

Holding Hands: Evaluating Quantitative Outcomes and Parental Perceptions

Submitted by Beth Lauren Hamlin to the University of Exeter as a thesis for the degree of Doctor of Educational, Child and Community Psychology (D.Ed.Psy) in 2012.

I certify that all material in this dissertation which is my own work has been identified and that no material has previously been submitted and approved for the award of a degree by this or any other university.

Signed.....

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Project Summary

Background:

Behaviour difficulties are one of the commonest problems for which parents seek professional advice. Behaviour difficulties in early childhood are associated with poorer educational and social outcomes in later life (Loeber & Dishion, 1983). The importance of early intervention and preventative work to support behaviour difficulties has been stressed in the literature and is a priority in the government's strategy for promoting positive outcomes for children.

It is now generally accepted that parenting programmes (PPs) are an effective mechanism for supporting children with behaviour difficulties. A review of the literature suggests that while there are numerous evaluations of PPs there is limited evidence of PPs that are successful outside of a clinic setting and even less evidence on particular aspects of PPs and how parents view them.

Aims

The main aim of this research was to explore a community based PP (the Holding Hands Group Programme (HHGP)) in terms of both its outcomes and the perceptions of the parents involved.

The aim of paper one was to investigate whether families who undergo the HHGP, notice any improvement in child behaviour, parental stress and parental confidence. A second aim was to compare the HHGP to the previously evaluated Holding Hands Individual Programme (HHIP).

The aim of paper two was to examine the process elements of the Holding Hands Group Programme (HHGP), seeking new insights and a detailed descriptive portrayal of how parents experience the HHGP.

Methods

The study utilised a pragmatic approach to evaluation, with mixed methods and differing methodologies.

Paper 1 involved a fixed quasi-experimental design using a pre-test, post-test single group evaluation. Outcome data was gathered from 34 parental responses to a range of psychometric measures completed on each of three occasions.

Paper 2 involved semi-structured interviews being carried out with 15 parents prior to, and on completion of, the HHGP. The interviews focused on parent's experiences of the programme and what they liked/disliked.

Results

Paper 1: At the start of the HHGP parents typically reported high levels of intensity of behaviour, behaviour that was a problem and stress levels. They also reported low levels of parental confidence. By the end of the HHGP parents reported significantly increased confidence and significantly reduced stress, intensity of behaviour and behaviour that was problem. These positive results were maintained beyond the end of the programme as indicated at follow-up meetings. The findings indicate that the HHGP was effective for all identified subgroups of the sample.

These findings broadly mirror the findings of the evaluation of the HHIP, although results do show some significant differences between the HHIP and the HHGP.

Paper 2: The interviews conducted with fifteen parents were analysed using a rigorous approach to thematic analysis to identify emerging themes. Six themes were identified from parental accounts: support, new knowledge, reconstructing, awareness, changes and interactions. Alongside these themes was a practical element about 'what worked'. Prior to the HHGP parents gave detailed descriptions about the difficulties that they were experiencing with their child, were able to identify what they wanted to achieve through the group and seemed able to predict what might be useful to them. After the sessions parents discussed what they had gained from taking part and were able to give suggestions for what had caused any changes.

Extensions and Implications

On methodological grounds it would be desirable to undertake further work with either a control group, or baseline wait list. A further extension would be to use a longer follow up period or to contact the current participants to see how this cohort is coping when they start school. This study relied on self report data, therefore future work could consider the use of videoing interactions. It would also be useful to extend the interview process to include the follow up period.

The results of this study imply that PPs can be delivered effectively to groups in non-clinic settings, and this suggests a route to more cost-effective delivery of PPs. However, as the results indicate that the HHGP was not successful for all, it reminds us that practitioners need to be vigilant in attempting to identify those families that are not helped and flexible in trying to assist them in other ways - perhaps via booster sessions or through the use of self-guided written materials.

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Paper 1

Holding Hands: Evaluating Quantitative Outcomes

Holding Hands: Evaluating Quantitative Outcomes

Abstract

Behaviour difficulties in young children present a significant concern to parents and professionals. If not dealt with promptly such difficulties can become resistant to intervention and are associated with poor social, educational and relationship outcomes. It is now generally accepted that Parenting Programmes (PPs) can be effective in supporting the development of young children with behaviour difficulties.

Aims: The primary aim of this study was to investigate whether families who undergo a community based PP, the Holding Hands Group Programme (HHGP), report any improvement in child behaviour, parental stress and parental confidence. A secondary aim was to compare the HHGP to the previously evaluated Holding Hands Individual Programme (HHIP).

Method: The first stage involved a fixed quasi-experimental design using a pre-test, post-test single group evaluation. Outcome data was gathered from 34 parental responses to a range of psychometric measures completed on each of three occasions. The second stage then compared the HHGP to the HHIP, for which comparable data had already been collected.

Findings: Prior to the HHGP the parents reported relatively high levels of stress, intensity of behaviour and problem behaviour and low levels of confidence. There were significant decreases in reported levels of parental stress, intensity and problem level of child behaviour and significant increases in reported levels of parental confidence from pre to post HHGP, with this positive trend being

maintained at follow up. The findings also indicate that the HHGP was effective for all identified subgroups of the sample, working in a similar way for different groups of parents. The HHGP also seems to work in a similar way to the HHIP, with the exception of one subscale on the parental stress measure.

Conclusions: This study adds to the growing evidence base that clinical PPs can be transferred to community settings. This study tentatively concludes that the HHGP is associated with the positive changes in parental confidence, stress levels and child behaviour.

1. Introduction

Early childhood can be characterised as a stage in which children show externalising behaviours and disobedience (Côté, Tremblay, Nagin, Zoccolillo, & Vitaro, 2002). These behaviours generally decrease over the course of natural development as children develop other strategies for getting their needs met and relatively few children continue to display such behaviour beyond early childhood (Tremblay, 2000). Nevertheless, behaviour difficulties are one of the most common problems for which parents seek professional advice (Kazdin, Bass, Ayers, & Rodgers, 1990). For the purpose of this study the term 'behaviour difficulties' will be used to describe behaviour that demonstrates frequent and persistent patterns of aggression, defiance and disruptiveness and is identified by parents as problematic and falling outside the normal expectations for the age group concerned. This definition was settled on after taking into account the definitions used in previous research into Holding Hands (Rait, 2011), and research into behaviour difficulties and PPs (Frederickson & Cline, 2009; Lahey & Waldman, 2003).

Again for the purpose of this study the term 'parent' will be used to describe the person attending the PP who provides and cares for the child in the home, or family context. This person can vary including carers such as biological parents, adoptive parents, foster parents, step-parents or others with parental responsibility. Although the term 'parent' is gender neutral, in most cases the parent attending a PP is the mother (Moran, Ghate, Van Der Merwe, & Britain, 2004). Care will be taken when discussing the results to minimise gender insensitivity and ensure that findings are not over-generalised; sex will not be ignored as a possible variable. However, sexual dichotomism – treating the sexes as two distinct social groups rather than as groups with overlapping characteristics will also be avoided (Eichler, 1988). This definition was settled on after considering the definition used in previous research into Holding Hands (Rait, 2011) and discussions between EPs within the Holding Hands team.

The pre-school years are a crucial stage of development (Nelson & Bosquet, 2000; Thompson, Easterbrooks, & Padilla Walker, 2003) and behaviour difficulties at this age are associated with significant risks of poor outcomes in the future (Campbell, Spieker, Burchinal, & Poe, 2006; Fergusson, Horwood, & Ridder, 2005; Shepard & Dickstein, 2009; Shortt, Capaldi, Dishion, Bank, & Owen, 2003; Tremblay, 2006). If behaviour difficulties emerging in early childhood are not addressed promptly they become more resistant to treatment later in life (Loeber & Dishion, 1983). Between 50%-75% of pre-school children who demonstrate behaviour difficulties continue to exhibit challenging behaviour up to 6 years later (DfES, 2003; Nixon, 2002).

The strong link between behaviour difficulties in infancy and difficulties later in life, together with the long-term cost implications of antisocial behaviour (Schweinhart,

et al., 2005), provide the rationale for early preventative action (Nixon, 2002; Shepard & Dickstein, 2009). Prevention and early intervention are priorities in the government's strategy for promoting positive outcomes for children (Teather, 2010).

Behaviour difficulties have been categorised as a special educational need within the category of Behavioural Emotional and Social Difficulties (Frederickson & Cline, 2009). Educational Psychologists (EPs) are often highly involved with supporting children with challenging behaviour (Frederickson & Cline, 2009). However, they are also well placed to work with parents to support them in managing challenging behaviour prior to children starting school (Scott & Dadds, 2009).

2. Theoretical Background

Explanations for behaviour difficulties tend to stress the probability of multiple causes or predisposing factors which, in combination, increase the likelihood that a child will develop behaviour difficulties (Lahey & Waldman, 2003). Possible causes fall into three interacting categories; child factors, (e.g. (O'Connor & Scott, 2007)), parent factors (e.g. (Waylen & Stewart-Brown, 2008)) and contextual factors (e.g. (Dodge, Pettit, & Bates, 1994)) (See Appendix 1 for further details).

This section examines three psychological theories that aim to explain behaviour difficulties and inform PPs. It discusses the current literature surrounding PPs which leads to the formulation of the research aims and the research questions. It intends to provide an overview of the literature rather than an in depth exploration (see Appendix 57 for the full literature review).

2.1 Psychological Theories

PPs are informed by three main psychological theories: social learning theory (Bandura, 1978), attachment theory (Bowlby, 1969) and parenting styles theory (Snyder & Stoolmiller, 2002). The increasing number of available, theory driven, PPs encourages researchers to question which PPs are most successful. Some researchers assert that utilising one approach is most effective, while others suggest that utilising a combination of approaches is a more effective strategy (Eyberg, Nelson, & Boggs, 2008).

2.1.1 Social Learning Theory (SLT)

Over recent years SLT has become the dominant theory explaining antisocial behaviour (Scott & Dadds, 2009) and revolves around modelling and reinforcement (Hogg & Vaughan, 2002, p. 447). Bandura (1978) proposed that behaviour is learnt from appropriate social models. This behaviour can then be reinforced by the response of the parent.

If behaviour is learnt, as proposed by SLT, then it should be possible to change the behaviour by altering both the initial modelling from the parent and the parent's response to the behaviour. A large range of effective PPs and interventions have evolved from this SLT approach, for example Triple P (e.g. Sanders, 2008; Webster-Stratton & Reid, 2003).

However, even successful SLT based PPs often fail to improve the situation for all families (McIntyre & Phaneuf, 2008; Scott & Dadds, 2009) with between a quarter and a third of families not benefiting. This suggests that there is something missing. SLT describes certain parental behaviours as being rewarding, for example granting

attention, and others as punishing, for example time-outs. However, SLT fails to offer an explanation for why these behaviours are categorised this way. Therefore when attention from a parent fails to reinforce positive behaviour SLT cannot explain it. SLT also focuses on observable behaviour, rather than the internal thought processes. It focuses on what the parent is doing rather than why they might be doing it.

2.1.2 Attachment Theory

Bowlby's (1969) attachment theory claims that the interactions between caregiver and child lead to particular patterns of attachment. The pattern of attachment then leads to the development of an internal working model which the infant uses to guide their expectations in later social situations.

Insecure attachments have been linked with poor achievement, less secure relationships in adulthood and behaviour difficulties in children (Brumariu & Kerns, 2010; Fearon, Bakermans Kranenburg, Van IJzendoorn, Lapsley, & Roisman, 2010; McCartney, Owen, Booth, Clarke Stewart, & Vandell, 2004; Moss, et al., 2006).

Bowlby (1969) originally proposed that attachment patterns were stable and persistent throughout development. Therefore, although attachment theory could explain why certain parental behaviours may not be rewarding in SLT approaches, it raises the question of how PPs can have an impact for children who have already formed insecure attachments. However, ideas about attachment stability have been modified and attachment patterns are seen as less fixed and irreversible. Schaffer (2003) proposes that the stability of attachment appears to be linked to stability in family context and care-giving. Belsky et al (2006) support this proposal and suggest

that attachment patterns can be altered with changes in the quality of care-giving. Therefore, if a PP can increase the levels of parenting sensitivity and responsiveness, outcomes for children can be improved.

2.1.3 Parenting Style Theory

A parenting style is a psychological construct that represents strategies a parent uses to raise their child. Baumrind (1971) proposed three categories of parenting style: authoritative, indulgent or authoritarian. A fourth category, neglectful parenting, was added by Maccoby and Martin (1983). Each parenting style is characterised by different parent behaviours and strategies.

A meta-analysis by Hoeve et al (2009) found that combinations of authoritarian and neglectful parenting were the best predictors of delinquency. Parenting that uses psychological control has been linked to high levels of externalising behaviour (Aunola & Nurmi, 2005) and lower emotional regulation (Manzeske & Stright, 2009) in children. Walton (2010) demonstrated that maternal warmth is an important factor for children to show regulated behaviour.

Baumrind (1971) described parenting styles as stemming from the parent's behaviour. This would suggest that if a PP could alter the behaviour of the parent then outcomes for the child would improve. However, this leaves out the vital influence of the child on the relationship. It seems more likely that parenting is a two-way relationship between the child and parent(s) (Gallagher, 2002) and that it can be influenced by the temperament of both the parent and child, as well as cultural and situational factors.

2.1.4 Parent-Child Interactions.

A common theme from the above three theories is Parent-Child Interactions (PCIs). All three theories offer explanations of how negative PCIs develop. SLT emphasises inappropriate modelling and parental use of inconsistent discipline that reinforces challenging behaviour. Attachment theory stresses the importance of the child's internal working model and PCIs in the first years of life. Parenting styles theory focuses on the beliefs held by parents about how a child should be parented and the strategies that grow out of these beliefs.

Just as each theory provides an explanation for negative PCIs, each provides a view of how positive PCIs could be achieved. SLT encourages the use of successful modelling and discipline techniques, attachment theory highlights the level of parental responsiveness and sensitivity and parenting styles theory emphasises parental behaviour to include high levels of warmth and consistent implementation of boundaries and consequences.

However, it is likely that all three explanations contribute to the development of negative PCIs. This suggests that an intervention that combined elements of all three theories would be the most effective in developing positive PCIs (Scott & Dadds, 2009).

2.2 Current Evidence Base on Parenting Programmes

PPs are accepted as being one of the most effective and successful methods of supporting behaviour difficulties (Barlow & Stewart-Brown, 2000; Barrett, 2010; Butt, 2009; Dretzke, et al., 2009; Moran, et al., 2004; NICE, 2006; Scott, et al., 2001; Webster Stratton & Hammond, 1999) with findings beginning to be replicated for

ethnic minorities (Barlow, Shaw, & Stewart-Brown, 2004) and teenage parents (Coren, Barlow, & Stewart-Brown, 2003). Improvements have been shown in both parent and child behaviour, increased parental self-esteem, improved parental attitudes towards their children and decreases in maternal depression and parental stress (Barlow, Coren, & Stewart-Brown, 2002; Dretzke, et al., 2005; Kane, Wood, & Barlow, 2007; Reyno & McGrath, 2006).

Despite the generally positive conclusions, sources raise questions across three themes; the lack of research on how PPs are successful (Barrett, 2010; Butt, 2009; Moran, et al., 2004), the maintenance of positive effects over time and the age of children being supported.

The first theme is particularly important given that even the most successful of PPs do not improve the situation for all families (Scott & Dadds, 2009). Kane et al (2007) review qualitative studies and conclude that parents find the increase in knowledge and skills important and also benefit from the support from other parents. Barrett (2009) suggests that matching parents to specific programmes, assessing the needs of the family prior to starting a programme and reflecting on progress throughout the programme may be methods to improve outcomes of PPs. It seems that the optimum design of a PP can vary from family to family and that the key to a successful PP is flexibility.

On the second theme of maintenance, the majority of academic review papers demonstrate that maintenance is rarely achieved (Barlow, Parsons, & Stewart Brown, 2005; Eyberg, Edwards, Boggs, & Foote, 1998; Nixon, 2002). However, Reyno

and McGrath (2006) suggest otherwise. The still contentious nature of this topic calls for future work to be clear when reporting on maintenance.

The final theme examines the age of children being supported. Academic and independent reviews and government funded work all report the striking finding that, despite research and background theory indicating that early intervention and prevention is advisable for supporting children with behaviour difficulties, there remains a scarcity of well designed outcome studies that have focused on pre-school children (Barlow, Kirkpatrick, Wood, Ball, & Stewart Brown, 2007; Barrett, 2009; Butt, 2009; Moran, et al., 2004).

Despite this lack of research many PPs claim that they are suitable for use with pre-school children or offer an adapted version for younger children. However, Sampers et al (2001) questions whether this is appropriate and suggests that PPs should be designed with the developmental stage of the child as a specific focus.

Recent work has taken these questions on board and has started to examine the effectiveness of PPs for pre-school children (Barlow, et al., 2005; Reyno & McGrath, 2006). However, due to the limited number of studies with this age range, further research is needed to draw firm conclusions.

Suggestions for future work have included: focusing on comparative studies of PPs, gaining better qualitative data (Barrett, 2010; Moran, et al., 2004) and evaluating PPs out of the clinic setting (Eyberg, et al., 2008).

One PP that combines ideas from a range of theories and begins to address the suggestions for future work is Parent-Child Interaction Therapy (PCIT). PCIT is 'designed for families with children between the ages of 2 and 6 who are

experiencing a broad range of behavioural, emotional and family problems' (Herschell, Calzada, Eyberg, & McNeil, 2003, p. 9).

PCIT has been shown to be effective using a large number of measures (Eyberg, et al., 2008) and when delivered by a range of professionals (Berkovits, O'Brien, Carter, & Eyberg, 2010). These findings have been replicated across different cultures (Werba, Eyberg, Boggs, & Algina, 2006), with both mothers and fathers (Schuhmann, Foote, Eyberg, Boggs, & Algina, 1998) and with group versions and shorter versions of PCIT (Berkovits, et al., 2010). Positive effects have also been shown to generalise to other children in the family (Brestan, Eyberg, Boggs, & Algina, 1997).

The preliminary research on PCIT indicates several factors which are important for success: therapist style that balances positive feedback and constructive advice (Herschell, et al., 2003) and including both parents and children in the PP (Pade, Taube, Aalborg, & Reiser, 2006).

The ability to generalise to community settings is the biggest criticism aimed at PCIT. Most research has been carried out in clinic settings at great expense. Replication in the community would not be possible due to cost and it has been questioned whether positive results would be found with a limited budget. (Herschell, et al., 2003)

3. Research Aims and Questions

Puckering (2009) highlights the importance that future research into PPs looks at new initiatives rather than merely focusing on existing PPs. Therefore using the gaps in the literature, and adapting PCIT, the Holding Hands Programme (HHP), a community based, home visiting, PP designed for pre-school children, was set up

and implemented by the Educational Psychology Service (EPS). It was evaluated as part of a Senior EP's continuing professional doctorate (Rait, 2011). Because it was delivered to individual parents it will now be referred to as the Holding Hands Individual Programme (HHIP). Due to the success of the HHIP it was decided by a working group including local authority commissioners, the EPS and the Children's Centres' Co-ordinator to expand the project and to run group sessions in Children's Centres; the Holding Hands Group Programme (HHGP). Therefore this research study sits within a wider research context within the EPS. This has impacted on some of the decision making processes.

The overarching aims of this study were to evaluate the HHGP in relation to outcomes and to explore parents' views about the HHGP. The HHGP was also compared to the HHIP. This paper examines the outcomes of the HHGP while paper 2 focuses on parents' perceptions.

In this paper the following more specific research questions were addressed:

1. Are there relationships between parental confidence, parental stress and the intensity and problem levels of children's behaviour at the start of the programme?
2. Following the HHGP do parents report improvements in:
 - the intensity and the problem level of their child's behaviour?
 - their level of confidence in meeting their child's behavioural needs?
 - their level of parental stress?
3. Do the reported outcomes vary for subgroups within the participants?

4. Does the preliminary data differ for those participants who completed the HHGP but did not complete follow up data and those who completed the HHGP and did provide follow up data?
5. Do the reported outcomes for those participants who report clinical levels of parental distress at the start of the HHGP vary from those who do not report clinical levels of parental distress at the start of the HHGP?
6. How do the child outcomes of the HHGP compare with similar evaluations of the HHIP?

4. Methodology and Methods

4.1 Research Design

The method chosen for this study was a single group repeated measures evaluation. This approach has been utilised in previous evaluations of community interventions (Coombes, Allen, Marsh, & Foxcroft, 2009).

