a short-term group treatment comparing BPT only versus BPT plus resilience interventions. No hypotheses were supported, although this may be due to limited sample size and low power. However, we did find significant improvements in child behavior problems, parental stress, and resilience over time across both groups. The use of resilience interventions in addition to BPT to reduce child externalizing behaviors and parental stress and to increase child resilience are not supported at this time. While these findings need to be examined in future studies, they do provide support for the use of short-term group based BPT programs to increase access for services.

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Table 1

Table 1. Means and Standard Deviations of Externalizing Behaviors by Group Type and Time

Variables	Standard Group *M*	Standard Group *SD*	Resilience Group *M*	Resilience Group *SD*
Externalizing Behavior: Pre-treatment	68.71	11.22	67.13	14.24
Externalizing Behavior: Mid-treatment	64.86	10.29	63.00	12.96
Externalizing Behavior: Post-treatment	63.43	9.68	63.38	12.15

Note. A 2X3 ANOVA was conducted on externalizing behaviors. No significant interaction was found, although there was a significant main effect of Time on externalizing behaviors.

Table 2

Table 2. Means and Standard Deviations of Parental Stress by Group Type and Time

Variables	Standard Group *M*	Standard Group *SD*	Resilience Group *M*	Resilience Group *SD*
Parental Stress: Pre-treatment	101.86	13.73	102.50	26.57
Parental Stress: Mid-treatment	98.43	16.05	89.51	22.46
Parental Stress: Post-treatment	89.00	27.38	91.38	20.35

Note. A 2X3 ANOVA was conducted on parental stress. No significant interaction was found, although there was a significant main effect of Time on parental stress.

Table 3

Table 3

Table 3. Means and Standard Deviations of Resilience by Group Type and Time

Variables	Standard Group *M*	Standard Group *SD*	Resilience Group *M*	Resilience Group *SD*
Resilience: Pre-treatment	36.86	9.28	37.13	7.62
Resilience: Mid-treatment	38.43	8.85	40.88	7.88
Resilience: Post-treatment	41.00	10.40	39.00	5.10

Note. A 2X3 ANOVA was conducted on Resilience. No significant interaction was found, although there was a significant main effect of Time on Resilience.

Figures

Figure 1. The Interaction Effects of Group and Time on Externalizing Behaviors with Means and Standard Errors.
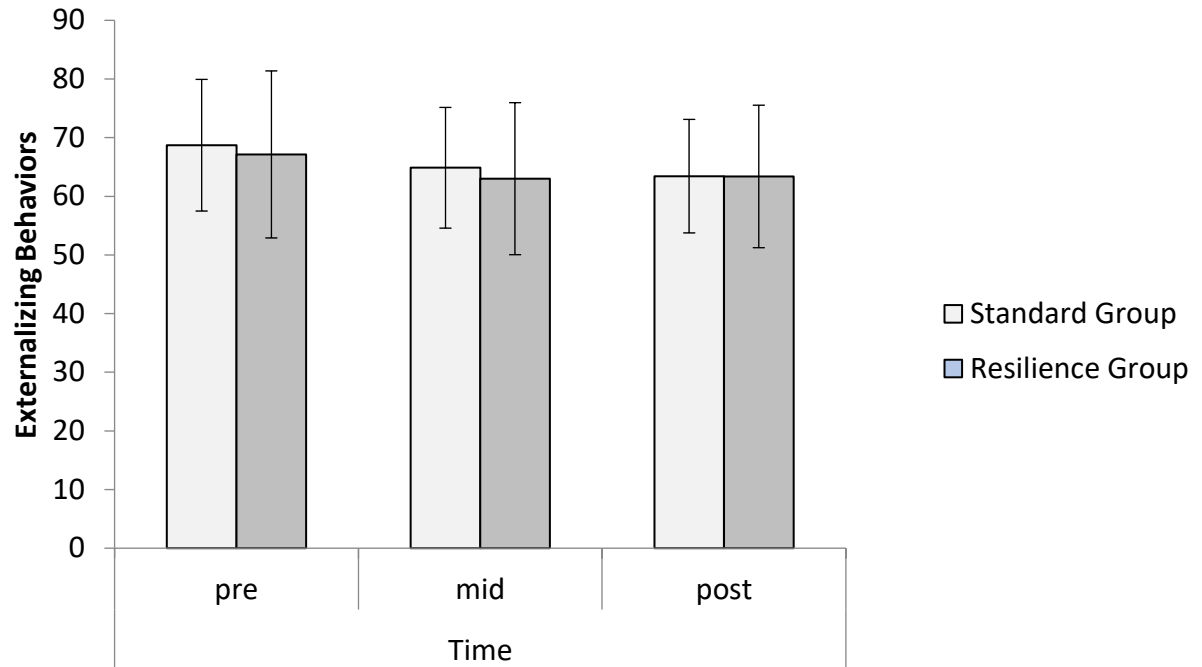
Note. A significant interaction effect was not found, $F(2,13) = .14$, $p > .05$, $\eta_p^2 = .01$, but there was a significant main effect of Externalizing behaviors, $F(2,13) = 3.62$, $p = .04$, $\eta_p^2 = .22$.

Figure 2. The Interaction Effects of Group and Time on Parental Stress with Means and Standard Errors.
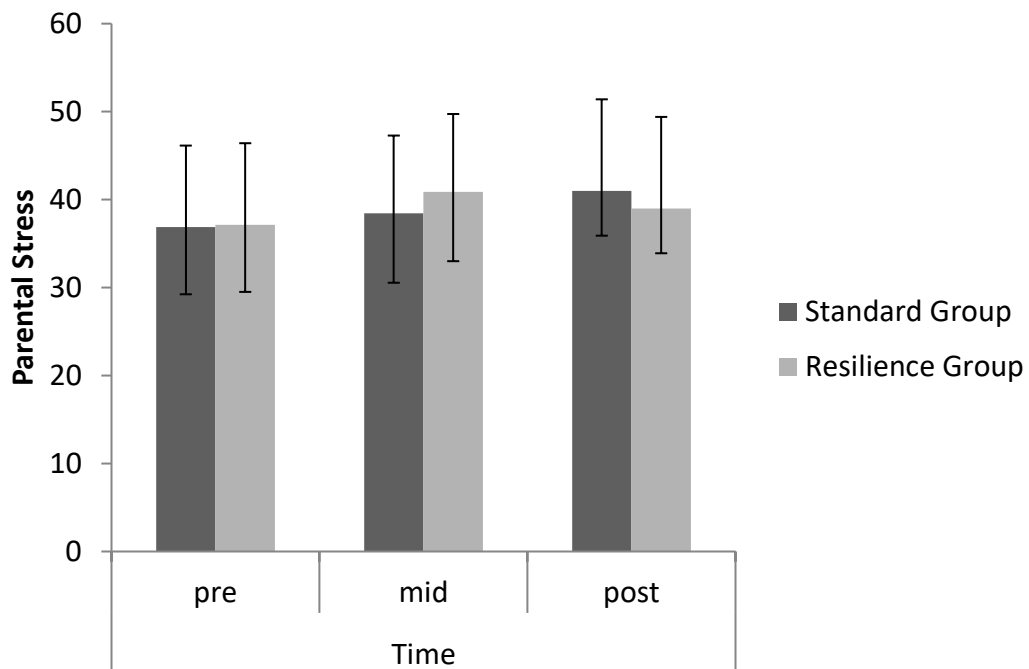
Note. A significant interaction effect was not found, $F(2,13) = 1.11$, $p > .05$, $\eta_p^2 = .08$, but there was a significant main effect of Parental Stress, $F(2,13) = 4.51$, $p = .02$, $\eta_p^2 = .26$.

Figure 3. The Interaction Effects of Group and Time on Resilience with Means and Standard Errors.

Note. A significant interaction effect was not found, $F(2,13) = 1.69$ $p = .20$, $\eta_p^2 = .12$, but there was a significant main effect of Resilience, $F(2,13) = 3.71$, $p = .04$, $\eta_p^2 = .22$.

APPENDIX A

MODULE I: WELCOME
Session 1

A.   Outline

1. Introduction: Purpose of the Group
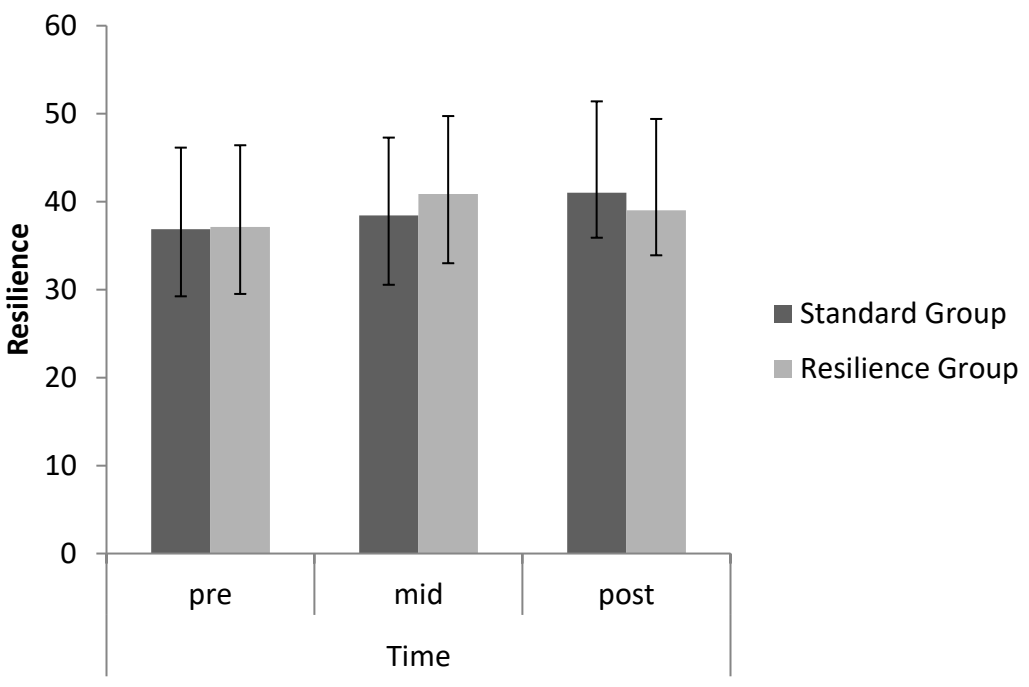2. Syllabus
3. Group Rules
4. Introduction of Group Members
5. Introduction of Parent Management Training
6. Introduction of PRIDE skills
7. Group practice
8. Resilience topic
9. Review of topic, goal setting, homework assignment

Materials needed:

1. Schedule for each group member
2. PRIDE and Do & Don't Skills handout for each group member
3. List of appropriate toys
4. Homework tracking

B.   Purpose of the Group

Therapist 1: "The purpose of this group is to provide parents and children opportunities to improve their relationship and teach parents effective ways to get children to listen. For the first two weeks we will be focused on improving your relationship with your child. After that, we will teach you effective discipline strategies to ensure your child listens to you when you tell them to do something."
Therapist 2: "Throughout these six weeks you're also going to learn specific skills to assist you in developing your parent-child relationship and get what you want from your kids. You're going to learn some skills to better help you in managing your children's behavior.

Research indicates children whose parents participate in their treatment, such as this parents' group, have better outcomes. The topics presented in this group are based on what is shown to be effective by other clinicians in the field, so we know it works. By the end of this group we expect you and your child will have a stronger relationship and you will have gained new skills to get your child to listen to you."

C.   Group Rules

In order for our group to run smoothly there are a few ground rules we need to go over.

1. Review confidentiality, including confidentiality among group members.
2. Emphasize attendance is very important for the group, especially since it is a small group format and runs for only 6 weeks.
3. Group members are free to share as much or as little as they like and still be respected.

4. "We would like this time to be a safe time for all group members to discuss what they are going through and experiencing. We are all coming from different backgrounds and sometimes do not agree on certain issues. Maybe we can agree to disagree on some things, but always remember this time is a time for everyone to feel safe and be treated with respect."

D.   Participants Introduce Themselves

"You are going to be spending a lot of time with one another so today we're going to spend some time getting to know each other. I would like group members to introduce themselves, tell us about who is in your family, a little bit about what has been going on in your life lately, and what you hope to gain from treatment."

E.   Schedule

"Here's a handout with the meeting dates and the topics we will be focusing on each week. (*Therapist Note: Highlight any potential scheduling problems such as Labor Day weekend, family vacations, etc. Problem solve any conflicts in attendance.*) The group meets for six consecutive weeks. There are also two more assessment sessions scheduled. One halfway through the treatment (which will take an extra 30 minutes) and one is after completion of the groups and will include any further recommendations the therapists have for your family. These are very important because they provide us information about your family's progress and are a way for us to make sure treatment is helping families like your own."

F.   Topics to be discussed over the next 6 weeks

Hand out topics sheet to each group member.   "We are going to be covering a wide variety of topics in a short period of time."   *(Therapist Note: Highlight some of the topics according to each group member's introduction of themselves and what they stated as wanting to gain from treatment. At this time, encourage parents to bring up any concerns or questions about any topic at any point during the 6 weeks of group.)*

"Each week we will meet together to review topics and practice our skills. While you are with us learning these skills, your children will be in the other room with our trained assistants who will be using the same skills you are learning in their interactions with your children. After we have reviewed the skills, we will rejoin the children so you get in-the-moment practice and feedback from us."

In Resilience Group say: "At the end of each session we will come back together as a group to learn a new resilience skill and you and your child will complete a fun activity together."

G.   Introduction of Parent-Management Training

"The goal of this program is to teach you how to build strong relationships with your children and get them to listen to you.

The skills we are going to be learning and practicing together are shown to be effective with children who have difficulty listening to their parents. A lot of different research studies show us these skills are the most effective in getting children to behave better. Beyond helping with disobedient behavior, this

program is designed to strengthen your relationship with your child so you can spend more time enjoying each other's company.

This program does not only teach you the skills; we will use in-the-moment coaching to help you know how to implement these skills in real life. At first we will practice these skills together and then you will break up into your family groups and receive in-the-moment coaching from us. However, it takes more than two hours per week to learn these skills, so we also ask that you find 5 minutes every day to practice these skills. It's very important that you practice these skills for 5 minutes every day for the next six weeks, otherwise the program will not work. Are there any concerns about the at home practices?