Randomized controlled trials (RCTs) are often held up as the gold standard of social research (MacDonald, 1996) and are often considered to be the most effective for establishing causal inference (Shadish, Cook, & Campbell, 2002). However, in this case, because the study is evaluating a community PP, RCTs are not considered appropriate (Pawson & Tilley, 1997). Jansen et al (2010) argue that RCTs have a rigid design that focuses purely on measuring outcomes rather than considering some of the ethical and moral issues of withholding a needed intervention. As the HHGP was not going to be run on a regular basis in each area any attempt to regulate participation would have been unethical and contrary to the programme's ethos. Also the medical/scientific basis of RCTs are not relevant to the complex social

problem being examined. A single group design establishing a baseline prior to parents starting the HHGP was also considered. However, because parents could self-refer to the HHGP it meant that group numbers were often not finalised until the initial coffee morning, which meant that recording a baseline was not possible.

4.2 Participants and Sampling Strategy

The HHGP took place in a large shire county in South East England, covering a mix of urban, rural and suburban areas. This evaluation was undertaken with the first 16 groups that took part in the HHGP, between January 2011 and October 2011. Each group consisted of a maximum of 4 parents, each attending with a single child. Participants could self-refer to the HHGP, or be recommended by a range of professionals. Each participant met the following criteria:

1. The family must live within the County
2. The child causing concern should be between 2 - 5 years of age.
3. The parents/carers must be seeking support for coping with what they feel to be significant behaviour difficulties for the child at home.
4. The child's main problem should not be a speech and language or medical difficulty or complex learning needs. If this were case then the child should be referred to the appropriate agencies.
5. The family was not accessing any other support services.

All parents attending the 16 groups were invited to participate in the study. Out of the 48 parents who attended the initial meetings 42 parents agreed to take part, with at least one member from each group agreeing to participate. Of the 42

parents who agreed to take part, 3 self-referred, 34 were recommended by Family Support Workers (FSWs), 4 were recommended by Health Visitors and 1 was recommended by adult education services. The other six parents completed the HHGP but declined for their data to be used in this research study. Of the 42 parents who started the HHGP, 40 completed the four sessions and 34 completed data at follow up. Table 1 summarises the characteristics of the participants and Table 2 illustrates which groups the participants attended.

Table 1: Characteristics of Participants

Characteristics of participant	Number of Participants		
	Pre	Post	Follow up
<u>Gender</u>			
female	22	21	19
male	20	19	15
<u>Ethnicity</u>			
White British	36	35	29
Ethnic Minority	6	5	5
<u>Adults per household</u>			
One	18	17	13
Two	24	23	21
<u>Children per household</u>			
One	19	18	14
Two	17	16	16
Three	3	3	3
Four	3	3	1
<u>Child age</u> (mean in months and (years))	33.98 (2.83)	33.98 (2.83)	31.79 (2.65)
<u>Parent age</u> (mean in months and (years))	377 (31.42)	381.76 (31.81)	384.69 (32.06)
<u>TOTAL PARTICIPANTS</u>	42	40	34

Table 2: Groups Attended by Participants

<u>Group attended</u> (total number in group)	Number of Participants		
	Pre	Post	Follow Up
1 (3)	3	2	2
2 (4)	3	3	3
3 (3)	3	3	3
4 (2)	2	2	1
5 (2)	2	2	2
6 (3)	3	3	2
7 (3)	1	1	1
8 (3)	3	3	1
9 (3)	2	2	2
10 (3)	2	2	2
11 (3)	3	3	3
12 (3)	3	3	3
13 (3)	3	2	1
14 (3)	3	3	2
15 (4)	3	3	3
16 (3)	3	3	3
<u>Total Participants (48)</u>	42	40	34

4.3 Measures

All participants completed a series of questionnaires on each of three occasions: prior to the HHGP, on the final session of the HHGP and again two months after the HHGP. The evaluations employed were: the Eyberg Child Behaviour Inventory (ECBI), the Parental Stress Index-Short Form (PSI-SF) and a Parental Confidence Rating Scale (PCRS) designed specifically for the pilot study of the HHIP by a senior EP (see Appendix 2 -6). These measures were decided upon primarily to fit with the research into the HHIP (Rait, 2011). Using the same measures allowed direct comparisons to be made between the programmes. However, during the decision making process other measures were considered, including the Child Behaviour Checklist, the Parenting Locus of Control and the Parenting Scale. However, the measures used by Rait (2011) were still considered to be the most appropriate for three main reasons; their brevity, their high levels of reliability and validity and the

fact that they have been used by other research into a variety of PPs (Eyberg, et al., 2008).

The ECBI is a standardised evaluation tool designed to assess parental reports of behaviour difficulties in children aged 2-16 (Eyberg & Pincus, 1999) see Appendix 2). Parents have to rate 36 behaviours using a seven point Likert scale indicating how frequently the behaviour occurs and then whether the behaviour is a problem, thus providing two scores. Scores of ≥ 131 (intensity) and ≥ 15 (problem) are within the clinical range (Eyberg & Pincus, 1999). However, Sanders et al (2000) used an elevated range for the ECBI (Intensity score ≥ 127 and problem score ≥ 11). This raises questions about what level of behaviour falls above a clinical level. However, as previous research into HHIP (Rait, 2011) and PCIT (Eyberg, et al., 2008) use the higher cut off points this will be continued in this study.

High internal consistency has been calculated with values of 0.98 being reported for both scales by Robinson and Eyberg (1981) and values of 0.95 for intensity and 0.93 for problem being reported by Eyberg and Pincus (1999). Inter-rater reliability has been reported as 0.86 for intensity and 0.79 for problem (Eyberg & Pincus, 1999) and test retest reliability across a three week period has been shown at 0.86 for intensity and 0.88 for problem, and over a 12-week interval it was 0.80 and 0.85 (Robinson & Eyberg, 1981).

The PSI-SF was developed by Abidin (1990) and measures the parent's current levels of stress (see Appendix 3). The short form consists of 36 items and produces a total score, with a high score indicating a greater level of stress. Parents who score above

90 are considered to be experiencing clinically significant levels of stress (Abidin, 1990).

The total raw score can be broken down into three subscales: Parental Distress (PD), which examines personal distress of the parent, Parent-Child Dysfunctional Interaction (P-CDI), which focuses on the whether the parent feels negatively about their child, and Difficult Child (DC), which looks at basic behavioural characteristics. The PSI-SF also includes a Defensive Responding (DR) scale as part of the PD scale which assesses whether the parent is giving an accurate portrayal of themselves or attempting to present the most favourable impression. Haskeet et al (2006) report high internal consistency, with a value of 0.83, and test retest reliability across the period of a year has been shown at 0.75. Despite the positive aspects of the PSI there is one concern related to it. Milner and Crouch (1997) report that the defensive scale fails to identify responses that are portraying a more favourable image of themselves in over 50% of cases. They suggest that the 'PSI Defensive Responding Scale has limited utility in detecting individual cases of faking-good behavior' (p. 645). However, as other measures do not have this facility, the PSI is still the best questionnaire to use in this study.

The PCRS aims to measure the confidence level of parents in supporting and managing their child's behaviour. The PCRS includes seven items which the parents respond to on a ten-point Likert scale (see Appendices 4-6) with higher scores indicating higher levels of confidence. During the pilot of the HHIP the internal consistency of the PCRS was calculated as 0.82 using Cronbach's coefficient alpha (Rait, 2011).

4.4 Intervention

The HHGP is a community based PP run in children's centres. The aim when adapting both the HHIP and the HHGP from PCIT was to incorporate ideas of what is reported to work from the literature (Kaminiski, Valle, Filene, & Boyle, 2008; Moran, et al., 2004) and to maintain a strong theory base (Attachment Theory, SLT, Parenting Style Theory) within the ecological model (see Appendix 7). Appendix 8 provides a brief summary of the main similarities and differences between the HHGP and PCIT and Appendix 9 provides a summary of the similarities between the HHGP and the HHIP. The HHGP aims to model and inform parents of 4 key messages referred to as FLIP:

- Follow the child's lead
- Label Praise
- Ignore unhelpful behaviours
- Provide limits and boundaries.

Each session is delivered via a themed play session, targeted at the child's age. A FSW and EP led the four sessions. They modelled positive interactions and explored strategies for behaviour management and the development of the parent/child relationship. Course content was delivered through presentations, group discussions and role play activities. Parents were also given the opportunity to discuss any successes or challenges that they had faced in the previous week as part of collaborative problem solving activities. Further details of the sessions are included in Appendix 1, Appendix 1 and Appendix 12.

4.5 Procedures

Parents were invited to an initial coffee morning where the HHGP was outlined and they were provided with a leaflet (see Appendix 13). If the parents were interested

in taking part they were then asked to complete consent forms (see Appendix 14 and Appendix 15) and the questionnaires outlined in section 4.3.

There were then four weekly sessions of an hour and a half led by an EP and a FSW (see section 4.4 for more details). The HHGP ends with a second coffee morning which provides an opportunity to reflect on the sessions and for all parents to complete post data questionnaires. The parents are then invited to a follow up coffee morning two months after the HHGP, which provides an opportunity to discuss any ongoing issues and to collect follow up data.

4.6 Ethical Considerations

The British Psychological Society (2009) and the University of Exeter's ethical guidelines and codes of conduct were followed for the period of the research. These consider areas including issues of informed consent, debriefing, the dissemination of findings and confidentiality (see Appendix 16 for more details). For example the ethical issue of withholding benefits from a comparison group was avoided by choosing a pre-test, post-test single group design (as outlined in section 4.1). Results were disseminated to the parents via the Children's centres using a simple summary sheet (see Appendix 17). Ethics approval was sought from the University of Exeter and the certificate is included in Appendix 18.

4.7 Data Analysis

Results of the within subject repeated measures are reported over three time periods: pre HHGP (T1), post HHGP (T2) and two month follow up (T3). SPSS (v19) was used to carry out all statistical analyses. Descriptive statistics, Shapiro-Wilks tests for normality and histograms were used to assess overall trends and whether

raw data met the assumptions for parametric statistical analysis (see appendices 19-21).

The majority of raw data met the assumptions for parametric testing, therefore this is the analysis reported in the paper. However, data at T2 and T3 for the problem scale of the ECBI did not meet the assumptions for parametric testing, therefore non parametric analyses were also carried out and can be seen in Appendix 22.

Correlation coefficients were calculated for all the T1 raw scores using Pearson's correlation. However, as above the non-parametric Spearman's Rho was also calculated and can be seen in Appendix 23.

T1, T2 and T3 data for each participant were analysed in several ways. Repeated measures Analysis of Variance (ANOVA) was used to compare scores at T1, T2 and T3 for each of the seven measures separately. A significant value in Mauchly's Test of Sphericity indicates that the assumption of sphericity has been violated and the correctional adjustment, Greenhouse-Geisser, should be employed. Three measures used the correction, while four measures could assume sphericity. In conjunction with the F statistics, partial eta squared (η^2) and effect size are reported using Cohen's (1988) guidelines (0.01=small, 0.06=moderate, 0.14 large effect).

The above analysis informed whether there was an overall significant difference in means. However, to know between which time points this difference occurs post hoc tests using the Bonferroni adjustment were carried out.

A Multi Analysis of Variance (MANOVA) was also employed to examine the interaction of the seven measures. Wilks Lambda reports whether there is a significant change in mean scores between the three time periods taking the seven measures in combination.

The data were also examined to see if there were any significant differences between subgroups within the sample. The following variables were used to group the data: child gender, number of parents in the household, presence of siblings, parent age and child age. Parent age and child age were divided into 2 subgroups using the median as a cut off point in order to create two roughly equal subgroups. Nationality and Parent gender could not be examined due to the two subgroups being very unequal (5 and 29 and 1 and 33). Repeated measures ANOVAs were carried out on each subgroup individually to compare scores at T1, T2 and T3 to see if the HHGP was successful for both subgroups. Repeated measures ANOVAs with between-subject factors were carried out to see if there was any difference between subgroups. As well as looking for a general difference between groups the interaction effect between time and the between subject factor was examined. If there was a significant general difference between the groups this was assumed to be at all time points. However, when a significant interaction was found, independent t-tests were carried out to see at which time point this difference occurred.

This same statistical analysis was carried out to compare those parents who scored above the clinical level for parental distress prior to the HHGP and those who did not and to compare the data collected for the HHGP pilot and the data collected for the HHIP pilot.

Pre-data for those who completed the HHGP and provided follow up data was compared with pre-data for those who completed the HHGP but did not provide follow up data, using an independent groups t-test.

5. Results

Raw data indicates that at T1 parents reported relatively high levels of intensity of behaviour (mean score 126.88), problem behaviour (12.06) and stress levels (87.12). However, they reported relatively low levels of parental confidence (43.56). The mean scores for intensity of behaviour, problem behaviour and stress levels all dropped between T1 and T2 and continued to decrease between T2 and T3. The mean score for parental confidence rose between T1 and T2 and continued to increase between T2 and T3 (see Appendix 19 for full descriptive statistics). The significance of these changes will be discussed in section 5.2.

The percentage of parents falling above the clinical level for ECBI and the PSI at each time point can be seen in Table 3.

Table 3: The Percentage of Parents Falling Above the Clinical Level on Each Measure

Measure (clinical cut off)	T1	T2	T3
Eyberg Child Behaviour Inventory (Intensity) (raw score ≤ 131)	41	0	9
Eyberg Child Behaviour Inventory (Problem) (raw score ≤ 15)	35	0	3
Parent Stress Index (raw score ≤ 90)	38	21	21

(n=34)

5.1 Relationship Between Pre-Intervention Measures (RQ1)

Table 4: Correlation Coefficients for Pre Data Using Pearson’s Correlation

Measure	Eyberg Intensity	Eyberg Problem	Parent Stress Index	Parent confidence
Eyeberg intensity	-			
Eyberg Problem	0.681**	-		
Parent Stress Index	0.438**	0.464**	-	
Parent Confidence	-0.465**	-0.28	-0.704**	-

** p < 0.01

Statistical analysis indicates inverse correlations between the PCRS and the ECBI and PSI, and positive correlations between all other measures. The only correlation that is not significant is that between the PCRS and the ECBI problem scale. The same trend was found using Spearman’s Rho correlation (see Appendix 23). As one of the assumptions for using a MANOVA is that the dependent variables are correlated, this justifies the use of this statistical process in subsequent research questions.

5.2 Reported Improvements (RQ2)

Descriptive statistics and main effects for time are presented in Table 5 for each measure. All measures produce a significant, large effect over time ($\eta^2 = 0.429$ (Intensity), 0.553 (Problem), 0.663 (Confidence), 0.356 (Total Stress), 0.327 (Parental Distress), 0.185 (Parent Child Interactions) and 0.226 (Difficult Child)). In addition the MANOVA result indicates a statistically significant impact and a large effect size ($\eta^2 = 0.529$).

Table 6 demonstrates that for all measures, statistically significant differences were found between T1 and T2 and T1 and T3 but not between T2 and T3. This demonstrates a significant positive change after the completion of the HHGP which is then maintained at follow up. The same trend was also apparent with non parametric analysis (see Appendix 22).

These results demonstrate that following the HHGP parents report improvements in: the intensity and the problem level of their child’s behaviour, their level of confidence in meeting their child’s behavioural needs and their level of stress.

Table 5: ANOVA and MANOVA Results for all Participants (n=34)

	Time 1 Mean (SD)	Time 2 Mean (SD)	Time 3 Mean (SD)	Main effect over time				
				F	Df	Sig	partial η^2	Effect size
Eyberg Intensity #	126.88 (23.20)	101.71 (18.55)	97.71 (24.97)	24.84	1.55	0.000**	0.429	Large
Eyberg Problem #	12.06 (6.38)	4.12 (4.28)	3.53 (4.51)	40.86	1.16	0.000**	0.553	Large
Parent Confidence #	43.56 (8.48)	54.65 (7.90)	55.79 (8.16)	65.06	1.56	0.000**	0.663	Large
Parent Stress total ##	87.12 (19.19)	74.97 (16.39)	72.85 (18.95)	18.26	2	0.000**	0.356	Large
Parent Stress parental distress ##	30.65 (9.06)	25.79 (7.82)	24.85 (8.79)	16.02	2	0.000**	0.327	Large
Parent Stress PCI ##	23.76 (8.35)	20.79 (6.07)	19.88 (5.94)	7.50	2	0.001**	0.185	Large
Parent Stress DC ##	32.79 (6.70)	28.09 (7.69)	28.12 (8.36)	9.61	2	0.000**	0.226	Large
MANOVA	Wilks $\lambda = 0.222$ F=9.615 (df 14,120), p<0.000** $\eta^2 = 0.529$ effect size = Large							

Greenhouse-Geisser correction ## sphericity assumed ** significant at 0.01 level

Table 6: Post Hoc Tests for all Participants

Scales	T1-T2			T1-T3			T2-T3		
	MD	SE	Sig	MD	SE	Sig	MD	SE	sig
Eyberg Intensity	25.18	4.39	0.000**	29.18	5.47	0.000**	4.00	3.37	0.73
Eyeberg Problem	7.94	1.23	0.000**	8.53	1.28	0.000**	0.59	0.42	0.50
Parent Confidence	-11.09	0.96	0.000**	-12.24	1.46	0.000**	-1.15	1.08	0.89
Psi total	12.15	2.57	0.000**	14.27	2.80	0.000**	2.12	2.25	1.00
Psi PD	4.85	0.94	0.000**	5.79	1.16	0.000**	0.94	1.18	1.00
Psi PCI	2.97	1.13	0.038*	3.88	1.16	0.006**	0.91	0.83	0.84
Psi DC	4.71	1.28	0.003**	4.68	1.37	0.005**	-0.29	1.03	1.00

Adjustment for multiple comparisons: Bonferroni

* significant at the 0.05 level, **0.01 level

5.3 Reported Outcomes for Different Subgroups (RQ 3)

The total sample (34) was divided into 10 subgroups defined around 5 pair wise distinctions: boys (15), girls (19); those in 2 parent households (21) , those in 1 parent households (13); those with siblings (20), those without siblings (14); those with parents above the median age (15), those with parents below the median age (19); those children above the median age (12) those children below the median age (22). Table 7 summarises the results for each sub group and each subgroup comparison (for detailed results see appendices 24-38).

Table 7: Results for Each Subgroup and Each Subgroup Comparison

Sub group	Significant main effect	Comparison between subgroups
Boys	Yes – 5 out of 7 measures	No significant differences between boys and girls
Girls	Yes – all 7 measures	
2 parent household	Yes – all 7 measures	No significant differences between 1 and 2 parent households
1 parent household	Yes – all 7 measures	
Siblings	Yes – all 7 measures	Significant difference relating only to ECBI intensity scale (F = 6.046, p = 0.020).
No siblings	Yes – 6 out of 7 measures	
Older parents	Yes – all 7 measures	No significant differences between older and younger parents
Younger parents	Yes – all 7 measures	
Older child	Yes – 6 out of 7 measures	Several significant differences. Total PSI score (F = 11.028, p = 0.02) PD subscale of the PSI (F = 8.537, p = 0.006) PCI subscale of the PSI (F = 6.534, p = 0.016) DC subscale of the PSI (F = 4.355, p = 0.045)
Younger child	Yes – 6 out of 7 measures	

There were no interaction effects (see appendices 39-43) so independent t-tests were not required to see at which time point differences occurred.

These results indicate that the HHGP provides benefits to all identified subgroups. As there are no interaction effects this indicates that these benefits occur in similar ways to all subgroups. However, there is some evidence that parents of older children report higher levels of stress at all three time points and parents of children with siblings report higher levels of intensity of behaviour at all three time points.

5.4 Pre Data Comparisons for Those Who Completed all Data and Those Who Did Not (RQ4)

Table 8 indicates that there is no statistical difference between the pre scores of those participants who completed the programme and provided follow up data and those who completed the programme and did not complete follow up data.

Table 8: Descriptive Statistics and Independent T tests

Measure	T1 Mean (completed programme and provided follow up data) [n = 34]	T1 Mean (completed programme and did not provide follow up data) [n = 8]	T	Sig (2 tailed)
ECBI intensity	126.88	144.63	-1.765	0.085
ECBI Problem	12.06	16.63	-1.639	0.109
PCRS	43.56	44.88	-0.390	0.699
PSI PD	30.65	30.50	0.039	0.969
PSI PCI	23.76	27.5	-1.088	0.283
PSI DC	32.79	33.25	-0.164	0.871
PSI Total	87.12	88.13	-0.120	0.905

5.5 Clinical Levels of Parental Distress (RQ5)

A repeated Measures ANOVA for each measure indicates that for those parents who reported below clinical levels of Parental Distress at T1 all measurements resulted in a significant improvement over time. For those who scored above the clinical level of Parental Distress all measurements except the PCI subscale on the PSI resulted in significant improvements over time. Tables can be seen in Appendix 44 and Appendix 45.