(Therapist note: problem solve any barriers to daily practice and treatment attendance)

Now that we've reviewed the goals of the program, we're going to explain how the program works. Our program can be broken down into two separate parts. For the first two weeks we will focus on strengthening your relationship with your child through play therapy skills. We need your relationship to be very strong because we want your child to want to please you. Once they are working really hard to please you we will implement our discipline program which is part two. Researchers have studied many different types of discipline programs and found that ours is the most effective program in getting children to listen. This program has been shown to work with children with behavior problems at many levels, including those with severe behavior problems."

H. PRIDE and Do & Don't skills

(*pass out handouts at the end*)

"Now that you know more about the program, we will jump right into the first part of treatment: working to make your relationship with your child as strong as possible. To do this, we will teach and coach you in using play therapy skills. These are skills used by people who are trained to do therapy with young children. We know these skills help build very strong relationships, and we know that building a strong relationship makes children easier to discipline. This is just the first step in the program, but it is vital to making the discipline strategies we will use later work."

Selling special play time:

"We want you to practice these special skills for 5 minutes everyday. It's important that you do them every day because otherwise 5 minutes is not very much time. Imagine you're trying to lift weights – if you lift weights one day for five minutes and then wait until the next week to lift them again you're probably not going to see any improvement right? But if you lift weights for a short period every single day you're probably going to see some improvement in your muscles! This program works the same way – nothing will change unless you can practice every day. Take a minute and think about how much better your relationship with your child could be if you took 5 minutes out of your day to focus all of your positive attention on your child. Think about how much better your relationship with your parents could have been if they took 5 minutes to focus all of their attention on you and reminded you how loved and how special you are daily! Some days it's hard to find time to spend with your children because we lead such busy lives, but by setting aside 5 minutes you can make sure no day goes by without telling your child how proud you are to be their parent. After a little while your child will be working very hard to get your positive attention even outside of special playtime.

You might be wondering why it matters that I play with my child in this special way for 5 minutes each day when we're supposed to be the ones working with your child. Well we have been in school for a very long time to learn how to work with children with behavior problems. We would use all these skills to get your child to listen to us, share their toys and play with us, and want to please us. But, when our time was up and I brought your child back to you they would probably begin acting up again because you wouldn't know these special skills. Instead, we've found that teaching you how to become your child's therapist is the most effective way to get your child to listen to you."

Therapist note: Problem solving tips

- *If children get 15 minutes on some days they may feel cheated on the days they only receive 5 minutes.*
- *Timers for the 5 minutes is not necessary*
- *When special playtime is up parents are to say "I'm going to pick up the toys now. You can help if you want," or "You can continue playing with the toys if you want, But, I have to do some other things right now."*
- *Special playtime is important even on days when the child has displayed bad behavior.*

"Now we're going to learn the specific skills you'll be practicing every day."

Labeled Praise: "First, we're going to learn about labeled praise. A labeled praise is when you tell your child exactly what you like that they are doing. Research tells us whenever we give a labeled praise a child is much more likely to continue doing the behavior we praised. So instead of being a reactive parent who only scolds after negative behavior, we're going to practice being proactive parents where you praise the positive behaviors. We know this is useful because if your kid is engaging in positive behaviors, they cannot also be misbehaving. When you do your 5 minutes of special play time I want you to practice giving a labeled praise once every 30 seconds. So, once every 30 s you'll be saying things like… "I like the way you shared the toys with me,"… "That was a beautiful boat you built,"… "Nice job of using your manners." Now, you can use labeled praises throughout the day, but I don't expect you to praise your child that often throughout the day, that would be weird. However, when you get so much practice using labeled praise during special play time it will start to naturally spill over into your everyday life."

Therapists demonstrate and model labeled praise.

"Again, labeled praise reduces problematic behaviors – children do behaviors you praise more frequently. Labeled praise also improves self-esteem."

REFLECTION: "Another play therapy skill is reflection. This involves simply reflecting back what your child says to you. Sounds simple right? The hardest part of reflection is ensuring you do not make it sound like a question. For example, if your child says, "I'm making the tallest tower ever" I want you to avoid asking, "Is it the tallest tower ever?" When you ask it that way, it sounds as if you do not believe your child or you were not listening to them. Instead I want you to repeat back what they said without changing your inflection to make it a question. This way your child will feel understood and it will improve your overall communication. Many adults believe that asking questions is the best way to engage in conversation with children, but research shows children talk more often when parents reflect rather than asking questions."

Therapists demonstrate and model reflection.

IMITATE: "Imitation is used to show your child you're interested in what they're doing and paying attention. A major component of special play time is letting the child lead and the easiest way to let children lead is through imitation. This involves imitating what your child is doing – if they build a tower, you will build a tower too. However, you need to ensure your imitation is not better than your child's original so they feel proud of themselves."

Therapists demonstrate and model imitate.

DESCRIBE: "You should watch your child's activity closely and comment on their appropriate play. For example, if your child was building a Mr. Potato Head you might describe by saying "You're looking at all the pieces. Oh, you put a green cowboy hat on Mr. Potato Head. Now you gave him a mustache. You picked the green glasses that match the green hat (child struggles to put them on). You're trying really hard." Description is similar to labeled praise, but involves more narration rather than praise. Research shows descriptions help children organize their thoughts as well as increase the length of time they spend on a task."

Therapists demonstrate and model description.

ENTHUSIASM: "Finally, a huge component of special play time is enthusiasm. You have to show your child you enjoy playing with them. Now we will put all 5 PRIDE skills in place and show you want it looks like."

Therapists demonstrate and model special play time skills.

"There are a few behaviors you as parents will need to avoid during special play time. These are instructions, questions, and critical statements."

Review don't skills

Avoid instructions

Avoid questions

Avoid critical statements and sarcasm

"Young children can't reason critically and independently. They truly believe what adults tell them, especially the adults who they trust the most. If a parent tells a young child pigs fly then the child believes pigs really do fly. Young children aren't able to think about what a pig really looks like and realize their parent is wrong because pigs don't have wings. So, if a parent tells their child they are dumb, the child will believe that and it will become part of their own self-image. They aren't able to think back to earlier in the day when they remembered all of their numbers correctly or were able to complete a difficult puzzle. Instead of realizing their parents are wrong and they're a pretty smart kid, they believe they are dumb.

We also try to avoid instructions because we want the child to lead the interaction, but when we give a child instructions it takes the focus off of them. Later in the program we will discuss the importance of not giving instructions unless you are going to follow through with a consequence, so we want you to practice not giving unnecessary instructions now.

Finally, we try to avoid questions for a couple of different reasons. Again, we want the children to be leading the interaction and questions can sometimes imply an instruction or make the child believe they are doing something incorrectly. Plus, repeatedly questioning someone can be really annoying – think about if a coworker questioned you like we sometimes question our children (*therapists demonstrate*). You'd get annoyed pretty quickly, right? Adults think that questioning children is the best way to talk to their kids, but what we know is that children are actually more likely to talk when adults reflect their statements rather than question them."

Overall rule: let the child lead the interaction.

MISBEHAVIOR DURING SPECIAL PLAY TIME

"If your child misbehaves during special playtime you will respond in one of two ways. If the misbehavior is big or dangerous, special play time is over. If the misbehavior is small and not dangerous you will use something called strategic attention and turn away."

Selective Ignoring: "We have all seen (or even been!) that parent at the grocery store when our kid sees all the candy at the checkout aisle. Often, our kids will ask nicely, "Mom, can I please have some candy?" We say no, because they don't need any. So, then our kids start to whine and maybe beg, "please, just this once? Please??" We try to ignore them, maybe look at our phone, or rearrange the groceries on the check out. Then they break out the louder voice, "PLEASE!!! Why not? It's not FAIR!!" Maybe they start to cry louder and people start to look over. Maybe we harshly say, "I said NO!" It's normal to feel embarrassed and as they get louder, we get more stressed, until finally we give them the candy. Unfortunately, we have just reinforced their tantrum by giving them what they wanted! This is an easy trap to fall into. Next time at the store, our kids will remember, "when I got loud and everyone was looking, I got candy," and they will start their demands for candy at a louder level. As humans, we are really smart at repeating the things we are reinforced for, and candy for kids is really reinforcing."

Strategic Attention

"Just like candy, your attention is really reinforcing for kids and they may act out to get it. Think of your child as having an attention gastank. Think of all your attention as fuel for your child – even the negative attention. If their attention gastank is empty they are more likely to act out in search of more fuel. This is because we usually react more strongly with negative attention than with positive attention. When your child does something well you may say "Great job!" and move on which provides little attention. However, when your child misbehaves you are more likely to be frustrated and provide lots of attention for that behavior. While we view it as negative, kids with low levels of fuel in their attention gastank simply see it as fuel that reinforces their negative behaviors. Instead, we can use our positive attention to top off their attention gastank throughout the day to help prevent the need for kids to act out for negative attention."

"So instead of reinforcing these behaviors we don't want, we can use selective ignoring to stop these bad behaviors."

- Ignoring the child until a positive behavior is done is important so that when attention is given back to the child it is a labeled praise. *Therapist model*
- If an appropriate behavior is lasting a long time the parent can "ignore and distract" by moving away, playing with a different toy, and enthusiastically describing their own play, but as though they are talking to themselves. Most often the child will cease the disruptive behavior and join the parent. *Therapist model*

- "Modeling the opposite behavior" is also effective. *Therapist model*

Disruptive behaviors that can't be ignored:

- Behaviors that are dangerous cannot be ignored.
- At home parents should respond to dangerous behaviors by discontinuing that day's special playtime session and disciplining the child using any safe method of their choosing.
- In the clinic the parent will be asked to leave and the therapist will come in with a stern voice explaining the rules of safety.

*Catch em being good: "*Again, whatever behaviors you praise will increase so one great strategy we use is called "catch em being good." This involves praising your child throughout the day when we see them behaving. What usually happens when we see children playing quietly? *(Therapist note: wait for parents to answer)* We sneak by so we don't jinx it, right? In reality, if we took a minute to praise our kids and say "Wow, I really love how nice and quietly you're playing with those toys" we'd be more likely to see those behaviors increase. We often focus our attention on misbehavior, but if children received positive attention from behaving, their gastank would be full and they wouldn't need attention from misbehavior right? We can use the special play time skills in mini-bursts throughout the day. When your child is playing nicely, go over and give them labelled praise, describe what they are doing, and give them that positive attention for a few seconds. This will "top off" their gastank."

Q & A time

I.   Practice

Parents will break into families and practice PRIDE skills while therapists rotate and provide individual coaching.

J.   Resilience (Alvord, Zucker, & Johnson Grados, 2011) – **Resilience Group only**

Hand out Resilience Topics

Parents and children are together for this portion of the group

"Resilience is a popular topic right now, and some of you may have heard multiple explanations about resilience. However, for the purpose of this group, we'll focus on developing resilience skills that will enable your kids to adapt to difficulties and challenges successfully. Essentially, each week we will learn a new skill that will help your child successfully navigate life's challenges."

To Kids: "Each week after you've had fun playing with your parents we're going to come back together and learn something new! Some weeks you'll get a coloring sheet and other weeks we'll all do an activity together. This week we have a coloring sheet for you all to color along as we talk about some new things." (pass out coloring sheets)

"Through the process of building resilience we will address five topics:

Optimistic Thinking or thinking happy thoughts,

Stress Management or how to handle tough things,

Empathy & Perspective Taking or imagining yourself in someone else's shoes,

Self-Regulation or how to calm down when you get upset

Self-Esteem or how to be proud of yourself

You might be wondering why resilience? The program works on developing skills including setting goals, planning, problem solving, thinking optimistically, and building a more positive sense of self through these facets.

1. First, our program will teach self-regulation skills because research shows children who can self-regulate their emotions in childhood have more advanced social and cognitive skills later in life. Additionally, we will teach you and your child how to calm down when you become upset by identifying triggers, changing up our thoughts, and using relaxation exercises. Who wouldn't want a child (or parent) who can calm themselves down?

2. Another important component of our program is the use of connections and attachments. We will address effective communication, ways to make friends, and appropriate social skills. This is an important component of our program because we know peer rejection can lead to later behavior problems and substance use.

3. We will also highlight the importance of recognizing achievements and resilient children are often actively involved in sports, theater, etc. The program aims to improve self-esteem by asking children to identify what they enjoy and what they have accomplished that took effort, and to complement one another in the sessions.

4. We know that it sometimes takes a village to raise a child, so we will emphasize the role of the community. Community can be defined by your family in many ways, but we want to help you recognize the importance of developing and maintaining supportive relationships outside of just your family. These relationships are helpful in managing stressful times as well as by providing your children with more positive role models.

5. One of the purposes of this program is to teach you Proactive Parenting. This is important because research demonstrates parents who hold their children to high behavioral standings and use effective, consistent behavior management programs are more likely to raise resilient children. The first part of this program is designed to teach you how to implement an effective, consistent discipline program, so you will be able to meet that standard! However, you can go above and beyond to be a proactive parent by learning and practicing the techniques we discuss in your daily life. Children learn by watching you, so if you can model how to effectively calm down when you're upset, your child will be much more likely to follow your example."

"Each week we will end our time together by learning and practicing a new resilience skill together, and you will be asked to practice these skills over the next weeks. Are there any questions?"

J.   Review & Homework

Provide a brief review of PRIDE and don't skills and have parents set goals for the program. Pass out homework sheets, review the importance of practicing daily for 5 minutes.