A repeated measures ANOVA with between subject variable indicated that the following measures differed significantly between the two subgroups: the PCRS (F=5.79, p=0.22), with those parents reporting clinical levels of Parental Distress also

reporting lower confidence at all three time points; the total PSI scale ($F=19.805$, $p=0.000$), the PD subscale of the PSI ($F=44.339$, $p=0.000$) and the PCI subscale of the PSI ($F=5.607$, $p=0.24$), with parents reporting clinical levels of PD also reporting higher levels of stress in other categories at all three time points (see Appendix 46).

There were no interaction effects (see Appendix 47) so independent t-tests were not required to see at which time point differences occurred. This suggests that the benefits occurred in a similar way for all participants with both subgroups showing a similar level of improvement.

5.6 Reported Outcomes for HHGP vs. HHIP (RQ6)

Similarly to parents in the HHGP the parents in the HHIP reported improvements in: the intensity and the problem level of their child's behaviour, their level of confidence in meeting their child's behavioural needs and their level of stress. Repeated Measures ANOVAs indicate that these changes were significant and that the changes occurred between T1 and T2 and T1 and T3 but not T2 and T3 (see Appendix 48).

In addition the MANOVA result indicates a statistically significant impact and a large effect size ($\eta^2 = 0.449$).

A repeated measures ANOVA with between subject variable indicated that the following measures differed significantly between the two subgroups: the problem scale of the ECBI ($F=4.487$, $p=0.39$), with parents attending the HHGP reporting lower levels of problem behaviour at all three time points; the total PSI scale ($F=6.441$, $p=0.14$), with parents attending the HHGP reporting lower levels of stress at all three time points and the PCI subscale of the PSI ($F=6.032$, $p=0.17$), with

parents attending the HHGP reporting lower levels of difficulty with parent-child interactions at all three time points (See Appendix 49).

There was a significant interaction effect between time and the between subject factor of HHGP vs. HHIP for the Difficult Child subscale of the PSI ($F=4.127$, $p=0.019$) (see Appendix 50). Independent t-tests indicated that there was a significant difference between scores at T1 ($t= -3.027$, $p=0.004$), with parents attending the HHGP reporting lower levels of Difficult Child than parents attending the HHIP, but not at T2 or T3 (See Appendix 51). This suggests that the HHIP produced a greater effect on this measure than the HHGP.

6. Discussion and Conclusions

6.1 Child Behaviour

Results indicate that parents in this study reported significant reductions in both intensity of behaviour and problem level of behaviour (as measured by the ECBI) between the start and the end of the HHGP. This is consistent across all subgroups examined. Although there was no significant difference between the scores on the ECBI at T2 and T3, there was certainly no return to higher levels over this 2 month period, as the raw mean scores continued to fall albeit insignificantly (from 101.71 to 97.71 for intensity and 4.12 to 3.53 for problem). This is in line with research examining the effectiveness of PCIT (Berkovits, et al., 2010).

However, it is worth noting that the ECBI problem data returned very high standard deviations, suggesting a wide distribution of scores, which potentially reduces the reliability of the statistical analysis.

Prior to the HHGP the mean scores for intensity/problem (126.88/12.06) were lower than those recorded in the HHIP pilot (139.06/15) (Rait, 2011) and also lower than previous research into PCIT (Leung, Tsang, Heung, & Yiu, 2009; Phillips, Morgan, Cawthorne, & Barnett, 2008). This suggests that either the children in the present study were exhibiting lower levels of behaviour difficulties or that the parents were categorising the behaviour in a different way. However, this difference in mean scores continued through both the post and follow up measures, suggesting that the HHGP worked in a similar way to the other PPs but with a different population of people.

Despite the mean scores being lower in this study than in others, the percentage of parents reporting clinical levels of behaviour at the start of the PP were relatively high (41% for intensity and 35% for problem). Initially the HHIP and the HHGP were designed to be delivered at the secondary level of prevention, aiming to reduce the prevalence of a problem before it becomes a crisis. However, the above figures suggest that the HHGP could be successful with clinical populations as well as community populations. This is further supported by the results that indicated that the HHGP resulted in significant changes for both those parents who reported above clinical levels of PD at T1 and those who did not.

Despite the positive statistical result there were 3 participants who, despite reporting lower scores at T2, compared to T1, reported clinical levels of intensity and problem behaviour at T3. Although this finding could be interpreted as 'statistical noise' it could also provide useful information with regards to the development of the HHGP and as such has implications for practice which are discussed in section 6.7.

6.2 Parent Confidence

A statistically significant inverse correlation was identified between parent confidence and parent stress. This is an unsurprising finding and is consistent with established literature (Coleman & Karraker, 2000). Similarly, a statistically significant inverse correlation was identified between parent confidence and the intensity of behaviour. This supports literature in the field by Jones and Prinz (2005). It is also further support for the argument that low parent confidence acts as a mediating factor between parental stress and behaviour difficulties as suggested in previous research (Hutchings, Appleton, Smith, Lane, & Nash, 2002).

Results indicate that parents in this study reported significant increases in levels of confidence between T1 and T2. This is consistent across all subgroups examined. Although there was no significant difference between parent rating of confidence (as measured by the PCRS) at T2 and T3, there was certainly no return to lower levels, as the raw mean scores continued to increase, albeit insignificantly (from 54.65 to 55.79).

However, similarly to child behaviour, there were three parents that despite reporting an increase in confidence at T2 reported a decrease in confidence at T3. Only one of these parents also reported clinical levels of behaviour at T3. It is possible that external circumstances impacted on their perceptions of confidence. It is also possible that attending the HHGP highlighted issues that the parent was previously unaware of, either through gaining more information or by comparing themselves to other members of the group. This failure to be beneficial for all has implications for practice that will be discussed in section 6.7.

Throughout this research it has been accepted that confidence is an individual and measurable concept. However, feeling confident and acting in a confident manner, although related, are not necessarily the same thing. Someone might feel extremely confident but not be acting accordingly and vice versa. Indeed both processes are influenced by a range of factors including own personal feelings and the perceived thoughts of others (Bandura, 1955). While confidence is likely to be an important factor in parenting it is a complex topic and may not be easily understood by a simple self report measure.

6.3 Parent Stress

A statistically significant positive correlation was found between parent stress and intensity of behaviour and problem level of behaviour. This is similar to previous research that suggests a causal relationship between parental stress and child behaviour difficulties (Karr-Morse & Wiley, 1997). However, it could also be argued that raising a child with behaviour difficulties is a stressful experience. More likely it is a cyclical relationship.

Results indicate that parents in this study reported significant reductions in parental stress between T1 and T2. This is consistent across all subgroups examined. Although there was no significant difference in parental stress (as measured by the PSI) at T2 and T3, there was certainly no return to higher levels, as the raw mean scores continued to fall, albeit insignificantly (from 74.97 to 72.85).

Prior to the start of the HHGP the mean total score for parent stress (as measured by the PSI (87.12)) was lower than both that of the HHIP (100.13) (Rait, 2011) and of a community-based study (113.04) (Phillips, et al., 2008). Similarly to the behaviour

levels this suggests that HHGP was working with a different population to previous studies. This is further supported by the number of participants who reported stress levels above the clinical cut off. In this study 38% of parents fell above the clinical level of stress prior to the HHGP compared to 74% of parents who report clinical levels of stress in the HHIP pilot. Since both the HHGP and the HHIP worked on the basis of self-referral, the difference in populations cannot be explained by that fact alone.

However, statistical analysis demonstrates that all outcome measures, with the exception of the PCI subscale of the PSI, produced a significant main effect over time, regardless of whether the participant was above the clinical level of stress or below it. This suggests that the HHGP can be successful with a range of levels of need.

Seven parents reported a rise in their levels of stress suggesting that the HHGP was not successful for them. However, in five of these cases parents were experiencing other life stressors including a death in the family, family illness and three cases of redundancy. These potentially stressful factors may have been more influential in sustaining stress in the parents than could be realistically ameliorated by the HHGP. Another possible explanation could be that although parents did not report a drop in stress levels they were more able to manage it. This suggestion is supported by the result that all seven parents also reported an increase in confidence.

6.4 General Methodological Issues

A major strength of this research is that it adds to the growing evidence base that demonstrates that PPs can be transferred to the community setting. The results

indicate that parents can be motivated and capable of completing, and benefiting from, a brief time-limited PP. However, there are several limitations to the study including: small sample size, lack of a control group, utilising self report data and not coding direct observations of PCIs.

The main constraint associated with this research design focuses on the issue of causality. Causality is extremely difficult to establish, because there may be other factors not identified and the interaction of factors hard to disentangle. A control group, or baseline, methodology might allow some improvement in this respect, but was inappropriate for reasons discussed in section 4.1. The positive effect displayed in the results could be attributed to a range of possible causes including maturation and other environmental factors during the period of the intervention (Shadish, et al., 2002). At this stage it is only possible to conclude from the data that decreases in parental stress, intensity and problem levels of behaviour and increases in parental confidence occurred over time in association with completion of the HHGP.

However, a substantial body of research demonstrates that behaviour difficulties are typically persistent over time in the absence of any intervention (DfES, 2003; Nixon, 2002). Also given the severity of the behaviour difficulties at the start of the HHGP, with 35% of parents reporting problem behaviour levels above the clinical level, it seems unlikely that these improvements would have happened spontaneously. Therefore, although the research design cannot claim causality, it can infer that any improvement over a relatively short period is likely to be as a result of the intervention. However, usually caution needs to be exercised as it is possible that the expectancy of the parents and the group process is what makes the difference, rather than the specific intervention. Without further controls it is difficult to

conclude that it is the HHGP in particular that makes the difference, rather it illustrates the benefit of intervention in general. The generalisability of the findings is also limited to parents who are motivated enough to access and complete the HHGP.

The small number of participants could have led to exaggerated effect sizes (Field, 2009). However, other studies have utilised similar number of participants (Rait, 2011; Wolfe & Haddy, 2001).

Follow up data were collected at approximately two months after the completion of the HHGP. This is a relatively short time period. For firm conclusions to be drawn about the retention and application of the information a longer term follow up would be needed.

The final methodological issue to be considered is the use of self report measures. Patterson et al (1982) claim that self report measures overestimate change following an intervention. Therefore further research into this area could utilise observations or videoing PCIs and coding the behaviour to gain an understanding of whether self report measures match observable changes. This technique was employed in the HHIP but was not practical in the current set up of the HHGP.

With self report measures there is also the question of whether parents complete questionnaires to give a more favourable view of themselves. The PSI-SF has a defensive subscale to counter this. At the start of the HHGP only 2 parents gave responses that indicated that they were responding defensively, this rose to 4 parents on completion of the HHGP and again to 8 parents at follow up. This could suggest that the results are not as reliable as first thought. However, questions over

the validity of the PSI defensive subscale have been raised. Milner and Crouch (1997) report that the defensive scale fails to identify responses that are portraying a more favourable image of themselves in over 50% of cases. They suggest that the 'PSI Defensive Responding Scale has limited utility in detecting individual cases of faking-good behavior' (p. 645) This finding coupled with the positive views of parents, as found in paper 2, suggests that parents were being open and honest regarding their children's behaviour.

Finally confounding factors may have been influential in scores for all measures. Some of the follow up measures were taken during the summer holidays when many children and their siblings were at home. Thus parents could have been more aware of their children's behaviour difficulties and more affected by them in terms of stress and parental confidence. There were also two cases where parents had a baby between completing the HHGP and filling out the follow up data.

Despite these concerns there are benefits of this research design. As this study utilised a "real world" sample it would be considered to have greater ecological validity than evaluations of PPs utilising clinical settings (Chambless & Hollon, 1998).

6.5 Summary and Conclusions

In summary this study draws conclusions that the HHGP is associated with significant increases in parental confidence and significant decreases in parental stress and intensity of behaviour and problem behaviour. These positive findings are found in all subgroups examined suggesting that the HHGP works in similar ways for different groups of parents. The HHGP also appears to work in a similar way to the HHIP with the exception of one subscale of the PSI.

The results from this study are consistent with previous literature that found significant results for abbreviated and adapted PCIT programmes and the HHIP (Berkovits, et al., 2010; Nixon, 2002; Rait, 2011). This study contributes to knowledge and adds to the growing evidence that a well-established evidenced based programme such PCIT can produce positive outcomes, even when it has been significantly modified and ‘transported’ to a community setting.

The present study indicates that a PP can be flexible to the parent’s needs and adapt session content while still being successful. It also indicates the success of involving paraprofessionals (FSWs) to implement the PP.

Finally this research confirms the importance of adapting and modifying established PPs rather than continuing to evaluate existing PPs. It supports the investigation into ‘what works (best) for whom’ (Moran, et al., 2004, p. 18), which is of particular relevance in the current economic climate where services are under pressure to use programmes that are evidenced based and cost-effective.

6.6 Implications for Research

Despite the generally positive results some of the methodological issues discussed above have implications for research. It would be desirable to undertake further work with either a control group, or baseline wait list. This could be achieved by using a naturally occurring wait list control group, where the parents have had to delay the start of the HHGP. A further extension would be to use a longer follow up period. Or alternatively the current participants could be contacted at a later date to see how the current cohort is managing when they start school. This study relied on

self report data, so as mentioned above future work could consider the use of videoing interactions.

6.7 Implications for Practice

The results indicate that it is likely that the HHGP will be beneficial to many parents who are having difficulty managing the behaviour of their preschool aged children. This might result in fewer behaviour difficulties when this cohort attends school, which in turn impacts on the practice of EPs.

The positive results allows for the continued development and implementation of the HHGP and point towards the constructive role that paraprofessionals can play in supporting families and young children. This in turn has implications for the cost effectiveness of the HHGP. With the short time frame of each group, lower training needs, and use of paraprofessionals the HHGP can be seen as an ideal PP for settings to run. However, cost effectiveness of PPs in an area that is under researched (Edwards, Céilleachair, Bywater, Hughes, & Hutchings, 2007) and further work would need to be done in order to examine the true cost effectiveness of the HHGP.

As the attrition rate within the HHGP is low, with only 2 parents (4.5%) in the pilot not completing the sessions, the pilot could inform practitioners about “what works” to keep parents attending.

While the results of this study are clearly positive at the statistical level, there were individual families who reported no improvement or some increase in behaviour difficulties or stress at T3. This reminds us that even successful PPs may not reach all families, so that practitioners need to be vigilant in attempting to identify those families that are not helped and flexible in trying to assist them in other ways-

perhaps via booster sessions or through the use of self-guided written materials.

This is a possible future adaptation for the HHGP.

Paper 2

Holding Hands: Evaluating Parent Perceptions

Holding Hands: Evaluating Parent Perceptions

Abstract

Parenting Programmes (PPs) are generally accepted as being a successful way of supporting children with behaviour difficulties. However, there is little research on how PPs operate to be successful.

Aims: The aim of this study was to seek new insights and a detailed descriptive portrayal of how parents experience the Holding Hands Group Programme (HHGP). This in turn can support future development and changes to the HHGP.

Method: Semi-structured interviews were carried out with 15 parents prior to, and on completion of, the HHGP. The interviews focused on the parent's experiences of the programme and what they believed to have had the main impact. The focus of the questions stemmed from the research questions and from the relevant theory. The interviews were transcribed verbatim and analysed using thematic analysis.

Findings: Six themes were identified from parental accounts: support, new knowledge, reconstructing, awareness, changes and interactions. Alongside these themes was a practical element about 'what worked'. Prior to the HHGP parents gave detailed descriptions of the difficulties that they were experiencing with their child, were able to identify what they wanted to achieve through the group and seemed able to predict what might be useful to them. After the sessions parents discussed what they had gained from taking part and were able to give suggestions for what had caused any changes. Implications for practice and future research are discussed in the light of these findings.

7. Introduction

Behaviour difficulties in young children present a significant concern to parents and professionals. Many children who demonstrate behaviour difficulties go on to have poorer outcomes in later childhood and adulthood. They have, on average, significantly lower academic attainment, mental and physical health and socioeconomic status than their peers (Campbell, et al., 2006; Fergusson, et al., 2005; Shepard & Dickstein, 2009; Shortt, et al., 2003; Tremblay, 2006). Children who demonstrate behaviour difficulties in early childhood are at an increased risk of continuing to have these difficulties later in life, compared to those who develop behaviour difficulties later in childhood (Nigg & Huang-Pollock, 2003).

PPs are accepted as being one of the most effective and successful methods of reducing behaviour difficulties, reducing parental stress and increasing parental self efficacy (Barlow & Stewart-Brown, 2000; Barrett, 2010; Butt, 2009; Dretzke, et al., 2009; Hallum, Rogers, & Shaw, 2004; Moran, et al., 2004; NICE, 2006; Scott, et al., 2001; Webster-Stratton, 1984; Webster-Stratton, Hollinsworth, & Kolpacoff, 1989; Webster Stratton & Hammond, 1999). A range of theoretical perspectives has been drawn on to establish successful evidence-based PPs, (social learning theory, attachment theory and parenting style theory). Recent literature has also started to adapt PPs to work in a range of contexts and to be delivered by a range of professionals and paraprofessionals (Reyno & McGrath, 2006). However, despite this positive research base, parents often display limited attendance and premature termination from PPs and little is known about how PPs work (Reyno & McGrath, 2006).

Paper 1's literature review highlighted risk factors associated with behaviour difficulties in children, for example parental factors such as parental mental health and pregnancy at a young age and contextual factors such as low socioeconomic status (Berlin, Brady-Smith, & Brooks-Gunn, 2002; Dodge, et al., 1994; O'Connor, Heron, Golding, Beveridge, & Glover, 2002). Reyno and McGrath (2006) suggest that these risk factors are also linked to poorer attendance at PPs, less favourable outcomes and also increase the likelihood of parents dropping out of PPs. This is a challenge to PPs as these are exactly the sort of communities that they would be most beneficial to. Wolfe and Haddy (2001, p. 77) agree with this stating that, 'Attrition is widespread, inconsistent attendance is common, and those parents most in need are often the least likely to participate'.

8. Theoretical Background

This section briefly examines the current literature on what makes PPs effective and how parents perceive PPs and react to them, which leads to the formulation of the research aims and the research questions (please see Appendix 57 for the full literature review).

Research demonstrates that PPs are a successful way of supporting behaviour difficulties in children (Barrett, 2010; Butt, 2009; Dretzke, et al., 2009; NICE, 2006; Webster Stratton & Hammond, 1999). This evidence has led to an increased number of PPs being offered to families. However, 'greater availability of parenting programs can only effect positive change if they result in increased uptake' (Hindman, Brooks, & Van der Zwan, 2012, p. 129), and this has not been shown to be the case. Indeed, while the research has been mainly positive with regards to outcomes of PPs there

have been several criticisms levelled at them including difficulties with attendance and the fact that even the most successful of PPs do not improve the situation for all families (e.g. results from paper 1, (Butt, 2009; McIntyre & Phaneuf, 2008; Scott & Dadds, 2009). Despite these difficulties associated with PPs they are still commonly used. Wolfe and Haddy (2001, p. 77) suggest that 'To make the most of that investment, it might be useful to understand what works and why, rather than settling for modest gains.'

However, Paper 1 highlighted the shortage of information on how PPs are helpful or what elements parents find important (Barrett, 2010; Butt, 2009; Moran, et al., 2004). The ultimate aim of PPs is to enable and empower parents to develop their own confidence in parenting, which in turn supports the child's behaviour difficulties. To achieve this it is important to know what parents find helpful.

Earlier sources often raise the area of parent perceptions and experiences as an area for further investigation, or provide some qualitative detail to support quantitative outcomes (Scott, et al., 2001; Stewart Brown, et al., 2004). However, more recent work is starting to demonstrate some interesting contributions in this area (Barrett, 2009; Kane, et al., 2007; Reyno & McGrath, 2006).

After reviewing studies that attempt to identify variables that might predict, or explain, how successful a PP might be, Reyno and McGrath (2006) conclude that socioeconomic status and maternal depression are the only two factors that impact negatively on outcomes of PPs. Meanwhile Kane et al (2007) review qualitative studies and conclude that parents find the increase in knowledge and skills important and also benefit from the support from other parents. Barrett (2009) suggests that matching parents to specific programmes, assessing the needs of the

family prior to starting a programme and reflecting on progress throughout the programme may be methods to improve outcomes of PPs. Despite these suggestions Barrett questions whether some parents might need something in addition to a PP. It has also been suggested that active participation (Orrell-Valente, Pinderhughes, Valente Jr, & Laird, 1999), and intervention format and intensity (McIntyre & Phaneuf, 2008) impact on outcomes. It seems that the optimum design of a PP can vary from family to family. It might be that the key to a successful PP is flexibility or the ability to match families to particular PPs.

Hindman et al (2012) suggest that until recently too much emphasis has been put on socio-demographic variables. They suggest that unfortunately these factors are difficult to change and that there should be exploration of 'more easily-amendable factors' (p129) that can increase the appeal of PPs. They support previous research that indicates that the time commitment required to access the PP, the time of day the PP is held and the distance parents have to travel to access the PP are all important factors that influence the uptake of PPs and the likelihood that parents will continue to attend (Dumas, Nissley-Tsiopinis, & Moreland, 2007). Haggerty et al (2002) previously stated that when parents were offered places on two PPs that differed only in the number of sessions, participation was far greater for the PP with fewer sessions.

Wolfe and Haddy (2001, p. 85) suggest that 'while parent education is widely acknowledged as a potentially useful construct, the elements necessary for its success are often hard to pinpoint'. They built on work previously carried out by First and Way (1995) and aimed to provide 'insight about participants' perceived experiences and program impact' (p78) by interviewing 15 mothers who took part in

the parent education programme 'Listening to Children'. Four areas of importance were revealed from the data; increased social support, heightened self-awareness, improved parenting skills and enhanced sense of empowerment. Wolfe and Haddy (2001) suggest that if future work supports these findings, that opportunities are made to include these ideas in the way practitioners work with families.

Levac et al (2008) carried out a detailed qualitative study examining 'mechanisms of change'. They report that a sense of feeling accepted and supported within the group was important. This impacted on the parents' ability to reflect on their own behaviour and alter their parenting practice.

Although these studies provide useful information with regards to parental experiences of PPs, there are several methodological issues that limit the usefulness of the findings. First, the studies were conducted in America and Canada, which minimises the reliability with which the results can be generalised to the UK. The PPs in question (Listening to Children and Incredible Years) are extended courses; it may be that the length of the course is important. The characteristics of the samples used also raise several questions. First, the age range tended to be older than preschool age, a frequent occurrence when examining the literature on PPs. Second, in Levac et al's study (2008) the children displayed behaviour within the normal range suggesting that the cohort would not be categorised as having behaviour difficulties. While in Wolfe and Haddy (2001) it is not clear what the level of behaviour difficulties is.

The research discussed above indicates that examining the experience of parents who take part in PPs can provide insights to support attendance and adjust PPs to include what parents find useful. Although there has been a recent surge of interest

in this area, there is still a lack of research in UK contexts examining how parents experience PPs. Therefore there is a need for researchers and practitioners to develop their understanding of the learning process and experiences of the parents participating in PPs.

9. Research Aims and Questions

The main aim of this research study was to explore the HHGP in terms of both its outcomes and parental perceptions. By assessing the outcomes of the HHGP in paper 1, the study was able to draw tentative conclusions on the success of the intervention. This paper will examine the parents' perceptions allowing a discussion about what parents find useful. Carrying out both evaluations in parallel, using the same families, allows a discussion on the extent to which the perceptions of the participants are in line with data on measurable outcomes.

More specifically the rationale for this paper was to understand how the HHGP was experienced, in order to inform the delivery and development of the programme and to inform professional practice.

In this paper the following more specific research questions will be addressed:

1. What do individual parents like, or dislike, about the HHGP?
2. What can parents' accounts tell us about how changes resulting from the HHGP vary from participant to participant?
3. How do parents understand their difficulties and how does this impact on their participation in the HHGP?
4. What can these accounts tell us about the learning process?

10. Methodology and Methods

10.1 Research Design

This paper is explorative and aims to examine the process elements of the HHGP. It seeks new insights and aims for a detailed descriptive portrayal of how parents experience the HHGP. It achieves this aim by taking an interpretivist position and employing a flexible and qualitative design using semi-structured interviews.

10.2 Participants and Sampling Strategy

The outcome evaluation of the HHGP used data from the first 16 groups to be completed. From the 42 participants who agreed for their data to be used in paper 1 a sub group of 15 took part in semi-structured interviews. All 42 parents were invited to attend an interview, either in the Children's Centre or over the phone. However, since the later groups took place in smaller Children's Centres, where the physical layout made interviews impossible for reasons of confidentiality, and as no parent took the offer of a phone interview, all of the interviews were carried out with parents from the first 6 groups. Of the 17 parents who took part in the first 6 groups 16 of them agreed to take part in the research as a whole but one parent did not want to take part in the interview process. All 15 parents who were willing to be interviewed were included in the study. The sub group of 15 all fulfilled criteria for taking part in HHGP (see page 30 in Paper 1), and came from 6 different areas of the county. 2 of them self-referred to the HHGP, 12 were recommended by a FSW and 1 was recommended by adult education services. Table 9 shows the characteristics of the participants who were interviewed compared to those who were not, while

Table 10 demonstrates which groups the participants attended. The sub-sample demonstrates fairly similar characteristics to the sample as a whole, although it does have an over-representation of boys.

Table 9: Characteristics of Participants

Characteristics of participant	Those who were interviewed	Those who were not interviewed
<u>Gender</u>		
female	5	17
male	10	10
<u>Ethnicity</u>		
White British	13	23
Ethnic Minority	2	4
<u>Adults per household</u>		
One	7	11
Two	8	16
<u>Children per household</u>		
One	8	11
Two	6	11
Three	0	3
Four	1	2
<u>Child age</u> (mean in months and (years))	32.00 (2.67)	27.19 (2.27)
<u>Parent age</u> (mean in months and (years))	372.73 (31.06)	311.04 (25.92)
<u>TOTAL PARTICIPANTS</u>	15	27

Table 10: Groups Attended by Participants

<u>Group attended</u> (total number in group)	Number of Participants	
	Pre	Post
1 (3)	3	3
2 (4)	2	2
3 (3)	3	3
4 (2)	2	2
5 (2)	2	2
6 (3)	3	3
<u>Total Participants</u>	15	15

10.3 Intervention

The intervention was a four week community PP called Holding Hands. It is aimed at parents of children aged between two and five and delivered by Family Support Workers (FSWs) and Educational Psychologists (EPs) working in a large shire county in the South East of England. Further Details of the programme can be found in paper 1 in sections 4.4 and 4.5 and in Appendices 10-12.

10.4 Interviews

The 15 parents all completed two semi-structured interviews; the first at the initial coffee morning and the second after the final session of the HHGP. All parents completed the interviews at the Children's Centre. The interviews were carried out individually, with just the parent and interviewer present. They were all recorded digitally and transcribed verbatim.

Interviewees were asked a series of open-ended questions focusing on their expectations/experiences of the programme, their motivation for participating and what they believed to have been the main impact. An open-ended style was adopted in order to prevent 'priming' the parent's responses (Gillham, 2005). The focus of the questions stemmed partly from the research questions (e.g. what they like, dislike) and partly from the relevant theory (e.g. was labelled praise more or less useful than setting limits and boundaries). Tomlinson's hierarchical focusing method was employed to structure the questions from the most general to the most focused (Tomlinson, 1989). Therefore the focus shifted from the HHGP as a whole to individual sessions.

Semi-structured interviews are considered to be the most appropriate method for this study as they provide a flexible and adaptable way of gathering information. They allow the interviewer to modify the line of enquiry depending on the respondents' answers. This enables deeper and more valuable information to be collected. However, the inclusion of a range of predetermined questions give the interview a clear basic structure and ensures consistency, so that certain information is gathered from all participants.

As recommended by Gillham (2005) the semi-structured interview schedule was piloted and revised prior to administration (see Appendix 52 and Appendix 53). The pilot interviews were conducted in the months prior to the HHGP pilot and were trialled with 4 parents undertaking the HHIP. Additional questions were added to clarify information, gain more detail and to add a level of reflection. For example, during the pilot pre-interviews it was discovered that how the parent heard about the programme and how they became involved varied, so the questions were changed to reflect this. Parents also tended to talk mainly about their child. In order to gain information about both their child and themselves the questions were altered. Questions were added to the post-interview to encourage parents to reflect on what they had discussed at the pre-interviews. These changes allowed a deeper level of exploration.

10.5 Ethical Considerations

All names of people and establishments have been changed or omitted to protect anonymity. To allow quotations from the interviews parents have been given pseudonyms. The name of the authority has also been anonymised. The researcher fully complied with the ethical guidelines and code of Practice of the British

Psychological Society (BPS) which requires the researcher to consider issues of informed consent and the right to withdraw, debriefing and the dissemination of findings, effects on self esteem and mental stress, respectful treatment of participants, sexism in research, confidentiality, safe-guarding of vulnerable groups and equality in research planning and implementation. For example, during this process it was important to clarify the role of researcher as being distinct from the role of an EP. This dual role could potentially have caused a power imbalance between the interviewer and the participants. This ethical issue was overcome by the interviewer attending the coffee mornings of each group and at least one group session. This facilitated rapport and allowed a relationship to be established, potentially resulting in more in-depth answers. Further ethical issues are discussed in Appendix 16. Ethics approval was sought from the University of Exeter and the certificate is included in Appendix 18.

10.6 Data Analysis

The analysis of the transcribed interviews followed the five steps outlined by Braun and Clarke (2006) in their guidance on thematic analysis. The aim of the analysis was to identify a series of themes that summarised the parents' descriptions of the experience.

Phase 1: Gain familiarity with the data. The transcribed interviews were read through on several occasions to allow a sense of familiarity and allow the researcher to reflect on the answers given.

Phase 2: Generating initial codes. Transcripts were subject to open coding using Nvivo (v.9). These initial codes were data driven and involved all participants'

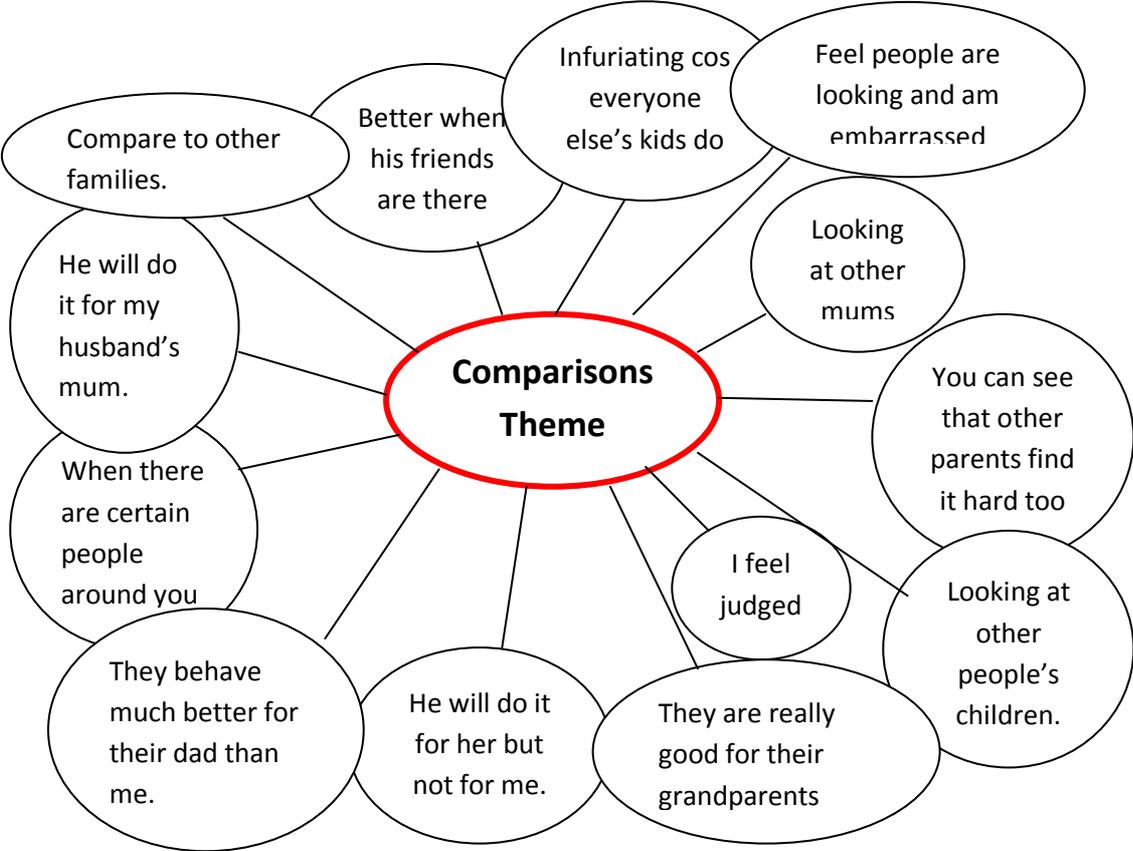
responses being coded line by line. Participant responses were given a code if they were relevant to the HHGP or the research questions. Table 11 illustrates an example of this open coding (see Appendix 54 for a full coded transcript).

Table 11: Open Coding of Transcript

Transcript	Open coding (initial theme)
<p>Interviewer (I): has it been useful for you? For (your child)?</p> <p>Parent (P): for both of us really, 'cos I feel that I have learned, it wasn't just about him learning, I've learned something to teach him basically. Like before in certain situations I would react completely differently, whereas now I feel that I am a lot more calmer.</p> <p>I: So how you're reacting is then having an impact on how he is?</p> <p>P: yeah definitely because before if I was to shout at him I could tell he would get frustrated and do it more whereas now I feel 'cos I'm a lot more calmer I feel that he is like that because of me being like it towards him.</p> <p>I: that's good. What do you think it is about the programme that has helped that?</p> <p>P: um well it is everything that we really talked about it. It wasn't just sitting there it was the activities and how we looked at each other. Even looking at the other mums you can see what they are doing as well which is kind of good because sometimes you don't know what you do wrong but if you look at someone else you can tell how they have done a certain thing and whether it is right or wrong.</p>	<p>I have learned (ideas)</p> <p>To teach him (strategies)</p> <p>React completely differently (self impacting on child)</p> <p>Calmer (consistency)</p> <p>He would get frustrated (difficulties with child)</p> <p>Calmer (consistency)</p> <p>He is like that because of me being like it (Self impacting on child)</p> <p>Not just sitting (positives)</p> <p>The activities (new strategies)</p> <p>Looking at other mums (comparisons)</p>

Phase 3: Searching for themes. The initial codes were then searched systematically for patterns or initial themes and Nvivo was used to create tree nodes to group the initial codes (see brackets in second column of Table 11). Figure 1 illustrates a selection of the open codes forming one initial theme (see Appendix 55 for full list of initial themes).

Figure 1: Open Codes for the Theme of Comparisons



Phase 4: Reviewing themes. The initial themes were then reviewed and adjusted with some themes being combined. For example, the initial themes of 'hopes for the group' and 'predicting what works' were combined to make one theme while the initial themes of 'self confidence' and 'child's point of view' became sub themes

within the wider theme of 'reconstructing' (see Appendix 56 for structure of reviewed themes).

Phase 5: Defining and naming themes. The themes, and sub-themes, were given titles to illustrate what aspect of the data they represent. Where possible the themes were named with language used by the participants.

11. Results

Thematic analysis identified six themes; support, new knowledge, reconstructing, awareness, changes and interactions. Each theme detailed different experiences of the parents and had several sub-themes which distinguished between different elements of the category. Alongside these six themes ran a more practical aspect of 'what worked' for the parents.

11.1 Support

All parents reported that the HHGP had been a supportive experience. It appeared to be an important factor in ensuring that parents returned to sessions, with one parent commenting "If it had just been me, or the people in charge were really pushy, I think I might have been a bit more nervous about doing it and I am not sure I would have come along" (Amy). The following three areas of support were identified from the data.

Support I: Other parents

The group aspect of the programme appealed to all parents. They were all aware of the HHIP and felt that the HHGP was "more for them". The support of other parents seemed important for three key reasons. First, it demonstrated to parents that they

were not alone in having difficulties with their child's behaviour. Having other parents who shared their concerns or circumstances seemed to reassure them.

"It was nice to be able to talk to other mums and at some points you think it's only your child doing everything wrong, and when you talk to other mums you know it's not just your child." (Rachel)

Second, it allowed parents to share ideas and strategies and witness how others interact with their children.

"it's just nice to share experiences with other mums and to know what their kids do at home as well." (Charlotte)

Finally, several parents felt that being a member of a group which contained parents they were already acquainted with was useful to building a supportive environment. While three parents commented on the fact that attending the HHGP had allowed them to build relationships with other parents that went on to extend beyond the group sessions.

"It helped me meet other mums you know. Like I see A out of this group and we meet up and our kids play together. It's nice cos we both went through this so we know what the other one is dealing with and we can remind each other." (Louise)

Support II: Professionals as supportive

All parents felt that the EP and FSW were useful and helpful. Common phrases used by parents in describing the professionals were "enthusiastic", "encouraging" and "supportive". One parent commented that they "made you want to come back". In

addition to these generalised qualities parents identified that the professionals were also able to help provide practical support.

“the FSW and EP were really good at modelling stuff and showing you different ways of doing it” (Amy)

“it was almost like you came with a problem and they helped you solve it” (Monica)

Parents reported a range of issues for which they received support and advice including sleeping and bedtime routines, feeding, controlled crying, learning and social interactions. One parent summed it up by saying “they know about lots of different things, I mean they see hundreds of children and you only see yours. You just have to ask. Even if they are not a hundred percent sure they know where to find it out or who you can ask”. (Tom)

The support of the professionals extended beyond those present at the HHGP. Two mothers reported that attending the HHGP had altered their perceptions of professionals in general and encouraged them to access other opportunities at the Children’s Centre.

“before I felt like anyone who got involved was doing it because they thought I was a bad mum. But now I can see that they only want to help...I don’t mind other people trying to help now, even when it is to do with my older ones at school”. (Jess)

“I come here more now... I can see it’s important now, whereas before I wouldn’t come cos I didn’t want the staff to think I was a rubbish parent” (Anna)

Support III: Being understood and listened to

All parents were positive about the professionals running the HHGP. The previous section highlighted practical elements that parents found particularly supportive. However, in addition to this there appeared to be an added importance of being made to feel understood. Several parents described the professionals as “non judgemental” and “understanding”. This was often compared to previous experiences where the parents had not felt this way. For example one parent commented “I mean you get some people who come across as really judgemental, like when the kids were younger and we had the health visitor come round, but [the FSW and EP] weren’t at all” (Jess).

One element of being understood seemed to stem from the act of being listened to and the flexibility demonstrated by the EP and FSW. One parent noted that: “I also liked it that we didn’t just sit and listen. They didn’t just do things that they thought were important. They asked us what we found hard and did things to help that” (Lucy).

11.2 Awareness

Throughout the interview process parents seemed to be very aware of the current situation. They were able to discuss, in detail, the difficulties that they were experiencing with their child and frequently made comparisons between their child and another child or between their own skills as a parent and the skills of others. Parents were also able to articulate what they wanted to take away from the HHGP and what part of the HHGP they thought would allow them to achieve this.

Awareness I: Difficulties with child

Prior to the HHGP all parents were able to identify what difficulties they had with their child. They were aware of which issues caused them the most problems and which they viewed as “a phase” appropriate for the child’s age. Parents often described their child’s behaviour as “confusing” and “distressing” because in the majority of cases the parents could not identify what triggered the behaviour. However, three parents commented that they thought it might be to “get attention”.

The descriptions used to describe the behaviour varied significantly from “we have slight issues at home” to “all of a sudden he will go mad”, “absolutely horrendous” and “unmanageable”. The reasons for why they found the behaviour difficult also varied, with some parents suggesting that “it is embarrassing when you go out”, others mentioned time constraints saying “if I have to get all three ready and he kicks off then it can be really hard to get anywhere on time” and another group of parents discussed how it made them feel, “it just gets me down all the time”.

What parents attributed the behaviour of their child to seemed to play an important role in how the parents engaged with the programme. If they saw the behaviour as something outside of their control then they were less likely to try and impact on the situation. After the HHGP several parents commented that they were “surprised” by the extent to which they could impact on minimising the negative behaviour.