MODULE 1: Handouts

Schedule

Date	Topic	Homework
1/22	PRIDE Skills, Selective Ignoring, Resilience Introduction *Assessment #1 for $15*	Special Play Time for 5 minutes/day
1/29	Practice skills with coaching, Optimistic Thinking	Special Play Time for 5 minutes/day
2/5	Practice skills with coaching and discipline introduction, Stress Management *Assessment #2 for $15*	Special Play Time for 5 minutes/day
2/12	Practice discipline skills with coaching, Empathy	Special Play Time for 5 minutes/day
2/26	Practicing discipline skills with coaching & house rules, Self-Regulation	Special Play Time for 5 minutes/day
3/5	Practice discipline skills with coaching, individual recommendations, discipline away from home, Self-Esteem *Assessment #3 for $15*	Special Play Time for 5 minutes/day

PRIDE Skills: Special Play Time

Do Skills	What is it?	Example	Why?
P PRAISE	*Specifically labeling what you like about your child's behavior, play, etc.*	I like the way you are sitting quietly and playing with your toys.	*Labeled Praise increases the positive behaviors you're praising*
R REFLECTION	*Repeating back to your child what they said*	Child: I'm building the tallest tower Parent: Oh wow, you are building the tallest tower!	*Keeps the child leading the interaction* *Demonstrates you are listening* *Increases the child's responses back, improves speech and communication*
I IMITATION	*Copy what your child is doing (but don't make yours better than theirs)*	Child: I'm going to build a tower Parent: I'll build a tower just like you	*Keeps the child leading the interaction* *Shows interest and approval*
D DESCRIBE	*Describe your child's behavior by commenting on what they are doing*	Now you're putting the red block on the blue block.	*Helps keep a child focused on one activity for longer periods of time* *Models speech and helps them organize concepts*
E ENTHUSIASM	*Show excitement to play with your child*	Show excitement through inflection and tone	*Keeps the child interested and highlights difference when ignoring for bad behavior*

Source: adapted from McNeil and Hembree-Kigin, 2010

Don't skills: Special play time

Don't Skills	What is it?	Example	Why?
Questions	Asking child questions	"Can you hand me the block?" "Oh is your cow flying over the moon?"	Doesn't allow child to lead the interaction, conveys you aren't listening or don't believe them
Commands	Instructing child to do something	"Hand me the yellow crayon"; "Look at this"	Doesn't allow child to lead the interaction; forces you to intervene for noncompliance
Criticism and Sarcasm	Insulting, teasing, or saying negative things about your child or their behavior	That's not how you build a tower; Don't do that; You're acting like a baby	Doesn't provide instructions on what to do; makes special play time negative; provides attention for negative behaviors

Source: McNeil and Hembree-Kigin, 2010

Selective Attention for Negative Behaviors: Steps

Ignoring Inappropriate Behavior	**What is it?**	**Example**	**Why**
Avoid looking, smiling, speaking to your child Ignore every time the behavior happens Expect behavior to increase at first Ignore until child does something appropriate (may be as short as stops yelling to take a breath) Quickly and enthusiastically Praise appropriate behavior	Remove attention for negative, inappropriate, and attention seeking behaviors	Child: Talks back to parent, then plays quietly and appropriately Parent: ignores attitude, praises playing quietly Child: hits parent Parent: Stops special play time, dangerous behaviors cannot be ignored	Children notice different parent reactions to appropriate and inappropriate behaviors Decreases negative/attention seeking behaviors over time

Source: McNeil & Hembree-Kigin, 2010

Suggested Toys for PCIT

Creative, constructional toys like:
• Legos, Duplos, Tinker Toys
• Mega Bloks, Magnetic or Bristle Blocks, or soft blocks
• Interstar Toys Master Builder Set
• Lincoln Logs
• Erector Set
• Mr. & Ms. Potato Head
• Dollhouse or schoolhouse with miniature people
• Baby Dolls
• Toy farm with animals
• Small stuffed or plastic animals
• Dishes, pots & pans, and play food
• Play Dough & molds
• Crayons, stencils, & paper
• Train set with tracks
• Play garage with cars

Toys to Avoid During PCIT
Toys that encourage rough play, for example:
• Bats, Balls
• Boxing gloves
• Punching bag

Toys that could cause harm to self and/or others, for example:
• Toy guns
• Toy swords
• Pixie sticks

Toys that can get out-of-hand and require limit setting, for example:
• Paints
• Scissors
• Airplanes

Toys that have pre-set rules or discourage conversation, for example:
• Board games & card games
• Books

Homework Sheets: Week 1

Directions: Practice Special Play time skills every day for 5 minutes

	Did you practice? Yes/No	**Skills Practiced**	**Problems, concerns, questions**
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

Do Skills: Don't:
Praise   No questions
Reflect   No instructions
Imitate   No criticism/sarcasm
Describe
Enthusiasm

MODULE II: REVIEW OF PRIDE SKILLS AND INDIVIDUAL COACHING
Session 2

A.	Outline

1. Summary of today's session
2. Review of homework and PRIDE skills
3. Therapist modeling PRIDE skills, selective ignoring
4. Families practice with individual coaching
5. Resilience Topic: Optimistic Thinking (Resilience Group Only)

Materials needed:

- Homework sheets
- Resilience Handout (Resilience Group Only)
- Glass for water (Resilience Group Only)

B.	Check-in on Children's Behaviors

Briefly check-in with each family to see how their children and family have been doing this past week and review homework.

C.	Introduction to Today's Session

"Today we're going to be continuing our discussion on the PRIDE and Don't skills. We will review these skills and practice with individual coaching."

D.	Review and model PRIDE and Don't skills

Review skills, therapists will model PRIDE and Don't skills, and field any questions from families.

E.	Individual Families coaching

The group will break up by family to practice Special Play time skills. Two families at a time will be coached individually by the co-therapists for approximately twenty minutes. Families who are not being individually coached will remain in the group room practicing their special play time skills. Families will rotate every twenty minutes between individual coaching and group practice. In the group practice, trained research assistants can provide basic information, but will not be coaching the families.

F.   Optimistic Thinking (Alvord, Zucker, & Johnson Grados, 2011)- **Resilience Group only**

Resilience topic handout

Parents and children are together for this section

"Today for our resilience skill we are going to talk about optimistic thinking. An optimistic outlook leads to greater happiness and more successful social interactions and today we will learn how to replace pessimistic thoughts with optimistic and realistic thoughts."

To younger kids say, "today we're going to talk about happy and sad thoughts. We all have sad thoughts sometimes, but today we'll learn how to turn our sad thoughts into happier thoughts."

Goals (for therapist reference):

- Explain and discuss the concepts of optimism versus pessimism
- Learn three healthy, optimistic ways to think about problems
- Explain that group members can change their negative thoughts to positive, realistic thoughts through self-talk
- Reinforce the concept that we have the power to choose how we react to a situation in a proactive way, thus influencing outcomes
- Practice a relaxation/self-regulation technique

Discussion:

Give children a handout to color in during the discussion

"We all talk to ourselves in our head - this is called self talk. Sometimes when we use self-talk we say nice things like "I can do this!" but sometimes when we get nervous or scared we may use our self-talk in a negative way to tell ourselves we can't do something. How many of you have ever told yourself something like that? (pause for responses) We all do it! And today we're going to talk about ways we can catch our negative self-talk and replace it with more optimistic, positive thoughts."

"First, we need to start out by talking about problems though. How many of you have ever had a problem? Have you ever noticed how we think about a problem can often make it better or worse? What's an example of a way we can think about a problem that might make it feel worse? How about an example of a way we can think about a problem to make it feel better?

We can all be guilty of thinking pessimistically or negatively sometimes, but there are three easy ways to think about a problem that can help you remember to think more positively.

The first way is to remember your problem is **temporary** rather than permanent. That means it won't last forever. Can anyone think of an example of a problem that feels permanent but is really only temporary? (Be prepared to prompt with – maybe a friend is playing with a toy, that doesn't mean you'll never get to play with that toy again).

[to younger kids say, "sometimes we can make ourselves feel better when we remember that our problems aren't going to last forever. So when your friend is playing with the toy you want you can remember you'll get to play with the toy again too!"]

Second, when we think of our problems as more **specific** to just what is happening now rather than something bad about ourselves we are thinking optimistically. Can anyone think of an example for

thinking specifically about a problem? (Be prepared to prompt with an example – missing one basket in basketball doesn't mean you're terrible at all sports).

[to younger kids say, "When we think of of our problems as specific we have happier thoughts. This means that if we hurt our fingers we don't think our whole arm is going to fall off, we just have a hurt finger."]

Finally, it's helpful to remember to be realistic about who is **responsible** for the problem. There will be times when a problem is your fault and it is good to take responsibility. However, some problems are not your fault. It can be helpful to think of these problems as limited and specific. For example, if you missed a question on a test an example of or positive self-talk can be 'I missed that question because I didn't do my homework' instead of 'I'm stupid.'"

"When your self-talk is negative, a problem seems huge and permanent, which can make you feel scared and sad. When you think positively, you see the problem in a realistic way – that it won't last forever and is only in this specific situation. That makes you feel more hopeful and happy because you realize you can fix the problem or work to make it feel smaller (by remembering what you're grateful for, for example)." (p.147)

"Once you've realistically explained the cause of the problem, you can now take control over what happens next and act in a proactive way."

Catching Negative Self-Talk Activity

- Point out that we can be aware of and change our thinking patterns.
- Demonstrate, using the glass of water. Say:
- "Raise your hand if you think this glass is half-full. How many people think this glass is half-empty? Guess what-you are all correct! The glass is either half-full or half-empty."
- "The great thing about choosing to think in a positive but realistic way is you can actually make yourself feel better. When you catch yourself using negative self-talk you can take control of the situation by catching the negative thoughts and replacing them with positive thoughts."
- Parents, this is a skill your kids can learn, but they will need your help. When you hear them say things that show they are having negative self-talk, help them change their thoughts. So, if your child comes in and says, "I'm the worst at baseball!", you can ask them to tell you about the times they did well, or about how hard they are practicing to get better, or about how much fun they have when they play. All of these will help them come up with a more

accurate thought. You can also prompt that with something like, "So, maybe you are still learning, and we know everyone who is learning will have times where things feel hard."

- [reference handout kids have been coloring] Parents help kids circle the optimistic/positive phrases they can use, create their own positive phrase, and put a star beside the one they like the best. Put this of refridgerator so they can remember to say positive things.

"Changing the Channel" Activity

1. Remind the group members that when you change your thinking, you also change how you feel.

2. Instruct the group to close their eyes and think about a happy scene from their life. Have them picture themselves as part of that scene. Wait 10 to 20 seconds and have them open their eyes. Ask, "What was that like?"

3. "Now we're going to change the channel." Tell the group members to close their eyes and picture a scene that makes them feel sadness, anger, frustration, or another negative emotion. "Alright we're going to change the channel again!" Tell group members to close their eyes again and this time think of a funny situation. Again, wait 10-20 seconds. Have the group members open their eyes and ask, "What did you think of, and how did you feel this time?" Encourage volunteers to share their thoughts and ask them how these thoughts made them feel.

4. Ask them to change the channel to either the happy or funny one. Say that when we learn to monitor our thinking, we can be aware of when we are being optimistic and when we are engaging in negative thinking.

Relaxation Exercise

If time, lead group members in a deep breathing exercise. Start by teaching the children and parents how to breath from their bellies. If needed, use bubbles to teach the children how to let their breaths out slowly. Practice having families breathe in for 5 seconds and then out for 5 seconds.

G.   Session review and homework review (Both groups)

The therapists will review any questions, concerns, or problems that arose during the session. Therapists will pass out homework sheets and help families solve any problems to ensure they can practice 5 minutes a day.

MODULE II: Handouts

Optimism Activity for Kids

Directions: Circle all the happy statements

You can do it!   This will never work out.   I know I can do better next time

Everything's ruined   It will get better!   I'm awful

Write in your own positive statement:

Directions: Color in your happy face
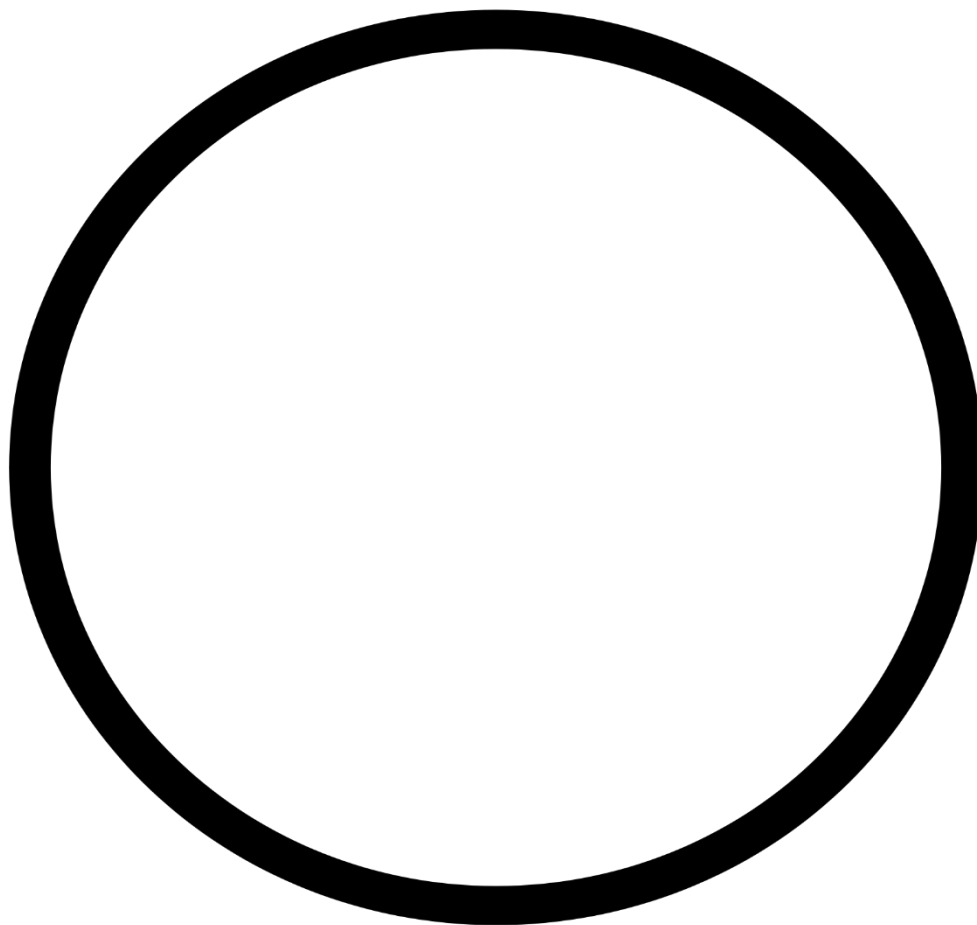
Homework Sheet: Week 2

Directions: Practice everyday for 5 minutes

	Did you practice? Yes/No	**Skills Practiced**	**Problems, concerns, questions**
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

Do Skills: Don't:
Praise   No questions
Reflect   No instructions
Imitate   No criticism/sarcasm
Describe
Enthusiasm

MODULE III: INTRODUCTION OF DISCIPLINE STRATEGEIS

Session 3

A.   Outline

1. Summary of today's session
2. Review of homework and PRIDE skills
3. Introduction of Discipline program
4. Group families coaching
5. *Resilience topic: Stress Management (Resilience Group Only)*
6. Completion of measures

Materials needed:

- Homework sheets
- Giving Effective Instructions handout
- PDI diagrams: Time out sequence
- Mid-point assessment materials

B.   Check-in on Children's Behaviors

        Briefly check-in with each family to see how their children and family have been doing this past week and review homework.