Awareness II: Comparisons

Alongside the awareness of the child's behaviour appeared to be the highly connected theme of making comparisons. Prior to the HHGP, 11 parents reported comparing their child to another child or commenting that their child behaved differently depending on who was looking after them.

"It is infuriating cos everyone else's kids do it" (Monica)

"they behave worse for me, they are much better for their dad". (Anna)

After the HHGP the majority of parents mentioned that this process of comparison had allowed them to feel "normal" in the group when they realised that other parents were also struggling with the same difficulties; "it's not just me" was a common phrase. This then seemed to allow parents to stop comparing themselves to other parents and children outside of the group. "it makes you realise that all children are different, they do things at different times and there isn't a right or wrong way, just what works for you and your child" (Lucy).

Awareness III: Hopes and predictions for group

Before the parents started the HHGP they all had an idea about what they wanted the group to help them with. They ranged from "being able to take a step back and maybe see some of the things unwittingly I've been doing" (Amy) to "some different ideas, some tips basically about the things that I don't do so well" (Louise). All parents reported wanting to gain some new strategies to use with their child, but each parent also had a more individual reason why they wanted to attend and what they wanted to gain from it. These included widening their social support after

difficult personal circumstances, encouraging their child to meet other children and wanting to take on a personal challenge.

Prior to the HHGP parents were asked what they felt was going to be most useful about the sessions. Responses included “the strategies to help control his behaviour” (Sarah), “getting some new ideas of fun things to do with her” (Charlottle) and “talking to other parents” (Rachel). When the sessions had finished and parents were asked what they had actually found most useful, 14 of the parents agreed with the comments they had made previously. The one parent who didn’t agree commented “I thought it would be useful to see him interact with other children, and don’t get me wrong it was, but I think I probably got more from talking to other parents and sharing ideas. I guess what I was seeing fed into the discussions I had but I think I would change what I said” (Tom).

11.3 New Knowledge

A common comment from parents was that, at times prior to the HHGP, they did not know why their child was behaving in certain ways. They suggested that they did not have enough understanding about how to deal with these situations.

“I didn’t know why he was doing it, and I would think is it something I have done or is he just naughty?” (Jess)

Parents highlighted three key areas in which they felt they gained new knowledge. In each of these areas there were some ideas that were repeated by numerous parents while there were other ideas that were particular to one individual.

New Knowledge I: Strategies

All parents reported that gaining “new ideas” and “strategies” to support their child’s behaviour was one of the biggest outcomes of the HHGP. During the interviews they outlined a range of practical strategies that they were now using at home including how “important it is to be really specific with praise” and “to ignore certain behaviours”. Others talked about the importance of routines and consistency and behaviour management techniques.

The majority of parents (13/15) also commented that they now felt as though they had a range of strategies that they could try rather than relying on the same ones all the time. One parent summed it up by saying “I think it is always helpful to chat through things and get some advice, it just gives you a range of options rather than getting stuck in a habit.” (Monica).

Parents identified that these strategies and new ideas were gained in several ways; through sharing ideas with other parents, through group problem solving sessions, advice from the professionals and also during practical trial and error sessions and role play scenarios.

Gaining new strategies during the HHGP allowed parents to reflect on the strategies that they used prior to the programme. Many parents commented that before taking part in the HHGP they used strategies which were ineffective and often negative. They commented that this rarely improved the situation and only made them feel more distressed or frustrated.

New Knowledge II: Ideas

A few parents went beyond describing particular strategies that they had picked up. They discussed broader ideas that had been discussed in group problem solving sessions about child behaviour, child development and psychological ideas, for example, Piaget's stages of development. One parent commented "I realise now that I was expecting him to do things that really an older child would do. Now I know more about what he should be able to do and I don't feel frustrated when he can't do things. I just remind myself that he is only 3." (Sarah).

New Knowledge III: Reinforcing previous knowledge

Some parents commented that the HHGP had also given them the confidence that some of the strategies that they were using before could be successful: "it reassured me that I wasn't doing everything wrong and that I just needed to tweak a few bits and pieces" (Amy). For some parents the focus on the positives that they brought to the sessions was extremely important: "[the FSW and the EP] weren't just sat there telling you that you were doing it all wrong. They pointed out things that you did well and encouraged you to build on them. I think if it had all been bad then I might not have come" (Jess).

11.4 Reconstructing

The majority of parents (14/15) reported that a consequence of the new knowledge that they had gained was a changed view about their child and about themselves. The following two categories were identified from the data.

Reconstructing I: Child's point of view

A commonly expressed theme was that parents reported a shift in their thinking regarding their child's behaviour; "I think I see her behaviour differently now". Parents tended to stop seeing the behaviour as being "deliberately naughty" and instead started to interpret the behaviour as a sign that they were seeking their parents' attention or needed something.

"we talked about almost the reasons why she might be hitting out or lashing out um and that was quite useful, before I would think she was doing it to annoy me but we were then linking it to how she was sort of feeling" (Monica)

Parents reported that this shift in thinking resulted in them responding to the behaviour in a different way, which in turn altered the behaviour that the child was displaying.

Reconstructing II: Self confidence

All parents reported feeling more confident after attending the HHGP. For the majority of parents this reconstruction was attributed to the acquisition of new knowledge.

"because I feel I know more I feel that I can manage his behaviour cos I have different things to try" (Anna)

However, three parents reported that the practical activities during the sessions allowed them to develop their confidence due to positive regard shown by others. It had helped them to think about themselves differently. One parent commented that "when you are at home on your own you don't tend to notice the good things that

you do, you just notice the things that don't work. It was nice to try things out and for people to point out that it was working, it made me feel better and then I was more likely to notice it working at home too" (Charlotte).

Although all parents felt more confident at the end of the HHGP one parent commented that after the first session she felt less confident because "other parents seemed to have more ideas than me and [my child] seemed to be behaving the worst" (Gemma). This potential ethical dilemma was discussed and planned for when considering ethical approval (see appendix 16). In this particular instance the situation was resolved when the parent raised this concern with the FSW and EP running the group. The issue was discussed, and the FSW and the EP were able to support the parent in reconstructing their view of themselves and their child. This message was reinforced at the weekly meetings with positive parenting practices and positive child behaviours being highlighted to the parent. At the end of the sessions the parent commented that "by the end I felt like I had some good ideas too and I could see that I was able to manage [my child's] behaviour and that really I wasn't the only one going through it all".

11.5 Changes

In the second round of interviews all parents made some reference to the changes that they had noticed as a result of attending the HHGP. While all parents noted that there had been changes, several parents commented that there were still further changes to be made and that the skills they had picked up during the HHGP would allow them to continue making progress after the sessions had stopped.

Changes I: Child behaviour

All parents noticed a change in their child's behaviour and were able to identify what had improved.

“yeah there has been some development in play and we have seen some progress. I mean she is still little so there is still some parallel play but she has started to share better and join in with other people” (Monica).

Parents were keen to report that these changes were not noticed solely by themselves, that others had also noticed the improvements. One parent noted that “it's not just me that feels the changes. It is everyone around him. Even like my family and friends, everyone has noticed that change in him” (Gemma) while another commented that “the FSW has commented that she has noticed the changes in other sessions here as well as this one” (Sarah). This indicates that the new knowledge discussed in a previous section is being transferred to other situations.

Changes II: Parental confidence and stress

As previously discussed all parents reported feeling more confident after taking part in the HHGP. Typical comments included “I feel better about myself” and “I know I can do it now”.

Most parents felt that feeling less stressed was a consequence of having more confidence in managing their child's behaviour; “Because I feel that I can handle more I don't worry as much” (Jess). They reported that using the new strategies and

considering the child's point of view encouraged them to stay calm and "stop and think" about the situation before rushing in.

Changes III: Parent-child interactions

Parents were able to describe how their interactions with their child had altered during the process of the HHGP. Parents commented that they spent more time with their child and that they enjoyed the 1:1 time that the HHGP provided. Many parents noted that they now spent more "special time" with their children outside of the HHGP. Several parents suggested that using the FLIP messages had encouraged this. "before I would interrupt what he was doing and correct him, but now I go along with what he is playing so he enjoys it more and it doesn't cause arguments" (Louise).

Parents also noticed that they spoke to their child in a different way and used different types of language. One mother commented that "before I would always be telling him things, what to do, what not to do etc. But now I ask him questions about what he is doing, and get his opinion" (Amy).

Parents who discussed the change in their interactions tended to see this as a result of reconstructing their ideas and taking into consideration the viewpoint of the child which in turn impacted on the child's behaviour. Other parents also saw the new strategies as being an important element in the interaction changes.

11.6 Interactions

During the second stage of interviews parents described changes in the interactions they had with their child. Not only were they able to identify what had changed, as

discussed in the above section, but they also highlighted the following three areas as possibly cause for these changes.

Interactions I: Self impacting on child

Several parents commented that after the HHGP that they were now aware of how their own behaviour, or reactions, could impact on, or exacerbate, their child's behaviour; "I can see now that shouting back just made things worse", "I feel that he is like that because of me being like it towards him". One parent summed it up by commenting that "I think how you feel can have a big impact on how your kid is. So if you feel better then it will be easier to manage the kid" (Charlotte).

Interactions II: Consistency

Many parents outlined how they were responding to their child's behaviour in a more consistent manner. For example "I've been telling my husband the things from here so we do things more in the same way now so I guess that is better" (Lucy) and "it is more consistent which I guess the kids are responding to". One parent commented that prior to the HHGP she would often use "empty threats" whereas now "I do it, rather than just say it".

Within this theme of consistency several parents reported establishing routines for activities such as meal times and bedtimes. They noted that these routines resulted in an improved atmosphere for the whole family.

Interactions III: Flexibility

Despite consistency being a strong theme amongst parents several parents added that within this there needed to be an element of flexibility, that being too "rigid"

often caused situations to deteriorate. One parent reported that she had learnt to “think about what is realistic and practical in different situations” (Clare) suggesting that although routines and consistency have their place it is important to consider each situation individually.

11.7 What Worked vs. What Did Not Work:

Alongside the six themes discussed above ran a parallel idea about the practicalities of the sessions; what parents liked and did not like.

The parents in this study described a range of experiences which supported their attendance, motivation and learning. These included the length and number of sessions, being able to bring their child to the sessions, the practical activities and the fact that they were not just sitting and talking, the group dynamics and the supportive environment established by the professionals. Parents also reflected on the flexibility of the sessions, and appreciated the fact that the sessions were tailored to meet their specific needs.

Three parents reported that although the number of sessions was adequate they would have liked there to be more. One parent also commented that they found the time of day difficult due to other commitments. However, they noted ‘it isn’t a big problem because it works for everyone else, so it shouldn’t just change for me’ (Tom).

11.8 Summary

Figure 2: A Diagram Summarising the Interaction of Themes

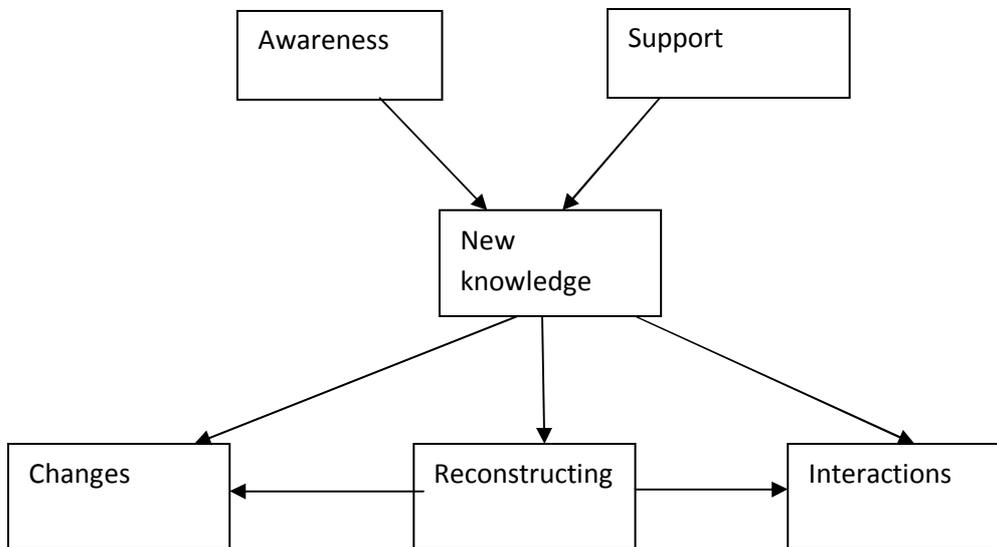


Figure 2 represents the relationships between themes that parents voiced. Parents felt that the supportive atmosphere of the group, from both the other parents and the professionals, was fundamental in encouraging them to continue attending the group and to absorb and use the information. Parents discussed the fact that feeling attached to the group, and supported by others, was important in allowing them to identify with, and take part in, the process of the group. Sections 12.2 and 12.4 discuss how these relationships were formed, and their importance, in more detail. Low attrition levels (2/42) demonstrate that this supportive atmosphere described by the parents is reflected in the attendance rates.

From the discussions with parents it also became apparent that their awareness of situations, and others, was also important in this process. Parents described situations where they learnt from others. They identified key ideas from SLT as being important to the learning process. For example parents highlighted that watching

the professionals interact with the children gave them new ideas and encouraged them to try alternative strategies.

These two factors allowed the parents to absorb, assimilate and use the new knowledge. This new knowledge seemed to provoke many parents to question their views of their child and reconstruct previous assumptions, which together allowed changes in child behaviour, parental confidence and parental stress to occur and interactions to develop. These changes described by parents in paper 2 support the results from paper 1.

The process of working through these themes seems important for the success of the HHGP. Without building the successful relationships and drawing on the parents' awareness it appears that parents would not progress through the themes and would not be able to absorb and apply the new knowledge. Therefore the process, structure and delivery of the HHGP are as important as the content in realising positive changes.

12. Discussion and Conclusions

In broad terms, the results reported above indicate that the parents involved in the HHGP viewed it favourably and were able to identify a number of features which they found helpful in responding to their needs. The various identified themes and interactions emerging for the interviews can be summarised in terms of their impact on parents understanding and participation, and on their learning process, and I will discuss each in turn before considering the links to the results of paper 1 and more methodological issues.

12.1 Understanding and Participation

At the start of the HHGP parents identified a range of difficulties. These included difficulties they were experiencing with their child and difficulties with managing their own stress. These difficulties were often exacerbated when parents drew comparisons between themselves and others. In the majority of cases, the difficulties parents were experiencing with their children were not occurring in isolation. The difficulties were linked to other issues within a more complex social situation, for example managing work and home life, financial difficulties and wider relationship difficulties. This finding emphasises the importance of PPs working within the wider ecological model (see Appendix 7). How parents viewed these initial difficulties evolved over the course of the HHGP as parents started to reflect on their learning.

One common theme from the interviews was that parents expressed a concern about not knowing why their child behaved in the way s/he did. This seemed to be a common motivator for why parents had attended the HHGP. This could potentially be explained by the fact that the majority of parents who attended the HHGP were selected for the group by Family Support Workers (FSWs). It might be that the FSWs selected families that displayed this trait. This is supported by the finding that the two parents in the interview subgroup who self-referred, both talked about possible reasons for their child's behaviour at the pre interviews, but indicated that they did not know how to respond.

This motivator of needing to understand was linked to the parents' desire to gain new knowledge and feel empowered within their role as parent. These ideas link to

previous research that highlights similar themes as important for parent education (Wolfe & Haddy, 2001).

12.2 The Learning Process

The themes from the data indicate that there are several elements that support the learning process for parents; establishing supportive relationships with others in the group, encouraging reflection about their child's behaviour and providing new knowledge to promote the reconstruction of ideas.

The importance of supportive relationships with other parents and professionals in the group was reported by all parents. Section 11.1 illustrates that parents saw being listened to and understood by those in the group as an important foundation for problem solving and self-development. This finding mirrors previous research which suggests that both individual and systemic support is important for positive outcomes in parental education (Kane, et al., 2007; Wolfe & Haddy, 2001). It also suggests a link with the area of Community Psychology which regards social support as an important product of community psychological intervention (Levine & Perkins, 1997).

In addition to social support being important while the group was taking place, several parents mentioned that this support extended beyond the group. Three parents commented that they met up in addition to the weekly meetings and several other parents were accessing the Children's Centre on a more regular basis. Parents anticipated that these activities outcomes would continue after the completion of the programme. This suggests that as well as being a condition for the successful running of the HHGP and a short term outcome, improved social support

was also a longer term outcome. However, this study represents a fairly short view of the parental experiences with interviews being carried out at the start of the programme and on completion of the programme. Further research could carry out a follow up, to see if this social support is maintained beyond the completion of the programme.

A second area that parents highlighted as key to the learning process was the opportunity to develop a reflective stance in relation to their children. Parents talked about the group giving them the opportunity to stop and think about their child's behaviour and their own reactions to it. This process then allowed them to take on board new knowledge and reconstruct their ideas about the situation and respond in a different way; applying their new knowledge from the PP. This reflective element of PPs has been discussed in previous literature (Levac, et al., 2008). Levac et al (2008) suggests that parents also reflect on their own childhood and the impact this has on their parenting. However, only one parent in this study mentioned personal history. This could either be because for this group of parents personal histories were not prominent in their reflective process or, more likely, that the interviewing style did not promote discussion of the parents' own childhood. Further research could be carried out to explore this process.

Parents viewed a calmer approach being a significant outcome of the HHGP learning process. However, they viewed this calmness as both a cause of other changes and an effect. This suggests that it forms a cyclical relationship.

12.3 Outcomes and Links to Paper 1

The findings from this paper, specifically the positive views of parents, can be linked to the positive outcomes found in paper 1. Parents were able to give a range of reasons why they felt more confident after attending the HHGP; a common theme was that they no longer felt they were the only parents in this situation. This might initially be thought to suggest that it is the mere fact of social contact and support rather than the specific content of the PP that facilitates the positive change in parents; but since the encouragement of mutual parental support is an important element in the design of the PP, this would be an over-simplification. At the same time, the second theme of empowerment strongly suggests that elements of the PP other than mutual support do play a positive role. Parents indicated that acquiring new knowledge helped them to become more self-affirming and think that they can have an impact on the situation.

Parents identified reduced stress as both a strategy to support improved child behaviour and interactions, and also an outcome of using successful strategies. Parents also indicated that reduced stress seemed to be a result of increased confidence. Further research could look at whether parental confidence acts as a mediating factor between parental stress and child behaviour.

Parents saw the change in their child's behaviour as a result of the changes that they had made. However, three parents did acknowledge that this change in behaviour then reduced stress further. Again this suggests a cyclical relationship.

12.4 Links to Psychological Theory

The two theories that most often underpin PPs are Social Learning Theory (SLT) and Attachment Theory (AT). However, this study followed advice from Scott and Dadds (2009) and used an 'eclectic approach', also utilising ideas from Parenting Styles Theory. These three theories were incorporated into the structure and content of the HHGP and are also evident in the results.

SLT stresses the importance of successful modelling and discipline techniques in developing positive parent-child interactions (PCIs) and reducing behaviour difficulties. These ideas were incorporated in to the HHGP in the form of two key messages: Ignoring ineffective behaviour and Providing limits and boundaries. The positive outcomes of paper 1 demonstrate the success of this theoretical underpinning, particularly the positive changes in the problem score of the Eyberg Child Behaviour Inventory. This finding suggests that after attending the HHGP parents are more able to ignore low level behaviour and stop classing it as a problem. Paper 2 highlights that by the end of the HHGP parents are aware of the ideas from SLT. This is picked up in the subtheme 'self impacting on child' where parents recognised that their own behaviour, and how they responded to their child's behaviour, can influence a situation. A second area highlighted by the interviews was that parents reported that SLT strategies used by the FSW and EP were successful in encouraging them to attend and engage in the process. For example parents commented that being able to see the professionals interact with their child and then being able to 'have a go' themselves was useful. This links to the idea of modelling. Parents also reported that having professionals point out positive parenting practices, and positive behaviour displayed by the children, allowed them

to reconstruct their previous ideas. This links to the idea of ignoring ineffective behaviour and responding positively to desirable behaviour. This suggests that the planned use of SLT is appreciated by parents and is a successful strategy.

Attachment theory stresses the importance of parental warmth and responsiveness. These ideas were incorporated in the HHGP in the key messages of: Follow your child's lead and Labelled praise. The success of this theoretical underpinning is evident in the positive outcomes reported in paper 1, particularly highlighted by the positive changes on the PCI subscale of the Parent Stress Index. The findings from Paper 2 suggest that attachment theory is also present within the HHGP in additional ways. All parents mentioned that the relationships and attachments that they formed in the group, with both other parents and professionals, encouraged them to continue attending the group and played a role in them feeling supported within the group. The sub-theme 'being understood and listened to' links to the ideas within the message of Follow your child's lead. This suggests that the way in which the FSW and EP responded to the parents allowed an attachment to form. This in turn allowed the attachments between the parent and child to develop: when parents felt supported by, and attached to, the group they were able to assimilate the new knowledge and make changes to their own behaviour and their reactions to their child's behaviour.

Parenting styles theory focuses on the beliefs held by parents about how a child should be parented and the strategies that grow out of these beliefs. It stresses the importance of parental warmth and consistent implementation of boundaries and consequences. This theory was incorporated into the HHGP both in the style of delivery and into the key messages: Follow your child's lead and Provide limits and

boundaries. Again the success of this theoretical underpinning is demonstrated by the positive outcomes reported in paper 1. However, similarly to SLT and AT parents discuss the ideas within parenting styles theory in paper 2. One sub-theme from the interviews that links strongly to parenting style theory is that of 'consistency'. Parents reported that after attending the HHGP they were more likely to follow through with consequences and that they used the same approach in different situations. This allowed parents to move towards an authoritative parenting style and successfully manage their child's behaviour. One area that is often considered in parenting styles theory is that of the parent's personal history, i.e. how they were parented. However, as discussed in section 12.2 only one parent in this study mentioned personal history.

12.5 Methodological Issues

A major strength of this research is that it adds to the growing evidence base of how parents experience PPs and "what works". The results suggest that parents are able to predict what will be helpful to them and can identify what helped them change. However, there are several limitations to the study including: limited generalisability, the potential power differential between the interviewer and the parent and the researchers own involvement.

The purpose of this study was to examine the perceptions of the parents attending the HHGP and their experiences of the programme. The aim was not to generalise to a wider population but to draw upon the voices of those involved in order to further develop and adjust the HHGP. This methodology, along with the fact that this analysis was undertaken with parents participating in a specific intervention, means that care should be taken when generalising these findings.

A second area to be discussed is the potential power imbalance between the interviewer and the parent. Although steps were taken to minimise this issue, there remains the question of whether the parents are being honest or telling the interviewer what they think the interviewer wants to know. However, the transcribed data suggests that due to the semi-structured interview style the interviews were more of a conversation between two people rather than a rigid question-answer style. This, coupled with the fact that the interviewer spent time at all group sessions, suggests that this methodological risk was minimised.

The final area to be considered is the impact of the researcher on the analysis process. The idea of reflexivity (Finlay & Gough, 2003) is well documented in qualitative research and it is generally accepted that the researcher's previous experiences, knowledge and views will impact on the research. This could result in findings being difficult to generalise as a different researcher might find different themes and results from the same data. However, Gilgun (2010) suggests that 'accounting for reflexivity can add to the integrity of the research' (p 3). In this case acknowledging this potential weakness and being aware of it during the process of research ensured that extra care was taken in being truthful to the data and not 'cherry picking' from it. Data was included whether it corresponded with pre-conceived ideas or not.

12.6 Summary and Conclusions

In summary this study concludes that parents perceive the HHGP favourably and that they are able to identify what has had an impact on their learning. Social support from both other parents and professionals is important in encouraging parents to attend, as are the length and timings of session. Parents also indicate that

the delivery style and the range of activities allowed them to develop their understanding of their child's behaviour and provided them with new knowledge. This new knowledge led to parents reconstructing their previous views which they felt resulted in the positive changes.

The results from this study are consistent with previous literature which found similar categories of what makes a PP successful (Barrett, 2010; Hindman, et al., 2012; Levac, et al., 2008; McIntyre & Phaneuf, 2008; Orrell-Valente, et al., 1999; Wolfe & Haddy, 2001). This study contributes to the knowledge in this area and adds to the growing evidence base of 'what works (best) for whom' (Moran, et al., 2004, p. 18), which is of particular relevance in the current economic climate where settings are under pressure to use programmes that are evidenced based and cost effective.

12.7 Implications for Research

Despite the generally positive results, the findings raise some questions which have implications for further research. It would be desirable to undertake further work that continued the interview process to the follow up period. Alternatively the current participants could be contacted at a later date to see how the current cohort is coping when they start school. This would enable conclusions to be drawn about whether the themes in the data are of short term importance, while the PP is being run, or whether they extend into the long term.

A further area that could be examined is whether the parents' childhood experiences have an impact on their own parenting strategies. This has been suggested by previous work but was not found in this study. Finally it would be

interesting to examine in more detail whether parental confidence acts as a mediating factor for parental stress.

The methodological issues raised above also have some implications for research. To address the potential power imbalance between the interviewer and the parents it would be useful to carry out further research with a range of interviewers. It would also be interesting to carry out research with more than one researcher to enable the process of thematic analysis to be compared. This would enable the research to conclude that the themes had not been selected due to the view of the researcher.

12.8 Implications for Practice

The results indicate what elements of the HHGP the parents found helpful, as well as any details that hindered the parents' experience. This information allows for future development of the HHGP. Paper 1 highlighted the low attrition rate within the HHGP, with only 2 parents (4.5%) in the pilot not completing the sessions. The information provided by the parents in paper 2 could inform practitioners about "what works" to keep parents attending.

The results also support EPs in working more generally with families with young children with behaviour difficulties. Not only can the HHGP be a resource that EPs promote families access but the information can be used by EPs to support families directly. For example, by using strategies and approaches that parents have described as supportive. If behaviour difficulties are successfully tackled with early intervention and prevention this could also impact on EP practice in the longer term.

Paper 1 pointed towards the constructive role that paraprofessionals can play in supporting families and young children, which in turn has implications for the cost

effectiveness of the HHGP. Paper 2 extends this finding by suggesting that parents find it easier and more supportive to work with paraprofessionals that know the family well and who have local knowledge. This suggestion that community based services can help families access preventative interventions is important given the suggested changes by the Government regarding Early Years settings and Children's Centres (Teather, 2010).

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Appendices

Appendix 1

Factors Influencing Behaviour Difficulties

Child factors that have been linked with behavioural difficulties include genetic factors (O'Connor & Scott, 2007), birth weight (Sykes, et al., 1997), child temperament (Caspi, Henry, McGee, Moffitt, & Silva, 1995), cognitive or language difficulties (Lundervold, Heimann, & Manger, 2008) and hyperactivity (Banaschewski, et al., 2003). O'Connor and Scott (2007) suggest that although genetic factors are important it is a complex area and as such there is no 'true' estimate of heritability. Perry (2002) supports this idea, concluding that genetics and experience are equally important when discussing behaviour difficulties. It is generally accepted that these within child factors often work in conjunction with life events or contextual factors rather than being solely causal.

Parental factors that have been linked with behaviour difficulties include mental health issues and stress (Waylen & Stewart-Brown, 2008), difficulties during pregnancy (O'Connor, et al., 2002), pregnancy at a young age (Berlin, et al., 2002) and addiction to drugs and alcohol (Bailey & Scott, 2000). However, many authors argue that there is likely to be a strong overlap between confounding risk factors. For example women who experience stress may resort to smoking as a way of coping and difficulties during pregnancy can result in post natal depression. There are several psychological theories that aim to explain the link between parental factors and behaviour difficulties in children including attachment theory, social learning theory and parenting styles theory.

Contextual factors that can impact on behaviour difficulties include poverty and low social economic status (Dodge, et al., 1994) and lack of family support (Bifulco, Brown, Moran, Ball, & Campbell, 1998). Proper and Rigg (2007) suggest that the way in which contextual factors impact on behaviour difficulties in children is not a simple relationship and that it could be different for different families. This was an idea previously mentioned by Trembley (2003) who suggested that contextual factors may not be as directly causal as child and parental factors. Rather it might be that

contextual factors impact on the individuals within the family which in turn impact on the child. Evans (2007) questions whether contextual factors merely lead professionals to overestimate behaviour difficulties in difficult communities.

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Appendix 2

Eyberg Child Behaviour Inventory (ECBI)

ECBI™ Eyberg Child Behavior Inventory™

Parent Rating Form by Sheila Eyberg, PhD

Your Name _____ Relationship to Child _____ Today's Date ____/____/____
 Child's Name _____ Child's Gender _____ Child's Date of Birth ____/____/____

Directions: Below are a series of phrases that describe children's behavior. Please (1) circle the number describing **how often** the behavior **currently** occurs with your child, and (2) circle either "yes" or "no" to indicate whether the behavior is **currently a problem for you**.

For example, if seldom, you would circle the 2 in response to the following statement:

	Never	Seldom	Sometimes	Often	Always	Is this a problem for you?
1. Refuses to eat vegetables	1	2	3	4	5	6 7 YES NO

Circle only one response for each statement, and respond to all statements. **DO NOT ERASE!** If you need to change an answer, make an "X" through the incorrect answer and circle the correct response. For example:

1. Refuses to eat vegetables	1	2	X	4	5	6 7 YES NO
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	How often does this occur with your child?							Is this a problem for you?	
	Never	Seldom	Sometimes	Often	Always	YES	NO		
1. Dawdles in getting dressed	1	2	3	4	5	6	7	YES	NO
2. Dawdles or lingers at mealtime	1	2	3	4	5	6	7	YES	NO
3. Has poor table manners	1	2	3	4	5	6	7	YES	NO
4. Refuses to eat food presented	1	2	3	4	5	6	7	YES	NO
5. Refuses to do chores when asked	1	2	3	4	5	6	7	YES	NO
6. Slow in getting ready for bed	1	2	3	4	5	6	7	YES	NO
7. Refuses to go to bed on time	1	2	3	4	5	6	7	YES	NO
8. Does not obey house rules on own	1	2	3	4	5	6	7	YES	NO
9. Refuses to obey until threatened with punishment	1	2	3	4	5	6	7	YES	NO
10. Acts defiant when told to do something	1	2	3	4	5	6	7	YES	NO
11. Argues with parents about rules	1	2	3	4	5	6	7	YES	NO
12. Gets angry when doesn't get own way	1	2	3	4	5	6	7	YES	NO
13. Has temper tantrums	1	2	3	4	5	6	7	YES	NO
14. Sasses adults	1	2	3	4	5	6	7	YES	NO
15. Whines	1	2	3	4	5	6	7	YES	NO

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	How often does this occur with your child?							Is this a problem for you?	
	Never	Seldom	Sometimes	Often	Always			YES	NO
16. Cries easily	1	2	3	4	5	6	7	YES	NO
17. Yells or screams	1	2	3	4	5	6	7	YES	NO
18. Hits parents	1	2	3	4	5	6	7	YES	NO
19. Destroys toys and other objects	1	2	3	4	5	6	7	YES	NO
20. Is careless with toys and other objects	1	2	3	4	5	6	7	YES	NO
21. Steals	1	2	3	4	5	6	7	YES	NO
22. Lies	1	2	3	4	5	6	7	YES	NO
23. Teases or provokes other children	1	2	3	4	5	6	7	YES	NO
24. Verbally fights with friends own age	1	2	3	4	5	6	7	YES	NO
25. Verbally fights with sisters and brothers	1	2	3	4	5	6	7	YES	NO
26. Physically fights with friends own age	1	2	3	4	5	6	7	YES	NO
27. Physically fights with sisters and brothers	1	2	3	4	5	6	7	YES	NO
28. Constantly seeks attention	1	2	3	4	5	6	7	YES	NO
29. Interrupts	1	2	3	4	5	6	7	YES	NO
30. Is easily distracted	1	2	3	4	5	6	7	YES	NO
31. Has short attention span	1	2	3	4	5	6	7	YES	NO
32. Fails to finish tasks or projects	1	2	3	4	5	6	7	YES	NO
33. Has difficulty entertaining self alone	1	2	3	4	5	6	7	YES	NO
34. Has difficulty concentrating on one thing	1	2	3	4	5	6	7	YES	NO
35. Is overactive or restless	1	2	3	4	5	6	7	YES	NO
36. Wets the bed	1	2	3	4	5	6	7	YES	NO

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Subtotals from page 1	

Scores	Raw score	T score	Exceeds Cutoff (✓)
Intensity			
Problem			

Comments:

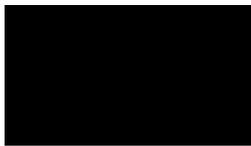
Appendix 3

Parent Stress Index: Short Form (PSI: SF)

Name _____ Gender _____ Date of birth _____ Ethnic group _____ Marital status _____
 Child's name _____ Child's gender _____ Child's date of birth _____ Today's date _____

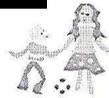
	SA = Strongly Agree	A = Agree	NS = Not Sure	D = Disagree	SD = Strongly Disagree
✓ 1. I often have the feeling that I cannot handle things very well.	SA	A	NS	D	SD
2. I find myself giving up more of my life to meet my children's needs than I ever expected.	SA	A	NS	D	SD
3. I feel trapped by my responsibilities as a parent.	SA	A	NS	D	SD
4. Since having this child, I have been unable to do new and different things.	SA	A	NS	D	SD
5. Since having a child, I feel that I am almost never able to do things that I like to do.	SA	A	NS	D	SD
6. I am unhappy with the last purchase of clothing I made for myself.	SA	A	NS	D	SD
7. There are quite a few things that bother me about my life.	SA	A	NS	D	SD
8. Having a child has caused more problems than I expected in my relationship with my spouse (or male/female friend).	SA	A	NS	D	SD
9. I feel alone and without friends.	SA	A	NS	D	SD
10. When I go to a party, I usually expect not to enjoy myself.	SA	A	NS	D	SD
11. I am not as interested in people as I used to be.	SA	A	NS	D	SD
12. I don't enjoy things as I used to.	SA	A	NS	D	SD
✓ 13. My child rarely does things for me that make me feel good.	SA	A	NS	D	SD
14. Sometimes I feel my child doesn't like me and doesn't want to be close to me.	SA	A	NS	D	SD
15. My child smiles at me much less than I expected.	SA	A	NS	D	SD
16. When I do things for my child, I get the feeling that my efforts are not appreciated very much.	SA	A	NS	D	SD
17. When playing, my child doesn't often giggle or laugh.	SA	A	NS	D	SD
18. My child doesn't seem to learn as quickly as most children.	SA	A	NS	D	SD
19. My child doesn't seem to smile as much as most children.	SA	A	NS	D	SD
✓ 20. My child is not able to do as much as I expected.	SA	A	NS	D	SD
21. It takes a long time and it is very hard for my child to get used to new things.	SA	A	NS	D	SD
For the next statement, choose your response from the choices "1" to "5" below.					
✓ 22. I feel that I am:	1	2	3	4	5
1. not very good at being a parent					
2. a person who has some trouble being a parent					
3. an average parent					
4. a better than average parent					
5. a very good parent					
23. I expected to have closer and warmer feelings for my child than I do and this bothers me.	SA	A	NS	D	SD
24. Sometimes my child does things that bother me just to be mean.	SA	A	NS	D	SD
25. My child seems to cry or fuss more often than most children.	SA	A	NS	D	SD
26. My child generally wakes up in a bad mood.	SA	A	NS	D	SD
27. I feel that my child is very moody and easily upset.	SA	A	NS	D	SD
28. My child does a few things which bother me a great deal.	SA	A	NS	D	SD
29. My child reacts very strongly when something happens that my child doesn't like.	SA	A	NS	D	SD
30. My child gets upset easily over the smallest thing.	SA	A	NS	D	SD
✓ 31. My child's sleeping or eating schedule was much harder to establish than I expected.	SA	A	NS	D	SD
For the next statement, choose your response from the choices "1" to "5" below.					
✓ 32. I have found that getting my child to do something or stop doing something is:	1	2	3	4	5
1. much harder than I expected					
2. somewhat harder than I expected					
3. about as hard as I expected					
4. somewhat easier than I expected					
5. much easier than I expected					
For the next statement, choose your response from the choices "10+" to "1-3."					
33. Think carefully and count the number of things which your child does that bother you. For example: dawdles, refuses to listen, overactive, cries, interrupts, fights, whines, etc.	10+	8-9	6-7	4-5	1-3
✓ 34. There are some things my child does that really bother me a lot.	SA	A	NS	D	SD
35. My child turned out to be more of a problem than I had expected.	SA	A	NS	D	SD
✓ 36. My child makes more demands on me than most children.	SA	A	NS	D	SD

Appendix 4
Pre Parent Confidence Rating Scale (PCRS)



Parent Questionnaire

GROUP



Child's Name _____
 Your Name _____
 Today's Date _____

PRE INTERVENTION

How do you manage behaviour at home?									
Very Poorly					Very well				
1	2	3	4	5	6	7	8	9	10
How confident are you that you can manage your child in most situations?									
Low Confidence					High confidence				
1	2	3	4	5	6	7	8	9	10
How confident are you that you can support your child's play?									
Low confidence					High confidence				
1	2	3	4	5	6	7	8	9	10
How well do you use praise and descriptive language with your child?									
Not very well					Very Well				
1	2	3	4	5	6	7	8	9	10
How well do you think you praise helpful behaviour?									
Not Much					Often				
1	2	3	4	5	6	7	8	9	10
How well do you think you manage to ignore unhelpful behaviour?									
Not Much					Often				
1	2	3	4	5	6	7	8	9	10
How confident are you that you can help your child to play and learn?									
Low Confidence					High confidence				
1	2	3	4	5	6	7	8	9	10

Version 1 - September 2011

Appendix 5

Post Parent Confidence Rating Scale (PCRS)



Parent Questionnaire

GROUP



Child's Name _____
 Your Name _____
 Today's Date _____

POST INTERVENTION

How do you manage behaviour at home?									
Very Poorly					Very well				
1	2	3	4	5	6	7	8	9	10
How confident are you that you can manage your child in most situations?									
Low Confidence					High confidence				
1	2	3	4	5	6	7	8	9	10
How confident are you that you can support your child's play?									
Low confidence					High confidence				
1	2	3	4	5	6	7	8	9	10
How well do you use praise and descriptive language with your child?									
Not very well					Very Well				
1	2	3	4	5	6	7	8	9	10
How well do you think you praise helpful behaviour?									
Not Much					Often				
1	2	3	4	5	6	7	8	9	10
How well do you think you manage to ignore unhelpful behaviour?									
Not Much					Often				
1	2	3	4	5	6	7	8	9	10
How confident are you that you can help your child to play and learn?									
Low Confidence					High confidence				
1	2	3	4	5	6	7	8	9	10
Please rate how your Family Support Worker and Educational Psychologist helped you.									
Very Poorly					Very Well				
1	2	3	4	5	6	7	8	9	10
How satisfied were you with the programme?									
Not Satisfied					Very satisfied				
1	2	3	4	5	6	7	8	9	10
Would you recommend this programme to other parents with similar needs? (please circle)									
Yes					No				

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Appendix 6

Follow Up Parent Confidence Rating Scale (PCRS)



Parent Questionnaire

GROUP



Child's Name _____
 Your Name _____
 Today's Date _____

FOLLOW UP
 (Approx 2 months after intervention)

How do you manage behaviour at home?									
Very Poorly					Very well				
1	2	3	4	5	6	7	8	9	10
How confident are you that you can manage your child in most situations?									
Low Confidence					High confidence				
1	2	3	4	5	6	7	8	9	10
How confident are you that you can support your child's play?									
Low confidence					High confidence				
1	2	3	4	5	6	7	8	9	10
How well do you use praise and descriptive language with your child?									
Not very well					Very Well				
1	2	3	4	5	6	7	8	9	10
How well do you think you praise helpful behaviour?									
Not Much					Often				
1	2	3	4	5	6	7	8	9	10
How well do you think you manage to ignore unhelpful behaviour?									
Not Much					Often				
1	2	3	4	5	6	7	8	9	10
How confident are you that you can help your child to play and learn?									
Low Confidence					High confidence				
1	2	3	4	5	6	7	8	9	10

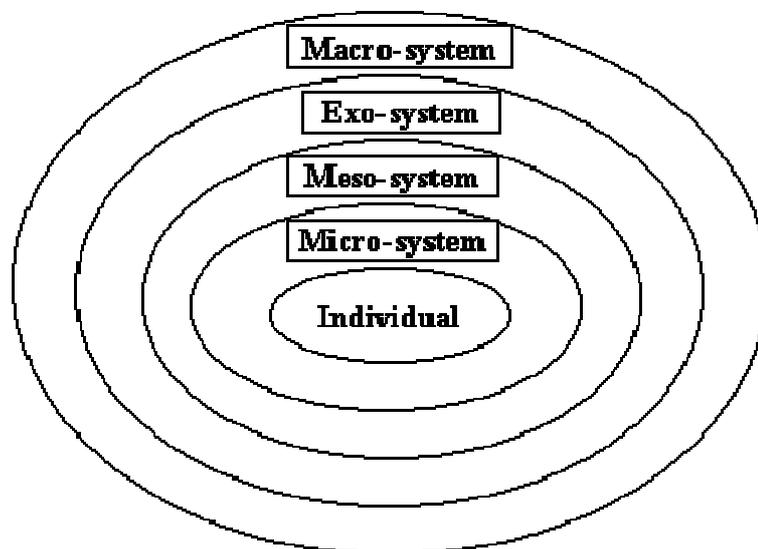
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Appendix 7

Ecological model

The ecological model of human development (Bronfenbrenner, 1977) provides a useful framework through which to explore the complex nature of parenting. It takes the view that humans are active and shape the environment in which they live and the relationships they have. The eco-systemic levels illustrate how factors that influence parents and child are entwined in a hierarchy. It takes the stance that secure relationships and interactions at the micro-level enable the individual to form good relationships in other areas of life. If these relationships and interactions break down the child will not have the tools with which to explore other parts of the environment.