C.   Introduction to Today's Session

        "Today we're going to review our PRIDE skills and introduce the discipline program we mentioned in session one."

D.   Review and model PRIDE and Don't skills

        Review skills, therapists will model PRIDE and Don't skills, and field any questions from families.

E.   Introduction to Discipline program: Parent-Directed Interaction (PDI)

"Before we get into the discipline program, I wanted to review the advantages to getting your children to listen to you. There are benefits for both you and your child, including: less embarrassment, less inconvenience, not having to leave work early for school behavior problems, easier time finding babysitters to help when needed, and overall less stress from parenting.

For kids, there are benefits to having parents set rules and limits for their behaviors: learning how to follow rules leads to development of early social skills such as following rules in games and taking turns, more fun times with parents since less time is needed for discipline, and young children really want parents to be in control because it lowers anxiety, and makes a safer environment."

Steps for teaching PDI skills

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1. Giving effective instructions
2. Determining if child has obeyed
3. Consequences for obeying - Praise
4. Consequences for disobeying - Timeout
5. Coach Parents as they role-play discipline skills

Importance of consistency, predictability, and follow through

- "When we talk about effective discipline we have to remember 3 key components: consistency, predictability, and follow-through.
- Consistency should be used in discipline so parents respond the same way to misbehavior each and every time. This ensures your children are clear on the rules and the consequences because children are notorious for pushing boundaries; they will test you to see how far you will let them go. The key to this discipline program is consistently implementing the consequence every single time.
- Predictability is useful so children begin to recognize there is no point in pushing the limits – they will receive a consequence every time they disobey. Additionally, we recommend implementing the discipline program using a neutral, robotic expression using pre-established words, so much of the stimulation is removed from the procedure. Think back to that attention gastank we talked about before, by using the same neutral, robotic procedure your kids are not inadvertently receiving attention from a discipline program.
- Follow-through is important because you have to say what you mean and mean what you say. If you issue an instruction and your children do not comply you must follow through every single time. We will discuss some times when you should not issue an instruction because you do not have the time to follow through – but just be aware that if you issue an instruction you must be prepared to follow through with our discipline program.

The first rule of PDI is that children must comply when told to do something.
- To get children to listen, parents should respond very differently to compliance versus noncompliance. Parents should also apply different consequences for compliance and noncompliance.
- Compliance should be followed by enthusiastic social reinforcement, which is labeled praise, which we learned during special play time, whereas noncompliance is followed by a neutral, boring, consistent, and aversive sequence of discipline steps which we will learn today. By the end I want you to sound like a robot by performing these steps automatically"

Giving Effective Instructions

Provide handout of giving good instructions

"A huge component of obtaining compliance from your children is to use effective instruction and a lot of problems we see with noncompliance can be fixed or at least helped by using these steps to issue effective instructions.

- First: make instructions direct. This makes it clear to the child what they are expected to do and parents are telling children what to do instead of asking whether they want to comply.
  - o When we talk with other adults it can seem rude to issue direct instructions, so you probably ask your partner if they would mind taking out the trash rather than a direct command to take the trash out, right?
  - o *Q: Ask parents what might be some problems with using indirect instructions with children (Therapists model example of children saying no if parents don't respond)*
  - o When asked if they can/will/want to do something, children will often say no and that's an acceptable response based on your initial question of "will you…."
  - o By simply switching up the phrasing you can avoid this problem by stating your instruction clearly and directly which removes the option for them to say no. For example, "Instead of, 'will you put on your shoes?" say, "Please put on your shoes." Model different voice inflections.
- Make instructions single rather than compound. Instructions need to be given one at a time, rather than grouping several together.
  - o *Q: What might be a common example of a compound instruction? What are the problems that usually occur? (e.g., forgetfulness, distraction)*
  - o A series of smaller instructions, particularly when the child is in the early stages of learning to comply, are better to use so the child can have more opportunities to experience the positive consequences of obeying.
  - o Again, the more we praise a child the more they are going to do that behavior, so the more opportunities you give your child to comply and praise them the more they are going to listen.
- State instructions positively. Tell your child what time-out DO rather than what NOT time-out DO.
  - o *Therapist model feet on table -have parents reply with how they would tell you to put your feet down. Typical response – "get your feet off the table." Therapist then puts feet on wall, etc. to demonstrate importance of saying exactly what you want them to do.*
  - o Children are more likely to comply with positively stated instructions.
  - o An added bonus of positively stated instructions is that they get the self-esteem boost from doing the right thing rather than stopping a bad behavior and getting in trouble.
  - o Some children see a "don't" command as a challenge to further engage in negative behaviors.

- Make instructions specific, not vague. Children can easily misinterpret the behaviors expected of them with a vague command.
    - *Q: how many of you have ever vaguely told your child to do something like clean up and the child's version of "cleaning up" is very different than your version?*
    - We can avoid issues like these by specifically stating our instructions. For example: "Please put all of your Legos in the blue bin." There's no wiggle room in that instruction because you've specifically stated your expectations.
- Give instructions in a neutral tone of voice. Children are experts at training their parents to teach them they are serious. Typically these cues are related to our body language. For example, we often see getting louder or yelling as a sign of seriousness which may signal to your child that you are not serious until you start yelling. *Therapist model.*
    - Another common signal is facial expression. We all probably have a stern you-better-listen-to-me-now face that we pull out when we're serious. *Therapist model.*
    - The problem with these cues is that children learn exactly when they have to listen. Maybe you've already given an instruction 3 times before you pull out the stern face and they listen. Our goal is to get children to listen to directions issued in your normal conversational tone. We use a neutral tone because it represents a strict, matter-of-fact approach without yelling or pleading with your child. This teaches children to listen the first time and saves you a lot of frustration.
- Be polite and respectful. A good habit for parents to start getting into is to start instructions with the word "Please." Again, we want our children to be polite and the best way is to teach them through our behavior.
- Be sure instructions are developmentally appropriate. You wouldn't ask your 10-year-old to drive down to the grocery store for some milk, so expecting your 3-year-old to clean their room without help or just by telling them "clean your room," is probably too much for them to handle.
- Use gestures. Use direct instructions only when really necessary. The goal of our work together is to greatly reduce the total number of instructions given to these children."

"I think there is a place for both direct instructions and indirect instructions in your parenting. I just want you to be a clear communicator with your child. When it is important to you that your child do what you're telling him to do and do it right away, that should be a direct instruction. For example, you would want to use a direct instruction when telling your child to put on his shoes. You should save indirect instructions for times when you just want to make a suggestion. An example of this might be, "Could you pass the salt please?," or, "Will you please give me a hug?" I respect you as a parent and I don't want to impose my own parenting values on you. But, I do want you to have a tool for getting your child to listen. I might choose to use a direct instruction for tasks of daily living that need to be accomplished like getting ready for school in the morning, doing chores, completing homework, coming to the dinner table, getting ready to go out the door, cleaning up after oneself, and getting ready for bed. On the other hand, I would use indirect instructions when I want my child to do a favor for me, like bring me a tissue, bring me my purse, answer my phone, or hold open the door. Another time when I might use an indirect instruction is when my child seems bored and needs something to do. Then I might use an indirect instruction like, "How about building something with your Legos," or "Why don't you call up a friend?" Giving rapid-fire direct instructions can make you sound like a drill sergeant, and I know you want home to be a calm,

relaxing place for both you and your child. So if you are at the dinner table and your child is sitting on his knees or blowing bubbles in his milk, I hope you will ask yourself, "Is it critical or essential that I give an instruction to correct this behavior?" If the answer is "no", then it would be better to use an indirect command or a play therapy skill such as ignore and distract."

- Incorporate choices when appropriate. Preschoolers often comply more readily when given choices; choices help children to become autonomous and learn decision-making skills.
  - When giving "choice instructions," a good rule of thumb is for parents to try to limit the choices to two equally acceptable behaviors.
  - For example, "you can put on your shoes or go get your coat."
- Provide a carefully timed explanation. It is sometimes appropriate to give children explanations for why they should do a requested behavior because they can be important teaching tools. To help parents understand the importance of using explanations with young children we explain the following:

"One time that is especially important to use an explanation is when you are asking your child to put away what she is doing to come and do what is on your agenda. If you think about it, we expect this of young children many, many times every day. The picture that she is coloring is just as important to her as getting to the grocery store is to you. However, we expect her to always drop what she's doing to conform to the schedules of the adults around her. Let me ask you something, when you are right in the middle of doing something and your partner comes in and asks for your help with something, do you always go right then? Or do you sometimes or even often say, "I'll be there as soon as I can," or "I'll be there in just a minute," and finish what you were already doing or get to a stopping point? Maybe wait until the next commercial, or until you finish the page you are reading. Imagine how frustrating it can feel for your child to always have to immediately drop what they're doing to go along with others. To smooth this transition, we like to use explanations when asking children to switch activities."

"However, explanations can get tricky with kids as they often try to use it as an excuse to stall their compliance. The key to providing an explanation to children is to time it correctly and keep it brief while refusing to engage in arguments or discussions about this explanation. This means the explanation should only be provided before issuing the initial instruction or after the child has complied. For example, if you need your child to put away their toys so you can go to the store, you can say, 'It is time for us to go to the store because I need some things to make dinner. Please put your toys away now so we can leave.'"

Determining Compliance

"So, now that we have given a child a strong, effective instruction in a neutral tone, how do we know if she complied?"
- Doing something slightly different from your request. *Therapist model – ask parents if it's compliance.* If a child gives you a red block when you asked for green this is noncompliance as long as they know their colors.
- Dawdling. *Therapist model – ask parents if it's compliance.* This is when a child is slow to obey. If the child has not complied or started to comply within approximately 5 seconds, it is noncompliance.

- "Playing deaf." *Therapist model – ask parents if it's compliance.* Sometimes a child will act like they did not hear you. If you are sure they heard you, do not repeat the instruction. You can use gestures to point, but wait and don't repeat. Usually kids are testing the limits and if you repeat the instructions, they learn they can wait and avoid or delay having to comply. If they don't start to comply in about 5 seconds, then it's noncompliance.
- Partially complying. *Therapist model – ask parents if it's compliance.* This occurs when the child starts to comply but stops halfway through. It is important for the parent to not treat this as compliance and to clarify the instructions. This is also another great time to use gestures.
- Complying with a bad attitude. *Therapist model – ask parents if it's compliance.* Parents are instructed to see this as compliance and ignore the bad attitude. The bad attitude is not rewarded with parental attention, so we find it rapidly diminishes. If the bad attitude continues the parents are instructed to include "nicely" in their instruction.
- Undoing. *Therapist model – ask parents if it's compliance.* This is when the child initially obeys and then behaves in a way that negates the obedience. This could be displayed as a child giving the parent a block and immediately taking it back. This is compliance because the parent didn't specify to leave the block in their hand. If undoing continues, the parent is to clarify and say "place the block in my hand and leave it there." If the child continues undoing it is noncompliance.

Time out rationale:

"Now that we have discussed what compliance is and how to tell if your child has complied we're going to get into the specifics of implementing our discipline program.

But first, how have you seen your children work for your positive attention (*therapist be ready with examples to prompt discussion*). How do you think your child would react if you stopped giving them attention for noncompliant behavior? Would they like that? Would it be considered a consequence? Now that our children are working for our attention, taking it away can be VERY powerful. They want us to praise and attend to them, and when that is gone, it sends a strong message that you do not like the behavior they were just displaying.

In fact, building the relationship with your children to be the strongest possible means that now taking away that attention when a child misbehaves will truly be a consequence. Therapists and researchers call this removal of attention Time Out."

"A lot of you may have previous experiences with time-out. What we find is that there are a lot of reasons it may not have worked for you before"
- not having all the positives – if a kid isn't getting positive attention, then there isn't much to take away
- not doing it the correct way – time-out is a very structured procedure that needs to followed exactly, every time for it to be effective
- extinction burst and not waiting that out

- need to be CONSISTENT and IMMEDIATE with consequences – just like we are for positive consequences, etc.

Reasons for choosing time-out over other forms of discipline include:
1. acting-out children are motivated to avoid time-out because it keeps them from stimulating activities, including getting attention from others
2. few consequences are more aversive to a young child than complete boredom
3. unlike some other consequences (e.g., restriction of privileges), time-out can occur within seconds of the inappropriate behavior
4. unlike spanking, short time-outs can be safely administered numerous times per day, thereby allowing the parent to be more consistent in following through with consequences
5. unlike spanking, time-out does not cause some children to become more aggressive because the parent does not serve as a model for hitting
6. time-out is a commonly used discipline strategy in classrooms: use at home will promote greater cross-setting consistency and enhance the child's behavioral adjustment at school as well as at home.

- "Many parents have tried something that they call time-out, but it may not be done exactly the way we will teach you, which has been used with thousands of children successfully. For time-out to be successful, it has to be done exactly right and in the context of building the parent child relationship in order to have the contrast for the kid between attention for good or neutral behavior, and complete removal of all attention for negative behavior."
- If parents are still doubtful say: "I understand your doubts, and that is why we don't send you home to practice without any help. We'll be there coaching you so you can be sure you know how to react when your child misbehaves. In fact, this technique has worked with so many other children I'm confident it can help your family too. Why don't we just try it out for now and we can reassess your feelings on time-out next week. How does that sound?"

(Therapist Note: See logistical issues associated with time-out if further issues arise)

Time out is a sequenced procedure. (pass out handouts with time-out procedure)

1. First, you issue an instruction.
2. You wait approximately 5 seconds to give your child a chance to comply – DO NOT COUNT ALOUD.
3. If they comply, you give an ethusiastic labeled praise. ("Thank you so much for listening! I love when you listen to me!")
   a. If they do NOT comply you give a two choice statement: "You can either [repeat intial instruction] or go to time-out."
4. Wait approximately five seconds for compliance or non compliance.
5. If child complies after this warning, give a labeled praise, but not as enthusiastically as if they complied the first time instruction was given. (Thank you for listening to me!")
6. If child does not comply, begin time-out procedure.
7. Time out does not end until the child has complied with the **original** instruction.

Getting the child to time-out:

"So once we've deemed the child has not complied and is going to time-out, you may run into some problems. While these problems are never fun to deal with, they indicate to us that time-out is working because the child does not enjoy going to the time-out chair."

- Problem behaviors that can occur on the way to time-out: *What problem behaviors have you seen before?*
- Escorting a cooperative child to time-out: parents are instructed to take child's hand and lead them to the time-out chair, and say, "you did not listen to Mommy, so you have to sit here and be quiet until I tell you to get up" and place them there with self-control and neutral facial expression. SAY NOTHING ELSE, no matter how child is behaving.

"Once it is clear the child is not complying with the time-out warning, your job is to get them to the time-out chair quickly, without providing any additional attention. If you think about it, on the way to time-out kids are on a center stage for misbehaving with a great big spotlight on them so we want to get them off this stage as quickly as possible. We do this by moving them quickly to time-out where we can ignore them. The only words you should say to your child are "You didn't do what I told you to do so you have to sit on the chair." Do not say anything extra on the way to the time-out chair. If they go limp like a wet noodle, don't say, "Come on. Get up. You can go to time-out. You know how to walk there." If they start to run away, don't say, "Come back here!" If they pull your hair, please don't say, "Ouch, that hurt!" Remember our attention gas tank? Any words are fueling their attention gastank with negative attention and rewarding misbehavior. This fuel will make it much harder to teach children how to appropriately walk to timeout."

Common Time out concerns:

What If the Child Agrees to Comply on the Way to Time-Out?

- Parent should still take child to time-out and say, "You didn't do what I told you to do quickly enough, so you have to sit on the chair. Stay on the chair until I tell you to get off."

What if the Child Takes a Toy to Time-Out?

- The best parental response is to quickly take the toy from the child's hand and to avoid saying things like "give me that toy!"

What if the Child Puts Himself in Time-Out?

- If the child goes to time-out before the parent tells them to so that they can be in control, the parent is instructed to give their instructions again and if the child does not comply say, "If you do not follow my instructions you're going to have to sit on the chair."

- If they continue to sit in the chair parents are instructed to say, "You didn't do what I told you to do so you have to sit on the chair. Stay on the chair until I tell you that you can get off."
- When the child learns that placing himself in time-out will not derail the procedure, this behavior will extinguish.

Length of Time-Out

- We use a time-out period of 3 minutes because it is the shortest time-out period that is still effective. In fact, a longer time-out means fewer chances for your child to practice complying with instructions and getting attention for her good behaviors. A 3-minute time-out is long enough for a child to notice he is not getting attention, but short enough to repeat as needed.
- After the 3 minutes are up, the parents should wait 5 seconds and if the child is silent for those 5 seconds, the parent will walk over to them and say, "You are sitting quietly in the chair. Are you ready to come back and [repeat initial instruction]?"
- Now there are some rules which may make time-out longer – children must be quiet for the last 5 seconds for time-out to be over. (AGAIN DO NOT COUNT ALOUD.) If children are not quiet for at least 5 seconds at the end of time-out then you must wait for 5 quiet seconds.
- At the end of 5 quiet seconds say, "Thank you for sitting quietly in the chair, are you ready to [repeat initial instruction]?"

Common Misbehaviors in Time-Out that Should be Ignored

- Parents should ignore all verbalizations, no direct eye contact should be made, parent should not show disgust, amusement, or irritation, instead the parent's face should be neutral and expressionless as a robot's.

Time-Out Does Not End Until the Original Instruction Is Obeyed

- "The key part of time-out is compliance and the child does not learn to comply through time-out. Instead, the child learns to comply when they have the opportunity to redo the initial instruction.
- It is extremely important that you DO NOT complete the task your child went to time-out for - child will learn she can get out of doing chores/requests and only has to sit for a few minutes. As adults, we would definitely choose a time-out over, say, washing dishes, and so would a child. The child must come back and do the instruction. The parent can't do it for them while they are in time-out."
- Child says "no" to the "are you ready" prompt: Parent's should say "Okay, stay on the chair until I tell you that you can get off," and walk away.
- Child says "Yes" to the "are you ready" prompt: take kid back to where you gave instruction and start over with the instruction, and do entire procedure again.
- Over correction – immediately after compliance, give a new instruction. Again, same steps for compliance or noncompliance, including another time-out if needed. This

teaches your child they must comply when you give instructions. *C**ompliance with second instruction indicates time-out is over.*

"Most parents shy away from giving another instruction right after their child has come out of time-out because they don't want to go through all of that again. But, if you do that you miss out on a really important opportunity. Right after you child has complied with that instruction after coming out of time-out, you have a teachable moment. About ninety percent of children are going to comply with the next instruction you give right after coming out of time-out. If you give a second instruction and they comply, that's your chance to do back handsprings and high fives. What you want to do is to maximize the contrast between how you respond when he complies right away versus what happens when he goes to time-out and then complies."

When NOT to use time-out:

"It is very important to not issue instructions when you do not have time to follow through with the entire time-out procedure. We want kids to learn that you mean what you say and they have to listen to you, so every single time you issue an instruction you must be willing to follow through with time-out if they don't comply. If you know you will not have time to implement time-out (e.g., school mornings) use alternatives such as choices or rewards."

- Use 2 to 3 choices to give children options without committing yourself to time-out. For example, "You can either brush your teeth, get your shoes on, or put your lunchbox in you backpack. What would you like to do?"
- Rewards can also be effective ways to achieve compliance without resorting to time-out procedures. For example, you can make morning routines a game and whoever gets ready first (and correctly) receives a special prize.

Three Time-Out Behaviors That Cannot Be Ignored

- Time-Out Escape. Parents are given the 50% of body weight rule, once 51% of the child's body weight is off the chair, the child is considered to have gotten out of time-out. If the child has left the time-out chair calmly take them by the hand and place them back in the time-out chair, just as you did for the initial time-out walk. After the first replacement, children should be taken to the back-up time-out. This is ideally a room in your house in which you can put your child for time-out. It should be free of toys or items that can hurt the child.
  - Back up time-out: The warning for the time-out room should only be given once in the child's life as follows, "You got off the chair before I said you could. If you get off the chair again, you will have to go to the time-out room. Stay here until I say you can get off," and the 3 minutes timing (NO TIMER) starts over again.
  - If the child escapes again the parent should say, "You got off the chair before I said you could, so you have to go to the time-out room." The child is then quickly and calmly taken to the timeout room and set down on the floor facing away from the door. The child should stay in the room for 1 minute plus 5 seconds of silence. Once this is completed, the child should be taken **back to the time-out chair** and told, "Stay on the chair until I tell you that you can get off" and the 3 minutes timing begins again. This is repeated until the child is able to stay in the seat.

- Scooting or vigorous rocking of the time-out chair. Children should be informed scooting and rocking the time-out chair are not permissible and will lead to a negative consequence.
- Standing on the time-out chair. This is dangerous to the child and should be handled assertively using back up contingencies.
  Back up contingencies = back up time-out

Therapists role play entire sequence.

Logistical Issues Associated with Time-Out

- Placement of the time-out chair should be in the "middle of nothing." This is so the child doesn't have anything to touch when in time-out. The TV should not be in view and the parent should be able to view the child but not allow the child to easily see the parent.
- Choosing the time-out chair. The chair should be sturdy so the child can't easily move it. It also is recommended to be adult size because it doesn't allow the child to move out of it as much as a child-sized chair.
- Do not try to do this at home yet! We will practice next week in session and once you have completed a time-out in session you will begin practicing at home!

F.   Families practicing

Families will break into families and practice each component of PDI: giving effective instructions, determining compliance, and time-out sequencing.

G.   Resilience Topic: Stress Management (Alvord, Zucker, & Johnson Grados, 2011) - **Resilience Group only**

Resilience group handout

"Today we are going to talk about stress management because we know having long term stress can cause you to experience physical problems like heart problems and weight gain. Stress is a part of life, so learning how to manage it effectively is really important."

Goals

•   To explain the concept of stress and to facilitate awareness of how stress affects the body and mind
•   To help group members understand their unique individual stressors and signs of stress
•   To teach that there are different ways to react to stress and encourage flexibility in thinking in order to reduce stress
•   To encourage participants to develop a plan for coping with stress, including coping thoughts and actions
•   To practice a relaxation/self-regulation technique

Define and Demonstrate Stress

1. Ask participants if they know what *stress* means and help them define and understand the concept.
    a. Stress is our response to pressure. We may experience a wide range of symptoms from feeling nervous or on edge to muscle tension and headaches.
    b. To younger kids, "stress is what you feel when you are worried or uncomfortable. This worry can make your body feel bad, you may feel angry or afraid."
2. To help the group understand the concept, demonstrate the burden of stress:
    a. Ask a group member to name his or her stressors. For each one, provide a book for the member to hold. As the list gets longer, the pile of books gets heavier! Then prompt the group member to come up with ideas to get rid of each book.
    b. To younger kids, what things make you worried or afraid.
    c. It is helpful to make a list of these stressors as generated so that group members can recognize some stressors they have in common.
3. Thermometer analogy – Stress Thermometer handout
    a. Give handout to kids with instructions to draw and color in their stress thermometer.
    b. "This is our stress thermometer, when our stress level increases so does the temperature on our stress thermometer. We all have some stress, so our stress thermometer usually rests around here. What are some things that raise your stress temperature? (Color in more of the stress thermometer as they list each stressor.) What might happen if our stress temperature gets to the top (prompt for answers like get angry, yell, panic). When our stress level gets too high we need to have ways to lower it so we don't get angry or panic."
    c. "What are some ways you can lower your thermometer level?"
        i. Sleeping well; eating well; exercising; relaxing; talking about your feelings; positive self-talk; riding your bike; spending time with friends; listening to music; writing in a journal; focus on one task at a time.

Discuss Coping Thoughts and Coping Actions

1. Explain that ways of coping with stress can be effective or ineffective. "One way we can cope with stress in an effective way is to use coping thoughts."
2. Have the group come up with coping thoughts: Say, "Suppose you're stressed out because you have a lot of things to do or you have to clean up your whole room and it's really messy. What could you tell yourself or think about to make yourself feel better?"
3. Also have the group generate coping actions: Say, "What can you do in response to stress when you are feeling it? What is your coping plan?"
    a. What are some thing you could try to do to make yourself feel better?
4. Explain that coping well with stress requires flexibility in thinking. Say, "When we deal with stress, we have to be flexible in the way we think."

Engage in Progressive Muscle Relaxation (PMR)- handout

"One way we can relax when we are stressed out is to use something called Progressive Muscle Relaxation where we tense and then relax all the muscles in your body."

H.   Session review and homework review

The therapists will review any questions, concerns, or problems that arose during the session. Therapists will pass out homework sheets and help families solve any problems to ensure they can

practice 5 minutes a day and inform parents not to use time-out yet but continue practicing special play time skills. Families will complete measures at the end of session.
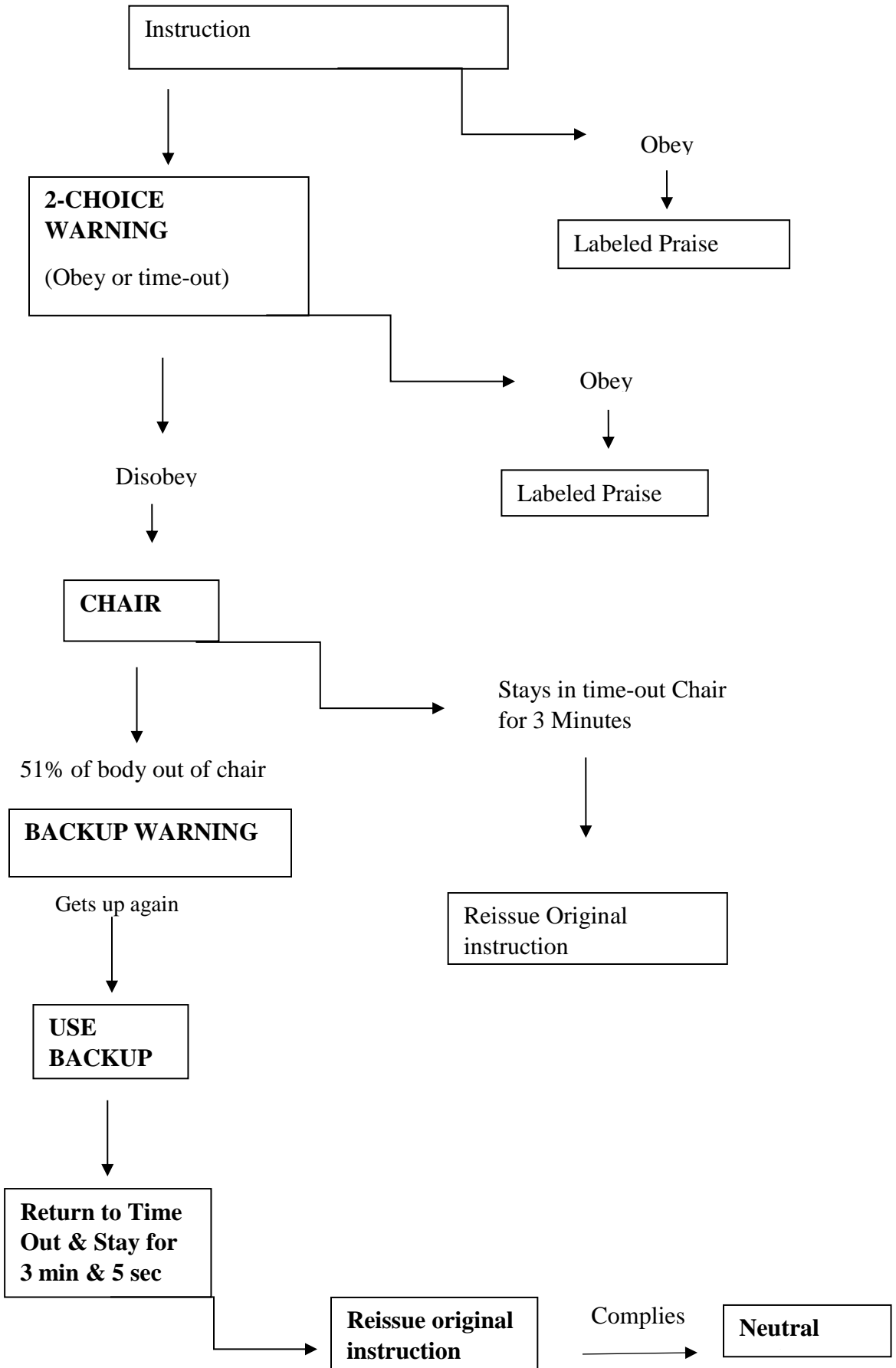
MODULE III: handouts