Bronfenbrenner's Model of the Ecology of Human Development



The eco-systemic levels of family dynamics.

Micro-system	Individual differences of the parent and child e.g. child temperament, parenting styles, activities, roles and interactions of the individuals.
Meso-system	The relation between two or more settings in which the individual participates e.g. work and home.
Exo-system	Settings which impact on the individual but are normally outside their control e.g. local community or church.
Macro-System	Wider political, social and cultural influences. Impacts on lower levels due to how it shapes values, laws and customs.

Due to the interconnectedness between and within levels, family dynamics and Parent Child Interactions are influenced by changes at a variety of levels. For example, family illness, marital conflict and divorce impact at the micro/meso-level whereas the introduction of paid paternity leave or a new nursery being set up in the community could impact at the exo/macro-level. These complex interactions links to ideas about the bi-directional nature of parenting styles (Gallagher, 2002).

An exploration of the services available to vulnerable families highlights that most tend to focus on the lower levels of the eco-systemic model; the micro and meso-levels. In other words, they tend to focus on the individual and the family. The literature proposes that holistic services which provide for a range of needs at all levels of the ecological model would be the most beneficial. However it is unlikely

that a single intervention can provide this. Moran et al (2004) suggest that the best that can be hoped for is that service providers are aware of the range of issues and factors which can impact on parenting style.

Parent Child Interaction Therapy (PCIT) is one intervention that works mainly at the micro/meso-system level. However, this study is exploring the implementation of a PP that has been adapted from PCIT to work in a community setting. Therefore it aims to work at the micro, meso and exo-systems level. Depending on the success of the programme, it could have implications for policy which would then be impacting at the macro-system level. It is attempting to bring together the most ecological package.

Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American Psychologist*, 32(7), 513-531.

Gallagher, K. (2002). Does child temperament moderate the influence of parenting on adjustment? *Developmental Review*, 22(4), 623-643.

Moran, P., Ghate, D., Van Der Merwe, A., & Britain, G. (2004). What works in parenting support? A review of the international evidence Retrieved 3rd Dec, 2010, from <http://downloads.nationalstrategies.co.uk/pdf/accd62c986f0fe7800ab71c2d0d3b808.pdf>

Appendix 8

Similarities and differences between PCIT and HHGP

Area	PCIT	HHGP
Core Aims	Encourage positive parent-child interactions.	Encourage positive parent-child interactions.
Population	Clinical: 2-7 years: externalizing behavioural problems.	Community: 2-5 years with behaviour difficulties.
Facilitators	Clinical Psychologists	Educational Psychologists and para-professionals: FSWs
Description of Intervention	<p>1st phase CDI:- following child's lead engaging in sensitive, responsive and nurturing interactions (AT)</p> <p>2nd phase PDI-SLT: setting limits and boundaries and responding consistently to undesirable behaviours, specific behaviour management techniques employed.</p> <p>Introduction to 2nd phase (PDI) only occurs following mastery on 1st phase (CDI).</p>	<p>Child directed interactions (CDI)- Attachment theory (AT)</p> <p>Following the child's lead; Labelling praise, using positive descriptive language</p> <p>Parent directed interactions (PDI): Social Learning Theory (SLT)</p> <p>Ignoring ineffective behaviours; Providing limits and boundaries.</p> <p>FL (CDI) and IP (PDI) delivered simultaneously.</p>
Setting	Therapeutic Room with one way mirror.	Children's Centre.
Sessions	12-20 weeks, 2.5 hours. Total time: 30-50 hours	4 weekly session, 1.5 hours. Total time: 6 hours.
Homework	Daily five-minute "special playtime" with parent.	4 handouts reinforcing FLIP message and encouraging five-minute "special playtime"
Outcome measures used	<ul style="list-style-type: none"> • ECBI (Eyberg & Pincus, 1999) • PSI (Abdin, 1990) • Therapy Attitude Inventory (Eyberg, 1993) • Dyadic Parent-Child Interaction Coding System (Robinson & Eyberg, 1981) 	<ul style="list-style-type: none"> • Eyberg Child Behaviour Inventory (ECBI) • Parenting Stress Index-Short Form (PSI-SF) • Parental confidence rating scale (PCRS)

Appendix 9

Similarities and differences between HHGP and HHIP

Area	HHGP	HHIP
Core Aims	Encourage positive parent-child interactions.	Encourage positive parent-child interactions.
Population	Community: 2-5 years with behaviour difficulties.	Community: 2-5 years with behaviour difficulties.
Facilitators	Educational Psychologists and para-professionals: FSWs	Para-professionals: FSWs With EP input on initial visit and review session.
Description of Intervention	<p>Child directed interactions (CDI)- Attachment theory (AT)</p> <p>Following the child's lead; Labelling praise, using positive descriptive language</p> <p>Parent directed interactions (PDI): Social Learning Theory (SLT) Ignoring ineffective behaviours; Providing limits and boundaries.</p> <p>FL (CDI) and IP (PDI) delivered simultaneously.</p>	<p>Child directed interactions (CDI)- Attachment theory (AT)</p> <p>Following the child's lead; Labelling praise, using positive descriptive language</p> <p>Parent directed interactions (PDI): Social Learning Theory (SLT) Ignoring ineffective behaviours; Providing limits and boundaries.</p> <p>FL (CDI) and IP (PDI) delivered simultaneously.</p>
Setting	Children's Centre.	Home visiting
Sessions	<p>An Initial Coffee morning (1hr)</p> <p>4 weekly session, 1.5 hours.</p> <p>A Final Coffee morning 1(hr)</p> <p>Total time: 8 hours.</p>	<p>An initial visit of 1 hour.</p> <p>6 weekly session of 1 hour.</p> <p>A review visit of 1 hour.</p> <p>Total time: 8 hours.</p>
Homework	4 handouts reinforcing FLIP message and encouraging five-minute "special playtime"	4 handouts reinforcing FLIP message and encouraging five-minute "special playtime"
Outcome measures used	<ul style="list-style-type: none"> • Eyberg Child Behaviour Inventory (ECBI) • Parenting Stress Index-Short Form (PSI-SF) • Parental confidence rating scale (PCRS) 	<ul style="list-style-type: none"> • Eyberg Child Behaviour Inventory (ECBI) • Parenting Stress Index-Short Form (PSI-SF) • Parental confidence rating scale (PCRS)

Appendix 10

Structure of the HHGP sessions

Session	Content/structure
Initial Coffee morning	This session took the form of an informal discussion between the parents and the FSW and EP while the children were provided with a range of free choice play activities. The HHGP was outlined by the FSW and EP and parents were provided with a leaflet (see Appendix 13). Any questions the parents had were answered. If the parents were interested in taking part they were then asked to complete consent forms (see Appendix 15 and Appendix 16) and the questionnaires outlined in section 4.3.
Session 1	Key message focused on Follow your child's lead.
Session 2	Key message focused on Labelled praise.
Session 3	Key message focused on Ignoring ineffective behaviour.
Session 4	Key message focused on Providing limits and boundaries.
	<p>These four sessions were planned to take the form of:</p> <ul style="list-style-type: none"> • an informal discussion about the key message, giving the parents opportunities to share experiences/ideas and to ask questions. • role play activity and modelling by the FSW and EP. • a play activity where parents could interact with their child and 'practice' strategies and ideas discussed and gain feedback from the FSW and EP. <p>See appendix 11 for a detailed plan of session 1. Within this structure there was a degree of flexibility to ensure that the needs of the parents attending were met. If a parent brought a particular problem to the group then the discussion might centre on this, or the type of role play could alter to take it into account.</p> <p>While it was planned that the key messages would be worked through in this order, this was flexible and if an opportunity arose where a different message was applicable then it was discussed/suggested.</p>
Final Coffee Morning	This session gave parents the opportunity to reflect on the sessions and for all parents to complete post data questionnaires.
Follow Up Coffee Morning	This session provides parents with an opportunity to discuss any ongoing issues and to collect follow up data.

Appendix 11

Example Session Plan

<u>Holding Hands Parenting Group Session Plan</u>	
Session number: 1	
Objectives for session	
<ul style="list-style-type: none"> ➤ To introduce / welcome group members ➤ To give overview of FLIP messages ➤ To look at "F" in more detail 	
Introduction (5 minutes) 10.05	Welcome, introductions. Badges
Overview of HH group sessions (5 minutes)	Go through structure of today's session and stick on whiteboard.
Ground rules (10)	Confidentiality Hand out sheet and read through.
10.15	Go over ground rules and scribe on paper on whiteboard. (Suggested ground rules: no questions is a stupid question, group discussions are confidential, try to be positive and supportive of others....) Group members to sign on flip chart.
Main activity (10 minutes)	Introduce FLIP messages (describe as tips to help parents strengthen their relationship with their child and manage behaviour).
10.15-10.25	<p>FLIP messages on sheet and displayed. Explain each session to focus on one message.</p> <p>Focus is on "F" - Overview (10 minutes) Why follow your child's lead in play? Children are very rarely given control and are often told what to do by adults. When we follow the child's lead, it signals that the parent is paying attention to the child's activity and boosts their self esteem, making them feel secure and valued.</p> <p>Key questions (KQ) <i>What are good ways of getting involved with your child when they are playing?</i></p> <p>Explain a good way is to follow your child's lead. Look through parent handout on following our child's lead and talk through.</p> <p>KQ: Is there anything on the list that surprises you or you think should be added?</p>
Main activity (10 minutes)	Role play / scenario (20 minutes)
10.25-10.35	<p>PART 1: Give parents list of examples of following their child's lead. Ask parents to watch EP/FSW role play of following their child's lead and tick on sheet which behaviours observed/not observed. Discuss in group and think about which ones they may find easy/difficult.</p> <p>PART 2: Ask parents to choose one good 'F' behaviour on list of examples and contribute to role play of child played by FSW or EP (with parents taking turns to make a verbal contribution to role play). EP or FSW supports by also giving verbal contributions.</p>

	Demonstrate and mention do's and don'ts during role play.				
	<table border="1"> <thead> <tr> <th>Do's</th> <th>Don'ts</th> </tr> </thead> <tbody> <tr> <td> <u>Reflect</u> your child's verbalisations. le: Child "I builded a house" Parent "You built a house" / "You built a green house with a yellow roof" <u>Imitate</u> by words and actions. Parents as <i>active participants</i>. le: pay attention, look, smile, play with same or similar toy in the same way (called parallel play – shows child you are interested, raises self-esteem.) Say what you see! "You are pushing a yellow van..." </td> <td> Try not to give commands such as "give me that crayon" or "put that block there". These take the lead away from the child. Try not to ask questions – this directs the child towards what the adult wants to know. Try not to criticise – "don't do it like that, that wasn't a good idea" / "that's not how it goes" may lower your child's self esteem / creativity. Remember... there is no 'right' way to play. </td> </tr> </tbody> </table>	Do's	Don'ts	<u>Reflect</u> your child's verbalisations. le: Child "I builded a house" Parent "You built a house" / "You built a green house with a yellow roof" <u>Imitate</u> by words and actions. Parents as <i>active participants</i> . le: pay attention, look, smile, play with same or similar toy in the same way (called parallel play – shows child you are interested, raises self-esteem.) Say what you see! "You are pushing a yellow van..."	Try not to give commands such as "give me that crayon" or "put that block there". These take the lead away from the child. Try not to ask questions – this directs the child towards what the adult wants to know. Try not to criticise – "don't do it like that, that wasn't a good idea" / "that's not how it goes" may lower your child's self esteem / creativity. Remember... there is no 'right' way to play.
Do's	Don'ts				
<u>Reflect</u> your child's verbalisations. le: Child "I builded a house" Parent "You built a house" / "You built a green house with a yellow roof" <u>Imitate</u> by words and actions. Parents as <i>active participants</i> . le: pay attention, look, smile, play with same or similar toy in the same way (called parallel play – shows child you are interested, raises self-esteem.) Say what you see! "You are pushing a yellow van..."	Try not to give commands such as "give me that crayon" or "put that block there". These take the lead away from the child. Try not to ask questions – this directs the child towards what the adult wants to know. Try not to criticise – "don't do it like that, that wasn't a good idea" / "that's not how it goes" may lower your child's self esteem / creativity. Remember... there is no 'right' way to play.				
Play session (20 minutes) 10.35-11.00	Play session. Parents to play with their children. Play theme: making playdough and using animal shape cutters. Laura to demonstrate making playdough then all to take part in play session. Second activity is to stick dried food on a plate – in a decorative way. The FLIP message for this session will be F, so during play, FSW / EP to circulate around the room, interacting with families with a focus on F (although can also reinforce other helpful FLIP messages). Photos taken as part of play session.				
Tidy up (5 minutes) 11.00-11.05	Encourage families to join in tidying away the toys.				
Take home activity (5 minutes)	All come together in circle. Go over Take Home Activity – and give out parent sheet, Emphasise the THA is to help suggest play ideas not to give parents another task to do.				
Song / finish time (5 minutes) 11.05-11.10	FSW to read the Hungry Caterpillar Book Reminder of the theme for next session (Music)				
Resources needed	Names badges Tea and coffee available House rules for parents to sign THA handout 'F' handout Plastic Wallets				

Appendix 12
Example Session Handout

F – Following your child's lead

Remember: that children like to repeat things over and over again, this is how they learn new things. Follow your child's lead rather than imposing your own ideas. Don't give too much help, give your child time and encouragement to solve things himself.

Following your child's lead is....

- ❖ Letting your child choose,
- ❖ Saying what you see,
- ❖ Repeating back what your child is saying,
- ❖ Joining in with your child's play,
- ❖ Listening and responding to what your child says,
- ❖ Being enthusiastic,
- ❖ Using a friendly voice and face,
- ❖ Encouraging your child's play,
- ❖ Copying what your child is doing in their play,
- ❖ Watching what your child is doing with interest,

More strategies/information for F

Background

- Following a child's lead means that, first and foremost, you are watching and focusing on what the child is doing, what they're playing with, etc. Are they building? Are they climbing? What are their current interests?
- Getting face to face with the child is a very important first step in letting them take the lead. When you are at eye level with the child, it is easier to connect and share. When you and the child can both see and hear each other, it is much easier to encourage the child to take the lead, and for your child to know that the adult is interested in the interaction.
- It is important to make sure that the play remains focused on what the child is interested in and how he/she wants to play with and to avoid trying to change or shift the focus of the play.
- Following a child's lead includes following a child with actions and words such as getting on the floor with them, smiling, giving eye-contact, copying what they are doing and repeating and extending what they are saying.

Strategies

- Once the adult is at the child's level, there are a number of things they can do to encourage them to take the lead. First is to, **watch** – take the time to look at the child's body language and actions to help figure out what he/she is thinking about. When you notice what the child is looking at, both the adult and child can share the moment and communicate.
- Second is to **wait** – this gives time to observe what the child is interested in. It will help to stop talking and lean into the child to show that they are ready for them to take the lead and respond.
- Finally, **listen** – paying close attention to all the words or sounds a child makes lets him/her know that the interaction is important. It will help if the child is not interrupted, if the adult is unsure of what the child is trying to say, look for clues in the environment if not, try to guess the meaning and/or copy the sounds/actions and wait to see if the child says anything else to make it clearer.
- It is also important to take the focus off trying to get the child to talk and ask too many questions; they will be more interested to talk things they are interested in.
- Sometimes a child might need extra help to learn how to take the lead. In this case the child could be given a toy/activity they have chosen and then shown what they could have done to take the lead and then encourage them to carry on with the activity.
- The child could also be encouraged by changing a familiar activity, such as hiding objects in a surprising place and waiting and watching for the child's reaction and following their lead.

Remember

- To watch the child and enjoy their play.
- Wait to show you want them to lead the play.
- Show the child you are interested in what they have to say by listening.

Appendix 13 Holding Hands Group Programme Leaflet

How can I find out more?

You can contact [redacted] Senior Educational Psychologist on [redacted]

[redacted] Senior Children's Centre Co-ordinator on [redacted]

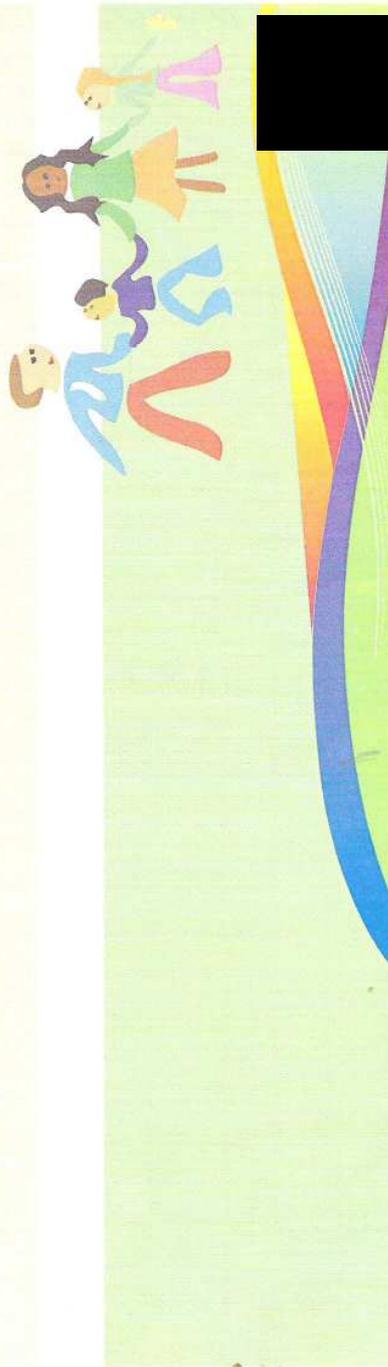
Email: [redacted]

A partnership of:

- Children's Centres
- Educational Psychology Service

Holding Hands Programme Parent Group Sessions

Your local Children's Centre is:



Holding Hands

Holding Hands is a complete four session programme for parents to help the play and development of their children.

Who is it for?

It is for parents with children between 2 and 5 years. All parents want the best for their children so they can do well at school and get along with other children.

What are the benefits?

To help children learn who they are, what they can do, how to get along with other children and build a warm relationship between you and your child.

What can I expect?

Meet for 1½ hours per week, over a 4 week period on the same day and time.

Meet with other parents and share each others ideas and views.

Children to meet with other children of their own age.

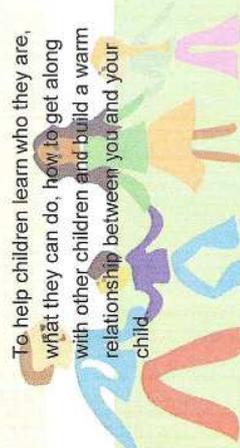
Opportunities to try out fun activities and toys with your child.

Opportunities to discuss issues relating to your child's play with the Holding Hands staff.

Parents will be issued with a certificate on completion of the programme.

What can parent(s) do?

- You get the chance to try out some simple activities in the Centre.
- A session of 1½ hours has a starter activity like a nursery rhyme or story, then some play activities based on most children's interests, for example- music, minibeads, sand and food plan and a closing activity.
- You can also try out some follow up activities at home.