Giving Good Instructions

Rule	Example
Make your instructions direct rather than indirect	<u>Direct:</u> Please put your feet on the ground. <u>Indirect</u>: Let's clean up your room okay?
Use single instructions, not compound	<u>Do this:</u> Please brush your teeth <u>Not this:</u> Please get your shoes, brush your teeth, and put on your jacket
State instructions positively – tell them what <u>to do</u> instead of what <u>not</u> to do	<u>Do this</u>: Please put your feet on the floor <u>Not this:</u> Stop kicking the wall
Use specific instructions	<u>Do this:</u> Please walk <u>Not this:</u> Calm down!
Use a neutral tone of voice	<u>Do this:</u> neutral voice <u>Not this:</u> begging, yelling, loud, etc.
Only use instructions when you can follow through with a consequence	
Use choices when appropriate	You can either go put your shoes on or brush your teeth.
Use appropriate explanations	Give the explanation before the command or after the child has complied

Source: McNeil & Hembree-Kigin, 2010

Time Out Procedures

Instruction

Obey

Labeled Praise

**2-CHOICE
WARNING**

(Obey or time-out)

Obey

Labeled Praise

Disobey

CHAIR

Stays in time-out Chair
for 3 Minutes

51% of body out of chair

BACKUP WARNING

Reissue Original
instruction

Gets up again

**USE
BACKUP**

**Return to Time
Out & Stay for
3 min & 5 sec**

Complies

**Reissue original
instruction**

Neutral

Stress Thermometer
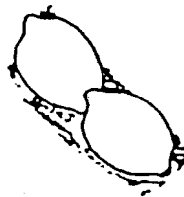
Draw and color in your own stress thermometer
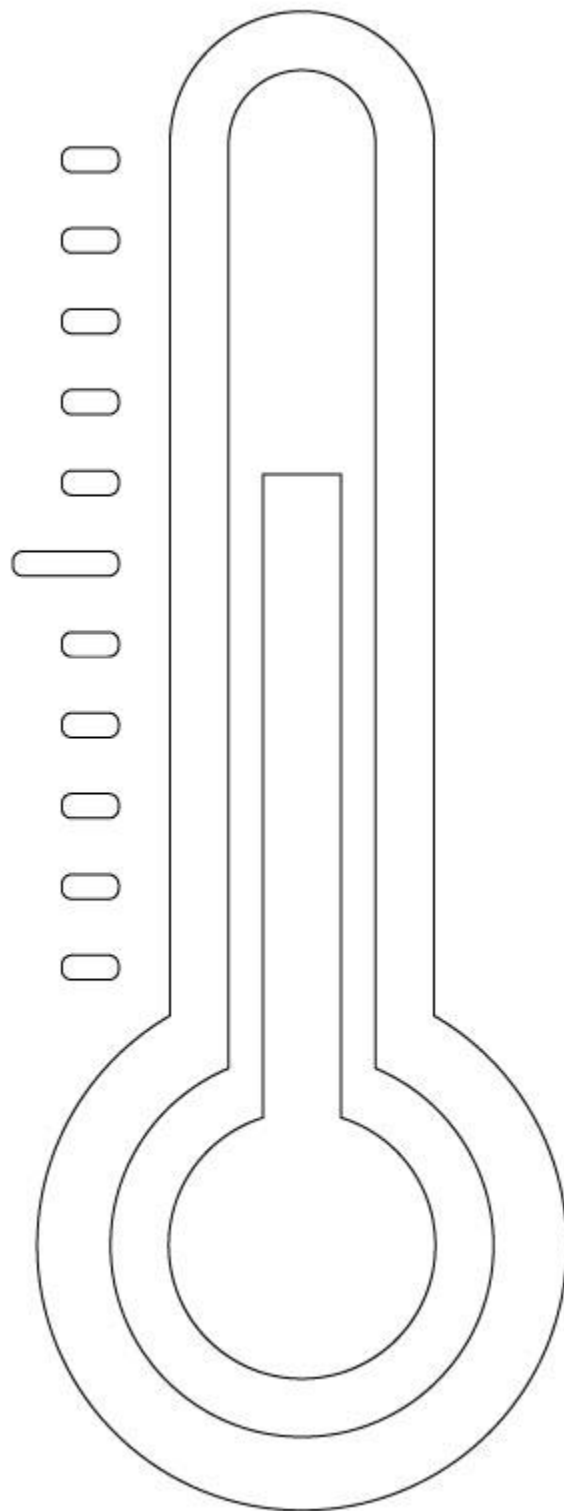
LEARNING time-out RELAX

Hands and Arms

Squeeze the juice out of a lemon.

Arms and Shoulders

You are a lazy cat stretching your arms in the sun.

Shoulder and Neck

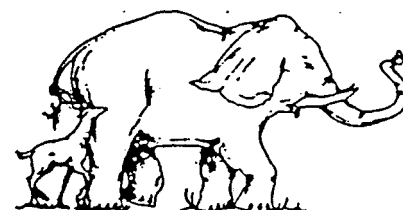You are a turtle. You sense danger and pull your head into your shell.

You have a giant jawbreaker bubblegum in your mouth and are trying to bite down.
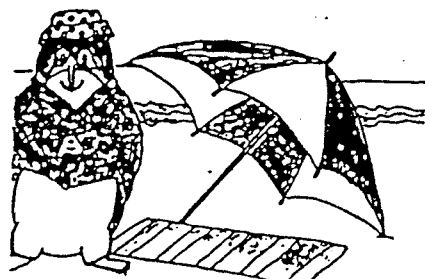
Face and Nose

A fly lands on your nose. Try to get it off without using your hands.

Stomach

An elephant is about to step on your stomach. Make it hard.

Legs and Feet

You are barefoot at the beach, squishing your toes in the sand.

Hands & Arms

Pretend you are squeezing a whole lemon in your left hand. Squeeze it hard. Try to squeeze all the juice out. Feel the tightness in your hand and arm as you squeeze. Now drop the lemon and relax. See how much better your hand and arm feel when they are relaxed. Repeat with the other hand.

Arms & Shoulders

Pretend you are a furry, lazy cat. You want to stretch. Stretch your arms out in front of you. Raise them up high over your head. Way back. Feel the pull in your shoulders. Stretch higher. Now just let your arms drop back to your side. Okay kitten, stretch again. Repeat.

Shoulder & Neck

Now pretend you are a turtle. You're sitting out on a rock by a nice, peaceful pond, just relaxing in the warm sun. It feels nice and warm and dafe here. Oh-Oh! You sense danger. Pull your head into your house. Try to pull your shoulders up to your ears and push your head down into your shoulders. Hold in tight. It isn't easy to be a turtle in a shell. The danger in past now. You can come out into the warm sunshine and once again you can relax and feel the warm sunshine. Watch out now. More danger. Hurry pul your head back into your house and hold it tight. Repeat.

Jaw

You have a Giant jawbreaker bubble gum in your mouth. It's very hard to chew. Bite down on it. Hard! Let your neck muscles help you. Now relax. Just let your jaw hang loose. Notice how good it feels just to let your jaw drop. Okay, Let's tackle that jawbreaker again now. Repeat.

Face & Nose

Here comes a pesky old fly. He has landed on your nose. Try to get him off without using your hands. That's right, wrinkle up your nose. Make as many wrinkles in your nose as you can. Scrunch your nose up real hard. Good. You've chased him away. Now you can relax your nose. Oops here he comes back again. Repeat.

Stomach

Hey! Here comes a cute baby elephant. But he's not watching where he's going. He doesn't see you lying there in the grass, and he's about to step on your stomach. Don't move. You don't have time to get out of the way. Just get ready for him. Make your stomach very hard. Tighten up your stomach muscles real tight. Hold it. It looks like he's going the other way. You can relax now. Let your stomach go soft. Let it be as relaxed as you can. That feels so much better. Oops, he's coming this way again. Get ready. Repeat.

Legs & Feet

Now pretend you are standing barefoot in a big, fat mud puddle. Squish your toes down deep into the mud. Try to get your feet down to the bottom of the mud puddle. Push down, spread your toes apart, and feel the mud squish up between your toes. Now step out fo the mud puddle. Relax your feet. Let your toes go loose and feel how nice that is. It feels good to be relaxed. Repeat.

Reference: Carkhuffm R.R. Helping and human relations, vol. 1, New York: Holt, Rivehart & Winston, 1969

	Did you practice? Yes/No	**Skills Practiced**	**Problems, concerns, questions**
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

Do Skills: Don't:
Praise   No questions
Reflect   No instructions
Imitate   No criticism/sarcasm
Describe
Enthusiasm

MODULE IV: REVIEW OF DISCIPLINE SKILLS AND INDIVIDUAL COACHING
Session 4

A.　　Outline

1. Summary of today's session
2. Review of homework and PRIDE & time-out skills
3. Therapist modeling time-out procedure
4. Families practice with individual coaching
5. *Resilience Topic: Empathy & Perspective Taking (Resilience Group Only)*

Materials needed:

- Homework sheets
- Resilience Topic handout *(Resilience Group Only)*

B.　　Check-in on Children's Behaviors

Briefly check-in with each family to see how their children and family have been doing this past week and review homework.

After checking in, inform the children their parents will be using time-outs when they don't listen. Use dolls to demonstrate the time-out procedure the children will be practicing with their parents today.

"Today your parents are going to be practicing their time-out skills. When you don't listen to your mom or dad you're going to have to go to time-out. We're going to show you what time-out looks like using our dolls so you know what you'll be practicing today with your parents."

Therapists model time-out procedure (don't give two choices) using dolls.

C.　　Introduction to Today's Session

Today we're going to be continuing our discussion on discipline skills. We will review these skills and practice with individual coaching.

D.　　Review and model discipline skills

Review skills, therapists will model discipline skills, and field any questions from families.

E.　　Individual Families coaching

Group will break up into families to practice discipline skills. Two families will be coached individually by the co-therapists for approximately twenty minutes. Families who are not being

individually coached will remain in the group room practicing their special play (not time-out) skills. Families will rotate approximately every twenty minutes between individual coaching and group practice.

Parents and children will begin by practicing special play time, incorporating instructions into the play situation. When a child does not comply, parents will be coached through the time-out sequence. If children are compliant, therapist and parents will push the children to be noncompliant through the use of rapid fire instructions to enable parents the experience of being coached through time-out. Rapid fire instructions consist of the parents repeating one instruction after another as quickly as possible to get to noncompliance.

In the event that noncompliance is still not obtained, the therapist will inform the child that they are going to pretend and role play the time-out procedure with the child so the parents can practice.

G.   Resilience Topic: Empathy and Perspective Taking (Alvord, Zucker, & Johnson Grados, 2011) - **Resilience Group only**

Resilience group handout

Goals

- To explain and discuss the concept of empathy
- To guide group members in understanding and practicing the steps in an empathetic response
- To foster appreciation for how it feels when someone responds to you empathetically
- To convey the idea that empathetic responses help strengthen relationships

Introduce Empathy and Perspective Talking
Give shoes to kids to color. Color your shoe and someone else's shoe

"Today we're going to talk about empathy and perspective taking. Empathy is the ability to understand/appreciate how another person is thinking or feeling."

1. Discuss the expression "putting yourself in someone else's shoes" and what it means to see a situation from different perspectives.
    a. Explain how two individuals may see a situation differently, and how empathy involves the ability to imagine what the other person is thinking and/or feeling.
    b. EXAMPLE: Two people see a situation differently. Co-leaders role play example. CT1: "We were in class together and got a test back, I was excited because I did better than I thought" and CT2 say "I was sad because I didn't do as well as I thought." CT1: I told CT2 how excited I was, but I noticed they seemed upset and I thought they were mad at me. CT2: I wasn't mad, but I got upset because CT1 talking about how well they did just reminded me how I didn't do as well as I thought. Once I told CT1 this, they understood how I was feeling and helped cheer me up.
2. Help group members understand the reciprocal nature of relationships and how empathy impacts our friendships. Say:
    a. "How do you feel when someone really listens and tries to understand how you feel? It's important to know that others care about us. People who take the time to really understand others are valued and appreciated as friends. Like conversations, relationships are *reciprocal*, which means that how each person acts influences the other person in the relationship. When we feel others care how we feel, it often

deepens our caring for others. And when we care for others, often they care even more for us. It helps us feel connected."

Discuss Steps in Responding with Empathy

1. Say, "When you respond with empathy, you are showing concern and understanding to others." Direct the group's attention to the Empathy Steps handout.

2. Discuss each step:
   a. The first step is to listen and to observe what the person is saying and how the person is acting.
   b. The second step is to put yourself in the other person's shoes and try to figure out what the person is thinking and feeling from his or her perspective or point of view.
   c. The third step is responding to the person in an empathetic way.
   d. Finally, you check in with the person to see if what you said or did was helpful and if it made the person feel understood.

Empathy Hunt

Therapists will lay sheets of paper with statements around the room, families must go on a scavenger hunt to find the pieces of paper and decide if the statements are empathetic or not. Have families go through empathy steps based on these scenarios.

H.   Session review and homework review

The therapists will review any questions, concerns, or problems that arose during the session. Therapists will pass out homework sheets and help families solve any problems to ensure they can practice 5 minutes a day. If parents were able to have individual coaching and a time-out occurred (or if you decide to go with the role play time-out and you as the therapist feel the parents can do it at home), they should begin to use time-out at home for non-compliance. Have them record any issues that arise to talk about next session.

MODULE IV Handouts
Resilience handouts

Directions: Color in this shoe with your favorite design so others know what it would be like to be in your shoes. Color the second shoe like someone else would like.

Empathy Steps

a. The first step is to listen and to observe what the person is saying and how the person is

acting.

b. The second step is to put yourself in the other person's shoes and try to figure out what the

person is thinking and feeling from his or her perspective or point of view.

c. The third step is responding to the person in an emphatic way.

d. Finally, you check in with the person to see if what you said or did was helpful and if it made

the person feel understood.

Homework Sheet: Week 4

Directions: Practice special play time for 5 minutes per day

	Did you practice? Yes/No	**Skills Practiced**	**Did you practice time-out? Yes/no & How many**	**Problems, concerns, questions**
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

Do Skills: Don't:
Praise   No questions
Reflect   No instructions
Imitate   No criticism/sarcasm
Describe
Enthusiasm

MODULE V: REVIEW OF DISCIPLINE SKILLS AND INDIVIDUAL COACHING
Session 5

A.   Outline

  1.Summary of today's session

  2. Check in & Introduction

  3. Review of homework & therapist modelling discipline skills

  4. Additional topics discussion

  5. Individual coaching

  6. *Resilience Topic: Self-Regulation (Resilience Group Only)*

  7. Review and homework setting

Materials needed:

- Homework sheets
- Additional topics handouts as needed

B.   Check-in on Children's Behaviors

  Briefly check-in with each family to see how their children and family have been doing this past week and review homework.

C.   Introduction to Today's Session

  Today we're going to be continuing our discussion on discipline skills. We will review these skills and practice with individual coaching. We will also discuss additional topics such as time-outs away from home.

D.   Review and model discipline skills

  Review skills, therapists will model discipline skills, and field any questions from families.

E.   Additional topics

"Many parents find having house rules for certain behaviors is helpful. For example, we don't want to use a warning if our child is hitting. That may be something that needs an immediate consequence. So, we can use a house rule that states we keep our hands to ourselves (positively stated). This means children do not get the instruction, two-choice warning, time-out sequence. If they break the rule, it is immediate time-out. Usually house rules are things children are being told over and over to do or not do. Many parents like to post these on the refridgerator or somewhere to remind the kids."

House rules:

- House rules should be kept to a minimum, only one or two at a time and enforced with 100% consistency.
- Before implementing house rules consider if the issue can be handled by selective ignoring, strategic praise, or using positively stated instructions to perform incompatible behaviors.
- House rules should be explained to the child when they are displaying good behavior and parents should explain why the rules are being set.
- For the first house rule, it is best to select a disruptive behavior that occurs with high frequency so that there will be many learning opportunities throughout the week. A 3-minute period for time-out with the 5 seconds of quiet at the end should be the consequence for noncompliance with house rules.
- When your child is following house rules they should be praised. This gives a positive reminder about the new rule and increases the chance they will follow the rules in the future, which gives less time for them to behave in a way you don't like. So, if the house rule is hands and feet to yourself, and your child is playing nicely with his sister, you can say, "Thank you so much for keeping your hands and feet to yourself! I am so proud of you following our house rules!!"

F.   Individual Families coaching

Group will break up into families to practice discipline skills. Two families will be coached individually by the co-therapists for approximately twenty minutes. Families who are not being individually coached will remain in the group room practicing their special play skills. Families will rotate every twenty minutes between individual coaching and group practice.

Again, be prepared for rapid fire instructions or role playing the time-out sequence.

G.   Self-Regulation: Anxiety and Anger (Alvord, Zucker, & Johnson Grados, 2011) - **Resilience Group only**

Goals

- To explain the concept of anxiety and how it affects the body and the mind
- To discuss the three parts of anxiety (body, thoughts, behavior)
- To identify body signals, or physiological symptoms, associated with anxiety
- To encourage reducing anxiety through self-talk, calming the body to calm the mind, and coping thoughts and coping actions
- To learn the "facing your fears" mindset
- To practice a relaxation/self-regulation technique

Discuss Anxiety

1. Ask participants if they know what anxiety means and help them define it.
   a. "Everyone feels anxious or worried at one time or another. In fact, anxiety is a biological process that warns us that there is trouble ahead or that we are being threatened. For example, if a lion is chasing you, your body prepares itself for "fight

or flight" because you will either need to fight the lion – if it catches you – or run really, really fast.

Your body feels anxiety as a means of survival, to help you survive. But most of us never encounter a lion, right? Instead, our body ends up feeling anxious when we see a situation as threatening, even though there isn't a real threat like a lion."

2. Explain that things like having to perform in a game or in school, having a lot of school work, or being in certain situations that we don't like can cause anxiety. Sometimes just thinking about these situations can cause us to feel anxiety.

3. Say, "So if thinking about something can cause you to feel something, then changing the way you think can change the way you feel."

Explain the Components of Anxiety [handout for parents & kids]

1. Explain that anxiety has three parts: body, thoughts, and behavior. Draw and label these three separate parts on the board.
2. Ask, "When you feel nervous or scared, how does your body feel?" Record ideas in the appropriate circle.
3. Point out that our bodies are related to our minds, so if we think anxious thoughts, we will likely feel the anxiety in our bodies. Ask, "When you are in a scary situation, what do you think?" Record ideas in the appropriate circle.
4. Finally, have the group generate a list of anxious behaviors.

Discuss Self-Talk and Anxiety

1. Review the idea that self-talk refers to the things that we say to ourselves in our own minds.
2. Ask the group to share examples of their own self-talk, both negative and positive. Have participants practice replacing their negative self-talk with positive self-talk. Record their ideas on the board.

Discuss Coping with Anxiety

1. Explain that if you learn how to relax your body, you will be less anxious.
2. Have the group list the different forms of relaxation they have learned and practiced in the group thus far. These may include calm breathing and progressive muscle relaxation.
3. Briefly review coping thoughts and coping actions, as discussed in Session 2.
    a. Have the group come up with coping thoughts.
    b. Also have them develop coping actions.

Face Your Fears Through Exposure

1. Explain the concept of challenging your anxiety by using the "face your fears" mindset and gradually exposing yourself to feared situations.
    a. Say "The third part of anxiety is behavior, and the most common behavior is trying to always stay away from what scares us. But if you face your fears, you will overcome them. In fact, it is almost impossible to get rid of your fears without facing them. For

example, if someone is afraid of dogs and usually avoids them, they will need to practice going near dogs, and this can be done gradually, in steps." (p. 254)
2. Emphasize that once you do something difficult over and over, it generally becomes easier to deal with and you begin to get used to it.

Discuss Body Signals of Anger [handouts]

1. Let the group know that the first step is to identify how it feels when you are angry, specifically how your body feels.
2. Ask the group to describe body signals of anger, highlighting those areas by coloring them in or circling them in red marker on a blank My Anger Body Signals handout.
3. Give group members copies of the My Anger Body Signals handout and red crayons or markers and have them mark their own personal signals in the same way.

Discuss Thought Signals of Anger

1. Remind the group of the mind-body connection and the link between thinking angry thoughts and feeling angry.
   a. Say "just like we talked about with anxiety, the same mind-body connection exists between our thoughts and feeling angry. And just like with anxiety, certain situations or thoughts may lead to us feeling angry. When we feel angry we may feel a lot of reactions in our body including feeling hot or tense."
2. Have participants check off common body signals and negative self-talk on the Anger Warning Signs worksheet and discuss.

Discuss Coping with Anger

1. Discuss the importance of coping with anger by calming the body and changing thinking.
   a. Say "Remember how we learned to change the channel on our negative thoughts? We can do that same with the thoughts that make us angry and replace them with positive thoughts. Remember that changing the way we think can change the way we feel."
2. Have the group practice replacing their negative self-talk with positive self-talk.
3. Remind the group they can also use the relaxation techniques taught in group to calm down. If time, practice deep breathing.

H. Review and homework setting

The therapists will review any questions, concerns, or problems that arose during the session. Therapists will pass out homework sheets and help families solve any problems to ensure they can practice 5 minutes a day.

MODULE V Handouts

House rules:

- House rules should be kept to a minimum, only one or two at a time and enforced with 100% consistency.
- Before implementing house rules consider if the issue can be handled by selective ignoring, strategic praise, or using positively stated instructions to perform incompatible behaviors.
- House rules should be explained to the child when they are displaying good behavior and parents should explain why the rules are being set.
- For the first house rule, it is best to select a disruptive behavior that occurs with high frequency so that there will be many learning opportunities throughout the week.
- A 3-minute period for time-out with the 5 seconds of quiet at the end should be the consequence for noncompliance with house rules.
- When your child is following house rules they should be praised. This gives a positive reminder about the new rule and increases the chance they will follow the rules in the future, which gives less time for them to behave in a way you don't like. So, if the house rule is hands and feet to yourself, and your child is playing nicely with his sister, you can say, "Thank you so much for keeping your hands and feet to yourself! I am so proud of you following our house rules!!"

Take a minute to write down some house rules you would like to implement in your household:

Anger Stop Signs

Draw what you look like when your anger is small.

Draw what you look like when your anger is big.

Anger stop signs are clues your body gives you to tell you that your anger is getting bigger. When you notice your anger stop signs you can hit your breaks and practice calming down. Parents help and develop their own anger stop signs

Circle your anger stop signs

My face feels hot.   Write down any other anger stop signs here:

I start to shake.

I raise my voice.

I go quiet.

My eyes get watery.

I try to bother people.

I can't think straight.

I feel annoyed.

I want to hit something.

Adapted from Therapist Aid, 2017

ANGER STOP SIGNS FOR THE FAMILY

Directions: Write down some anger stops signs for each family member. Then develop ways to calm down when you notice these anger stop signs.
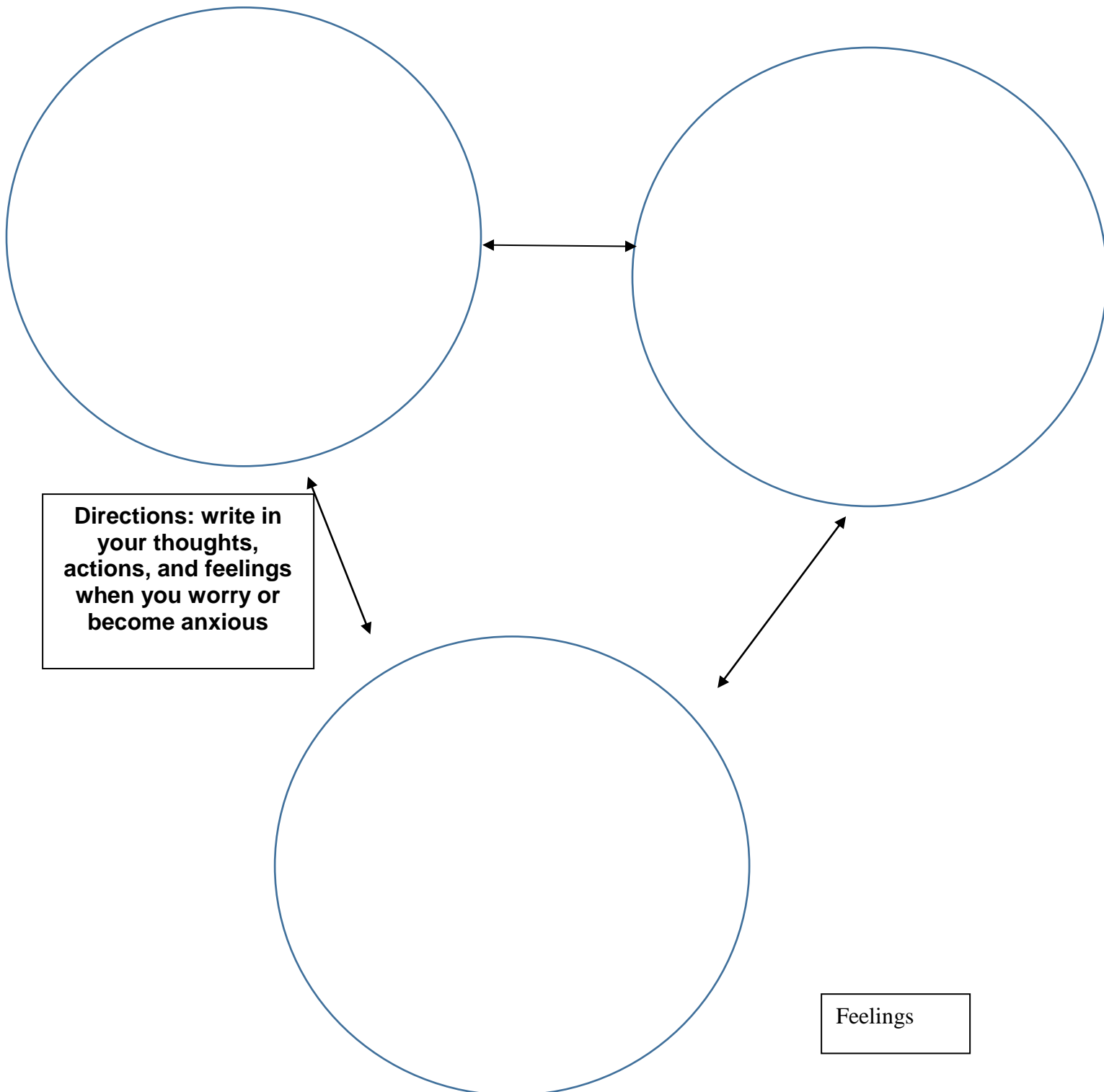
Thoughts, Actions, Feelings: Parents

Thoughts

Actions

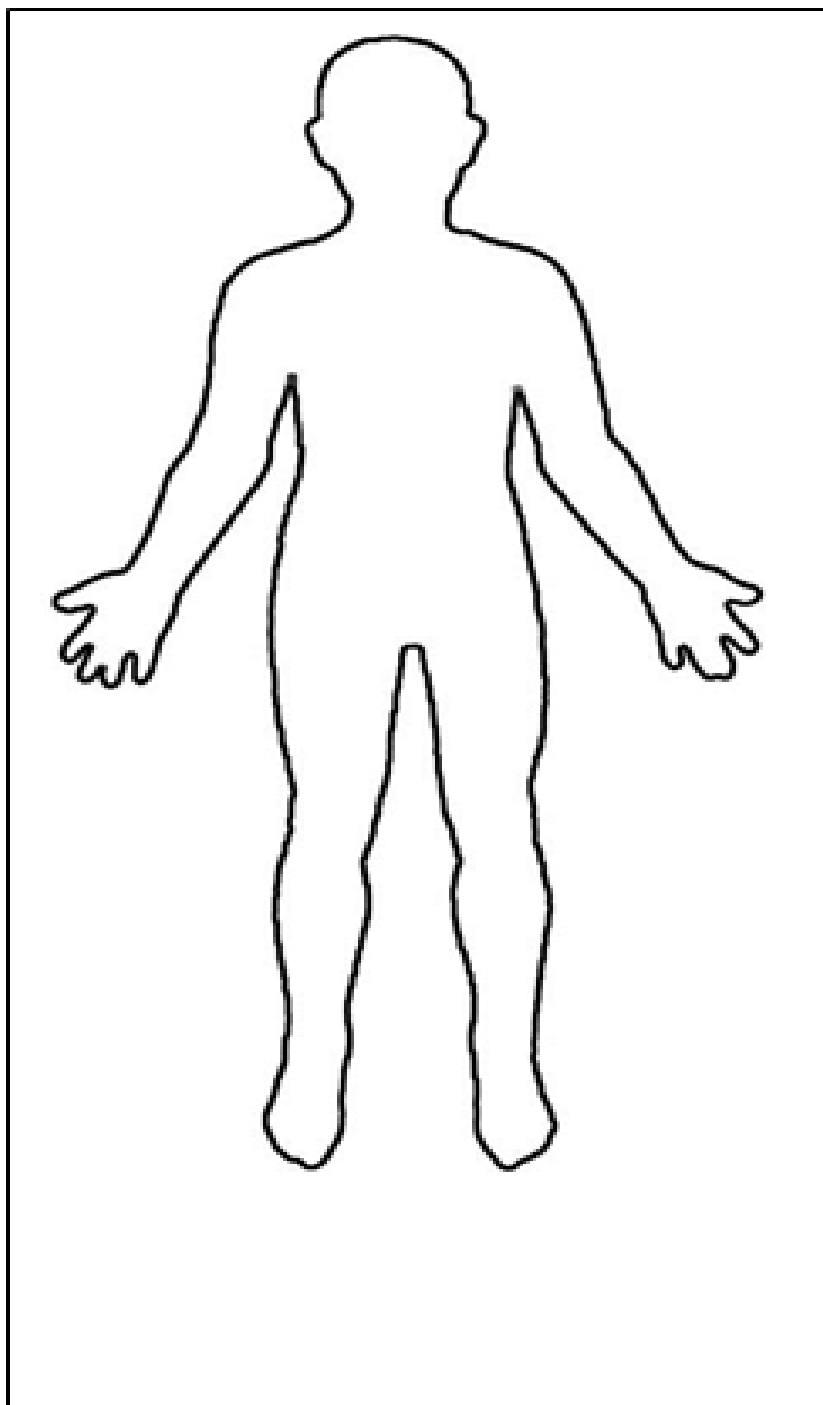DIRECTIONS:

Directions: write in your thoughts, actions, and feelings when you worry or become anxious

Feelings

Where Do You Worry: Kids

Directions: Color in the places you feel worry in your body. Use different colors for each worry feeling

Homework Sheet: Week 5

Directions: Practice special play time for 5 minutes per day

	Did you practice special play time? Yes/No	Did you practice time-out? Yes/No & How Many	Skills Practiced	Problems, concerns, questions
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

Do Skills: Don't:
Praise   No questions
Reflect   No instructions
Imitate   No criticism/sarcasm
Describe
Enthusiasm

MODULE VI: REVIEW OF SKILLS & TERMINATION PREPARATION
Session 6

A.　　Outline

1. Check in & Intro to today's session
2. Review of homework & therapist modeling discipline skills
3. Families practice with rotating feedback
4. *Resilience topic: Self- Esteem (Resilience Group Only)*
5. Review and homework setting
6. Completion of measures

Materials needed:

- Homework sheets
- References for termination
- End of treatment assessments

B.　　Check-in on Children's Behaviors

　　　Briefly check-in with each family to see how their children and family have been doing this past week and review homework.

C.　　Introduction to Today's Session

　　　Today we're going to be continuing our discussion on discipline skills. We will review these skills and practice with individual coaching. We will also discuss additional topics such as time-outs away from home.

Public behavior:

- The good thing about using time-out as your discipline strategy is it can be used anywhere, from the grocery store to Grandma's house.

Tips to help children behave well in public

Avoid taking a tired child out in public

Bring along snacks and beverages

Intersperse errands with fun activities

Explain rules and expectations in advance

Be prepared to cut outings short if child needs a break

Bring along a backpack full of small toys, books, and other entertainment

Offer incentives for good behavior

"For example, if you know you are going to a restaurant for dinner and this activity usually causes your child to act up you can implement these tips to make the experience easier for everyone. Which tips would be most useful for you to use in a restaurant? Typically, it's easiest to shape up this behavior through practice. When you're going to a restaurant you can give 2-3 rules that must be followed to earn a reward. Then, you can practice these rules in trial settings. So at first you can go to a restaurant during a time when it won't be busy and practice sitting at the table following these rules. You want to order something small like an appetizer so the experience is quick. Remember to praise your child throughout for good behavior. You can slowly work your way up to a full dinner at a restaurant using this method.

The same method applies to any public outing – grocery shopping, church, wherever. However, the most important rule is that if your child disobeys or breaks these rules you must follow through with timeout. Depending on the location, you can chose a time-out spot that is in a secluded area or take them to your car. However, we don't want kids to learn that acting up gets them out of things, so time-out is not over until they return to the activity (grocery shopping, eating at a restaurant, etc.) and behave appropriately.

D.   Review and model discipline skills

        Review skills, therapists will model discipline skills, and field any questions from families.

E.   Families practice

        Group will break up into families to practice discipline skills. Therapists will rotate among groups providing feedback. During the individual time with each family, families will be given individual feedback on their progress as well as provided with resources for continuing treatment as needed.

F.   Self-Esteem (Alvord, Zucker, & Johnson Grados, 2011) - **Resilience Group only**

Resilience topic handout

Discuss the Three Parts of Self-Esteem

1. *A*sk the group if they know what self-esteem means and help them define it. Record their ideas.
    a. Self-esteem is what you believe in yourself and how you feel about yourself and your abilities.
2. Explain that self-esteem develops from three different sources. Write "Three Parts of Self-Esteem" on the board. To demonstrate, draw a big triangle and label the three points as "Self," "Others," and "Events."
    a. "self-esteem is made up of three parts: the self, others, and events, meaning that self-esteem comes from yourself, from others, and from positive events that happen. The way you think about what happens to you will play a role in how you feel about what happens. For example, someone with good self-esteem about school can get a failing grade on one

test and still feel smart. Someone with poor self-esteem about his or her academic ability might get an A and believe it's a fluke." (p. 311)

3. Discuss the three sources of self-esteem in detail. Review and record examples of each of the three parts.
   a. Self
      i. Knowing and owning your strengths and positive qualities
      ii. Complimenting yourself
      iii. Being flexible with yourself even when you fail or fall short of perfect
      iv. Nurturing yourself
      v. Say, "Knowing your strengths is one part, but owning them is also very important because that means that even if you don't do well or fail at something, you still know that it is your strength. For example, if you believe that you are an excellent soccer player and you have a bad game, you do not question your ability in soccer and reevaluate whether you are a good player; rather, you understand that occasional poor performance is normal – we all have bad days. Likewise, if you are strong at math but have trouble with one part of it like addition, you do not allow that one piece to interfere with your knowledge of your strong math ability.

         In other words, the goal is not to be "all or nothing" but to be flexible in the way you think about yourself and your performance. Its not that you are either perfect or a failure; you can be good and skilled at something and simply have a bad day. Be kind to yourself and compliment yourself through positive self-talk." (p. 311)

   b. Others
      i. Receiving a compliment
      ii. Being invited for a play date or sleepover
      iii. Being listened to by others, such as your parents
      iv. Say, "part of feeling good about who you are is being able to accept compliments and appreciate it when someone points out something great about you or something you accomplished. We need to be able to accept compliments well, as opposed to either dismissing them or downplaying them with comments such as 'it was just luck.' Also, it can feel great to give someone a compliment when they do a good job on a class project, when they win a game, or when they handle it well when they lose a game." (p. 312)
   c. Events
      i. "Sometimes our self-esteem grows during events, for example…"
      ii. Receiving an award
      iii. Getting a good grade
      iv. Being invited to a party
      v. Competing in a piano competition
      vi. Discuss the positive feelings associated with being recognized for your accomplishments.

Discuss Effort Versus Outcome

1. Point out that there are two ways to define success: by the effort you put forth or by the outcome.
2. Explain the idea that effort = success, then discuss strengths in this light.

    a. Say, "When you face a challenge or a problem you're not sure how to solve and then struggle with it until you find a solution, you can feel good about yourself for doing it on your own. Self-esteem doesn't just come from compliments or praise from others, it also comes from your effort and hard work. It is the effort that you put into something that counts the most. Success is sticking with a task and trying your best." (p. 313)

3. Have each group member share about a time when he or she put forth excellent effort and worked hard at something that did not come easy. Ask, "What did you learn from this experience?"

Dealing with Failures and Setbacks

1. Explain that everyone has failures and setbacks—these are a part of life. The goal is to manage these difficult times well and not let failures interfere with your sense of self-confidence.
2. Explain that the messages you give yourself at these times help shape self-esteem and how we think of ourselves.
   a. Say, "When failures and disappointments happen, we have to be very careful not to make negative judgments about ourselves. Remember that thinking in a certain way can cause you to feel a certain way, and so by changing the way you think, you can change the way you feel. When things are not going well, you want to make sure that your thinking and self-talk are positive and realistic." (p. 313)
3. Have the group share examples of times when they had realistic and positive thinking, emphasizing what group members can say to themselves when they are feeling down— for example, "I know I will feel better tomorrow."

G.   Review & Measures

Thank you all for your participation in this group, we hope you received helpful information you can use in your daily lives. We have a certificate of completion for you all now. (Certificates for kids) Now we need you all to complete your final set of measures. When we have received your completed measures we will give you your final giftcard. Thanks again for participating in our program!

MODULE VI Handouts

CERTIFICATE of AWARD

IN RECOGNITION OF |

YOUR MESSAGE | You successfully completed The Strong Families Program!

ISSUED BY |

DATE |

Referral page

Family:

Concerns Initially:

Concerns upon completion of the Strong Families Program:

Therapist Recommendations:

Resources:

H.   References

Alford, M.K., Zucker, B., & Johnson Grados, J. (2011). Resilience Builder Program for children and adolescents. Champaign, Il: Research Press.

McNeil, C. & Hembree-Kigin, T. L. (2010) Parent-Child Interaction Therapy, Second Edition.

APPENDIX B

Demographics

Household Information

Annual household income (please circle one):

0-10,000	40,001 – 60,000
100,000+	
10,001-20,000	60,001 – 80,000
20,001 – 40,000	80,001 – 100,000

Please list the relationship, age, gender, and ethnicity for all members (adults & children) of your household:

Ex: Son, 5, male, Caucasian

_____   _____

_____   _____

_____   _____

Has anyone in your household been seen for mental health concerns (circle one)? Y / N

If yes, please provide information about who was seen, when they were seen, what were they seen for, & who saw them: _____
_____
_____

Parent 1 Information

Education level: _____

Marital status: _____

Employment: _____

Relationship to child (e.g. mother, step-mother, etc.): _____

Parent 2 Information

Education level: _____

Marital status: _____

Employment: _____

Relationship to child (e.g. mother, step-mother, etc.): _____

<u>Identified Child Information</u>

Age & Year of Birth: _____

Gender: _____

Ethnicity: _____

Previous mental health or learning difficulties: _____

APPENDIX C

The Strong Families Program Evaluation Form

Thank you for your participation in the Strong Families Program. This program is an ongoing project, so other families will also be participating in this program in the future. We would like your help in evaluating our project so that we know what we are doing well and the areas where we may need to improve. Thank you for your help in making the Strong Families Program the best it can be.

Please rate the following aspects of the Strong Families Program by circling the answer that best represents your views.

Therapists:

1. How supportive were your therapists? (For example – warm, understanding, helpful)
    1. Extremely supportive
    2. Very supportive
    3. Somewhat supportive
    4. Somewhat unsupportive
    5. Very unsupportive
    6. Extremely unsupportive
2. How knowledgeable did you find your therapists?
    1. Extremely knowledgeable
    2. Very knowledgeable
    3. Somewhat knowledgeable
    4. Somewhat knowledgeable
    5. Very knowledgeable
    6. Extremely knowledgeable
3. How well prepared for assessment and therapy sessions did you find your therapists?
    1. Extremely prepared
    2. Very prepared
    3. Somewhat prepared
    4. Somewhat prepared
    5. Very prepared
    6. Extremely prepared

Procedures:

4. How do you feel about the length of each session?
    1. Much too long
    2. A little too long
    3. Just the right amount of time
    4. A little too short
    5. Much too short

5. How do you feel about the number of sessions offered?
    1. Much too many sessions
    2. A little too many sessions
    3. Just the right amount of sessions
    4. Not quite enough sessions
    5. Many more sessions are needed

Session & Program Topics & Goals:

6. How relevant were the topics to you and your family's situation?
    1. Extremely relevant
    2. Very relevant
    3. Somewhat relevant
    4. Somewhat irrelevant
    5. Very irrelevant
    6. Extremely irrelevant
7. How engaged were you in learning and participating in each session?
    1. Extremely engaged
    2. Very engaged
    3. Somewhat Engaged
    4. Somewhat unengaged
    5. Very unengaged
    6. Extremely unengaged

Rating Forms & Assessments

8. How convenient was the weekly homework that you completed with your child?
    1. Extremely convenient
    2. Very convenient
    3. Somewhat convenient
    4. Somewhat inconvenient
    5. Very inconvenient
    6. Extremely inconvenient
9. There were 3 assessment periods to monitor your family's progress. How do you feel about the number of assessment sessions?
    1. Much too many sessions
    2. A little too many sessions
    3. Just the right amount of sessions
    4. Not quite enough sessions
    5. Many more sessions are needed

Overall evaluation of the Strong Families Program:

10. How would you rate the Strong Families Program's impact on your child?
    1. My child is very much better
    2. My child is much better
    3. My child is a little better

4. My child is the same as when the project began
5. My child is a little worse
6. My child is much worse
7. My child is very much worse

11. How would you rate the Strong Families Program's impact on yourself?
    1. I am very much better
    2. I am much better
    3. I am a little better
    4. I am the same as when the project began
    5. I am a little worse
    6. I am much worse
    7. I am very much worse

12. How would you rate the Strong Families Program's impact on your family?
    1. My family is very much better
    2. My family is much better
    3. My family is a little better
    4. My family is the same as when the project began
    5. My family is a little worse
    6. My family is much worse
    7. My family is very much worse

My own thoughts about the group:

13. What were some of the things you liked most about the group?
14. What were some of the things you liked least about the group?
15. If there were things that you could change about the group what would those things be?