Appendix 14

Holding Hands Group Programme Consent Form



GROUP CONFIDENTIAL HOLDING HANDS REQUEST FOR INVOLVEMENT

Name of Centre:	Family Support Worker:			
Child's Name:	Date of Birth:			
Child's Ethnicity:	Gender:			
Address:	Family composition: Names of parents/guardians:			
Postcode:	Names & ages of siblings:			
Telephone No. Home: Work: Mobile:				
Other services involved: e.g. health visitor				
Pre-school placement: e.g. playgroup, mother & toddler. Please circle sessions attended:				
Monday	Tuesday	Wednesday	Thursday	Friday
AM PM	AM PM	AM PM	AM PM	AM PM
<p>Briefly summarise the nature of the concern/areas you would like support with.</p> <p>Any other significant factors (health, hearing, vision, home circumstances)</p> <p>Any additional family information:</p> <p>Parents' Comments: (Briefly summarise nature of concerns, any significant factors (e.g. health or other relevant circumstances).</p>				

To be completed by parent/carer:

Please circle are you registered with a Children's Centre:
Have you received a copy of the HHP leaflet

Yes No
Yes No

Please rate each statement on a scale of 1 to 7, where 1 = 'never' and 7 = 'always'.

Item No.	Statement	Never	Score	Always
1	I feel my child's behaviour is difficult at home	1	2 3 4 5 6 7	
2	I feel my child's behaviour with other children/adults is difficult	1	2 3 4 5 6 7	
3	I feel my child has difficulty with sharing	1	2 3 4 5 6 7	
4	I feel my child has difficulty in listening	1	2 3 4 5 6 7	
5	I feel my child finds it difficult to play with other children	1	2 3 4 5 6 7	
6	I feel that my child does not handle things very well	1	2 3 4 5 6 7	
7	I feel my child reacts strongly when something happens that he/she doesn't like	1	2 3 4 5 6 7	

Do you have any other comments or concerns?

Permissions: I have received a copy of the Holding Hands information leaflet, and have read and understood this leaflet. I give my permission for the Holding Hands team to work with my child and for the information about my child to be collected to support this work. I understand and agree that information may be shared with partner agencies in health and local public services in the interests of my child, and in accordance with the Data Protection Act 1998. I am the parent/guardian of the child named on this form.

Name in full: (in capitals)

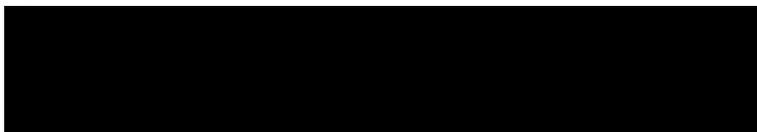
Signed: Date:

NB: The request for involvement form may be reviewed and updated in the future.

Name of person requesting involvement (Title)

(Email/Telephone)

Signed



This document should not be copied to a third party without the explicit permission of the EPS

Appendix 15

University Consent Form

Dear Parent,

As you are aware, you have received the Holding Hands leaflet and are taking part in the group project. The purpose of the project is to help children in their play and development and it involves you and your child working with a Family Support Worker and an Educational Psychologist over a period of four sessions.

Because this is a new project we are very interested in finding out the views of parents to know how well it works and how to improve it. You have agreed to take part in the evaluation which will take the form of three questionnaires and a short interview. These will be completed before the project, on completion of the project and again two months after the project.

This evaluation will be used to help the Educational Psychology Service improve the project. With your permission I would also like to use this evaluation data as my doctoral thesis. It is up to you to decide whether to agree for the data to be used in this way. I would of course find it very helpful if you could agree. However, if you decide that you do not want to take part it will not make any difference at all to your involvement in the Holding Hands Project.

If you decide to take part I shall ask you to sign a form, which simply says that you have agreed for the anonymised data to be used. If at any time you want to stop taking part in the evaluation you can do – with no questions asked.

 GRADUATE SCHOOL OF EDUCATION CONSENT FORM	
Title of research: Holding Hands: Outcomes and Parent Perceptions	
This study has been approved by the Exeter Research Ethics Committee.	
Participant statement:	
I..... have been fully informed about the aims and purposes of the project. I have read the information sheet and had the opportunity to ask any questions.	
I understand that:	
<ul style="list-style-type: none"> • If I participate in the research I can stop taking part at any point. • Any information which I give will be used solely for the purposes of this research. It will be held confidentially and securely. • It will not be possible to trace me or my child from any report that might be written (in accordance with the data protection act of 1998). • The evaluation findings will be published as a doctoral thesis and that I will be sent a summary copy if I would like one. • I have the right to refuse permission for the publication of any information about me • If applicable, the information, which I give, may be shared between any of the other researcher(s) participating in this project in an anonymised form. 	
..... (Signature of participant) (Date)
Researcher's statement:	
I Beth Hamlin confirm that I have carefully explained the purpose of the study to the participant and outlined any reasonably foreseeable risks or benefits (where applicable).	
..... (researcher's signature) (date)

Appendix 16

Ethical Considerations

The design of the research study has ensured that the following ethical issues have been addressed.

Informed consent of parents and right to withdraw

An informed consent form outlining the nature of the research will be completed by all participants. It will be made clear to participants that they can take part in the programme without consenting to take part in the research. It will also be made clear to the parents that they have the right to withdraw from the study at any time up until the date of submission.

During this process it will be important to clarify my role as researcher as being distinct from my role as an EP. It is important that participants are aware of this dual role. As an EP, I have privileged access to some information. It is important that this access is not used for the research and that consent is gained separately.

Debriefing and dissemination of findings

A summary of the findings will be distributed to the children's centres that participated in the programme for dissemination to parents by the children's centres as appropriate. The children's centres and parents will have access to the completed study and will be informed of this from the beginning of their involvement. All participants will have the opportunity to ask any questions they may have about the study. These processes will ensure that the participants are fully debriefed at the end of the programme.

Effects on self esteem and mental stress

During the programme parents will be participating in a group programme. They may make comparisons between themselves and others in the group. The participants will be made aware of the EPS phone number and encouraged to call the researcher to discuss any matters arising in meetings or interviews which raise issues for them.

Respectful treatment of participants

The information gathered from the participants will be stored securely to prevent unauthorised persons gaining access to it. It will be destroyed at the earliest appropriate time. Any written records on participants will be anonymised and their identity treated

confidentially. Respect for the participants will be maintained throughout the written report which will take a non-judgemental stance and focus on evidence based information.

Sexism in research

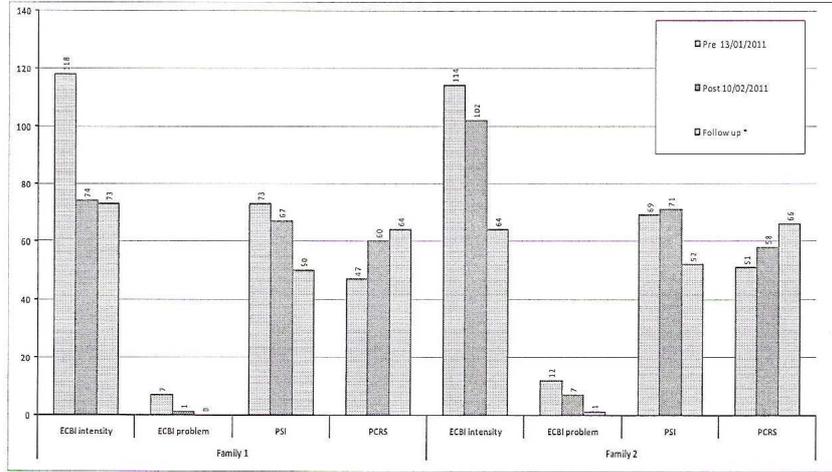
This research involves working with parents; most of whom will be mothers. Care needs to be taken when discussing the results to minimise gender insensitivity and ensure that findings are not over-generalised; sex will not be ignored as a possible variable. However, sexual dichotomism – treating the sexes as two distinct social groups rather than as groups with overlapping characteristics also needs to be avoided. The issues put forward by Eichler (1988) will be considered throughout the study. The gender of participants will be included in the report and non-sexist terminology will be employed.

Withholding benefits from comparison group

The research design has been chosen so that this particular ethical issue can be avoided.

Eichler, M. (1988). *Nonsexist research methods: A practical guide*. London: Unwin Hyman.

The following graph shows the scores for each family.



*approx. 2-3 months after post.

When data indicates that the responses have changed in the opposite way to that expected there are several possible reasons e.g. the parent may have been responding to the questionnaire defensively or the group may have initially highlighted difficulties to which the parent was previous unaware.

If you have any questions or queries please do not hesitate to contact the Holding Hands Programme team on [REDACTED]

[REDACTED]

Appendix 18

Ethical Approval Letter

STUDENT HIGHER-LEVEL RESEARCH



Graduate School of Education

Certificate of ethical research approval

STUDENT RESEARCH/FIELDWORK/CASEWORK AND DISSERTATION/THESIS

You will need to complete this certificate when you undertake a piece of higher-level research (e.g. Masters, PhD, EdD level).

To activate this certificate you need to first sign it yourself, and then have it signed by your supervisor and finally by the Chair of the School's Ethics Committee.

For further information on ethical educational research access the guidelines on the BERA web site: <http://www.bera.ac.uk/publications/guidelines/> and view the School's statement on the GSE student access on-line documents.

READ THIS FORM CAREFULLY AND THEN COMPLETE IT ON YOUR COMPUTER (the form will expand to contain the text you enter). **DO NOT COMPLETE BY HAND**

Your name: Beth Hamlin

Your student no: 590035314

Return address for this certificate: 47 Marshall Square, Banister Park, Southampton, SO15 2PB

Degree/Programme of Study: Doctorate in Educational, Child and Community Psychology

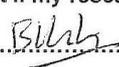
Project Supervisor(s): Brahm Norwich and Shirley Larkin

Your email address: blh206@exeter.ac.uk

Tel: 07739341125

I hereby certify that I will abide by the details given overleaf and that I undertake in my thesis to respect the dignity and privacy of those participating in this research.

I confirm that if my research should change radically, I will complete a further form.

Signed:..........date: 26/1/11.....

NB For Masters dissertations, which are marked blind, this first page must not be included in your work. It can be kept for your records.

Chair of the School's Ethics Committee
updated: July 2010

Certificate of ethical research approval

Your student no: 590035314

Title of your project: Holding Hands: Outcomes and Parental Perspectives

Brief description of your research project:

The importance of early intervention and preventative work to support behaviour difficulties has been stressed in the literature and is a priority in the government's strategy for promoting positive outcomes for children. It is now generally accepted that parenting programmes are an effective mechanism for supporting children with behaviour difficulties. A review of the literature suggests that there is limited evidence of parenting programmes that are successful outside of a clinic setting.

██████████ Educational Psychology Service developed a home visit individual parenting programme to try and tackle this issue with pre-school aged children. They are now developing it into a group based community programme.

This study aims to explore this community based parenting programme in terms of both its outcomes and the procedural evaluation of the parents involved.

Paper one is explorative and aims to examine the process elements of the programme. It aims to survey attitudes, perceptions and views of the parents involved in the programme. It will employ a flexible and qualitative design made up of multiple case studies. The data collected for this paper will derive from semi structured interviews with parents.

Paper two is a comparative evaluation that focuses on change and outcomes. It aims to report whether parents who participate in the programme notice any improvement in child behaviour, parent-child interactions, parental stress and parental confidence. It also aims to compare this community based programme with the previously evaluated home visiting programme. It will employ a fixed quasi experimental design in the form of a pre-test, post-test single group design evaluation. The data collected for this paper will derive from questionnaires, psychometric measures completed by the parents and informal non participant observations.

Information provided by this research will inform further development of the programme within ██████████

Give details of the participants in this research (giving ages of any children and/or young people involved):

Paper one participants:

Semi structured interviews: a number of children's centres across ██████████ will be piloting the community based parenting programme. Each programme will consist of up to 4 parent-child dyads. Parents have either been approached to take part in the programme by Family Support Workers and Health Visitors or have enquired about the programme themselves. Each parent will be asked for consent prior to the interview. The interviews will be carried out prior to the programme and again on completion of the programme.

Paper two participants:

Questionnaires and psychometric measures: Each parent taking part in the programme will be asked for consent to complete three questionnaires (the Eyberg Child Behaviour Inventory, the Parental Stress Index short form, and a parent confidence rating scale). These questionnaires will be completed prior to the programme, again on completion and again 2 months later.

Informal non-participant observations: Each parent-child dyad taking part in the programme will be observed during play prior to starting the programme and on completion of the programme. An observation schedule will be used to code parent-child interactions. Consent will be gained from parents prior to the observations being carried out.

Give details (with special reference to any children or those with special needs) regarding the ethical issues of:

I will be following the Code of Ethics and Conduct set out by the British Psychological Society in 2009. This covers issues such as respect, competence, responsibility and integrity. The areas of informed consent and autonomy and confidentiality fall in the category of respect and will be carefully considered as detailed below.

- a) **informed consent**: Where children in schools are involved this includes both headteachers and parents). An example of the consent form(s) must accompany this document. a blank consent form can be downloaded from the GSE student access on-line documents:

An informed consent form (please see attached) outlining the nature of the research will be completed by all participants. Records of when, how and from whom consent was obtained, will be recorded. It will be made clear to participants that they can take part in the programme without consenting to take part in the research. Participants will be made aware of how the research findings will be used. Essentially, informed consent will be an ongoing process throughout the research. It will also be made clear to the parents that they have the right to withdraw from the study at any time up until the date of submission and that data related to them will be destroyed. During this process my role as researcher will be clarified as being distinct from my role as an EP. It is important that participants are aware of this dual role.

- b) **anonymity and confidentiality**

Any written records (questionnaires, transcripts of semi structured interviews and observation notes) and audio recordings (of semi structured interviews) will be coded to ensure anonymity. Participants' identity will be treated confidentially and they will remain anonymous in the write up of the research. Records of the data collected will be stored securely to prevent unauthorised persons gaining access to it. Electronic information will only be accessible by the researcher with their username and password. It will be stored on a secure system with recognised virus protection. This electronic data as well as paper information will be locked in a secure building. Collected written data will be destroyed by shredding and securely disposing at the earliest appropriate time. Any audio recording will also be disposed of digitally.

Although the anonymity and confidentiality of the participants is vital it will be made clear to them that in the exceptional event that there is evidence to raise serious concern about the safety of the participant or other people information will be passed on to the relevant bodies in accordance with the Child Protection Act 1989.

Informed consent, anonymity and confidentiality form the basis of the respect category outlined by the BPS. Respect for the participants will be maintained throughout the written report which will take a non-judgemental stance and focus on evidence based information. Paper one focuses on the views of parents. I will ensure that they are listened to, respected, represented and acted upon. I will also

endeavor to respect individual, cultural and role differences, including those involving age, disability, education, ethnicity, gender, language, national origin, race, religion, sexual orientation, marital or family status and socio-economic status.

Give details of the methods to be used for data collection and analysis and how you would ensure they do not cause any harm, detriment or unreasonable stress:

Paper one will employ data gathered from the transcripts of semi-structured interview responses from parents taking part in the programme. With consent from the participants interviews will be recorded and transcribed. The interviews will focus on the expectations and experiences of the participants and what they believe has had the main impact. The transcripts will be uploaded to NVivo 9 for thematic coding and analysis. A grounded approach will be taken to ensure that the concepts emerge from the data rather than being forced on the data. As well as this immersive analysis there may also be able to be some frequency analysis e.g. how many parents viewed the programme as a success. Discussion of the findings will consider to what extent individuals differ in their opinions of the programme. Difference among views of participants will be explored and cross comparisons made with regards to factors such as geographical area. Discussion will also consider to what extent the difference of opinions can be addressed using the application of psychology.

Paper two will employ data gathered from parental responses to a range of psychometric measures. Participants will complete three (the Eyberg Child Behaviour Inventory, the Parental Stress Index short form, and a parental confidence rating scale) evaluations of three occasions: prior to the programme, on completion of the programme and finally two months after completing the programme. The scores from these three measures will be entered into SPSS, a statistical package. This will allow an overview of the descriptive statistics (mean, standard deviation, distribution) to be generated as well as comparisons of before and after the intervention to be made. Data from observations of parent-child interactions will allow these findings to be triangulated. Discussion of the findings will consider to what extent the programme has been a success and whether the community programme is a more or less effective way of running the programme than the home visiting system.

These processes will not cause any harm, detriment or unreasonable stress. However, the participants will be given opportunities to ask any questions that they may have about the study. Combined with informed consent and full debriefing the risk to participants is minimal.

Give details of any other ethical issues which may arise from this project (e.g. secure storage of videos/recorded interviews/photos/completed questionnaires or special arrangements made for participants with special needs etc.):

As previously mentioned paper data (individual data, questionnaires, observations and interview transcripts) will be kept securely within a locked filing cabinet in a secure building. Electronic data (interview recordings) will only be accessible by the researcher with their user name and password. All data will be destroyed when it is no longer required.

Give details of any exceptional factors, which may raise ethical issues (e.g. potential political or ideological conflicts which may pose danger or harm to participants):

NA

*This form should now be printed out, signed by you on the first page and sent to your supervisor to sign. Your supervisor will forward this document to the School's **Research Support Office** for the Chair of the School's Ethics Committee to countersign. A unique approval reference will be added and this certificate will be returned to you to be included at the back of your dissertation/thesis.*

N.B. You should not start the fieldwork part of the project until you have the signature of your supervisor

This project has been approved for the period: Feb 11 until: Dec 11

By (above mentioned supervisor's signature): B. Mansel date: 26/1/11

N.B. To Supervisor: Please ensure that ethical issues are addressed annually in your report and if any changes in the research occur a further form is completed.

GSE unique approval reference: D/10/11/24

Signed: Sabah D. Ali date: 02/02/2011
Chair of the School's Ethics Committee

This form is available from <http://education.exeter.ac.uk/students/>

Appendix 19

Descriptive statistics

All descriptive statistics, N=34

Measure	Minimum	Maximum	Mean	Standard Deviation
Eyberg Intensity Pre	77	170	126.88	23.201
Eyberg Intensity Post	60	128	101.71	18.553
Eyberg Intensity Follow Up	50	154	97.71	24.966
Eyberg Problem Pre	2	27	12.06	6.377
Eyberg Problem Post	0	14	4.12	4.277
Eyberg Problem Follow Up	0	15	3.53	4.514
Parent Confidence Pre	24	57	43.56	8.482
Parent Confidence Post	37	70	54.65	7.900
Parent Confidence Follow Up	38	70	55.79	8.157
Parent Stress (PSI) Total Pre	48	129	87.12	19.185
Parent Stress (PSI) Total Post	41	125	74.97	16.385
Parent Stress (PSI) Total Follow Up	39	115	72.85	18.948
PSI Parental Distress Pre	16	51	30.65	9.062
PSI Parental Distress Post	12	55	25.79	7.815
PSI Parental Distress Follow Up	12	49	24.85	8.794
PSI Parent Child Interactions Pre	14	43	23.76	8.349
PSI Parent Child Interactions Post	12	36	20.79	6.074
PSI Parent Child Interactions Follow Up	12	34	19.88	5.938
PSI Difficult Child Pre	18	44	32.79	6.700
PSI Difficult Child Post	12	48	28.09	7.689
PSI Difficult Child Follow Up	14	48	28.12	8.362

Appendix 20

Tests for Normality

Tests of Normality for Eyberg Intensity Scores

	Kolmogorov-Smirnov ^a			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
Eyberg Intensity pre	.113	34	.200*	.977	34	.666
Eyberg Intensity post	.124	34	.200*	.953	34	.155
Eyberg Intensity follow up	.067	34	.200*	.988	34	.966

a. Lilliefors Significance Correction

*. This is a lower bound of the true significance.

Tests of Normality for Eyberg Problem Scores

	Kolmogorov-Smirnov ^a			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
Eyberg Problem pre	.127	34	.184	.953	34	.147
Eyberg Problem post	.179	34	.007	.865	34	.001
Eyberg Problem follow up	.253	34	.000	.789	34	.000

a. Lilliefors Significance Correction

Tests of Normality for Parent Confidence Rating Scale Scores

	Kolmogorov-Smirnov ^a			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
Parent Confidence Rating Scale pre	.099	34	.200*	.967	34	.383
Parent Confidence Rating Scale post	.114	34	.200*	.969	34	.437
Parent Confidence Rating Scale follow up	.086	34	.200*	.974	34	.580

a. Lilliefors Significance Correction

*. This is a lower bound of the true significance.

Tests of Normality for Parent Stress Index Scores

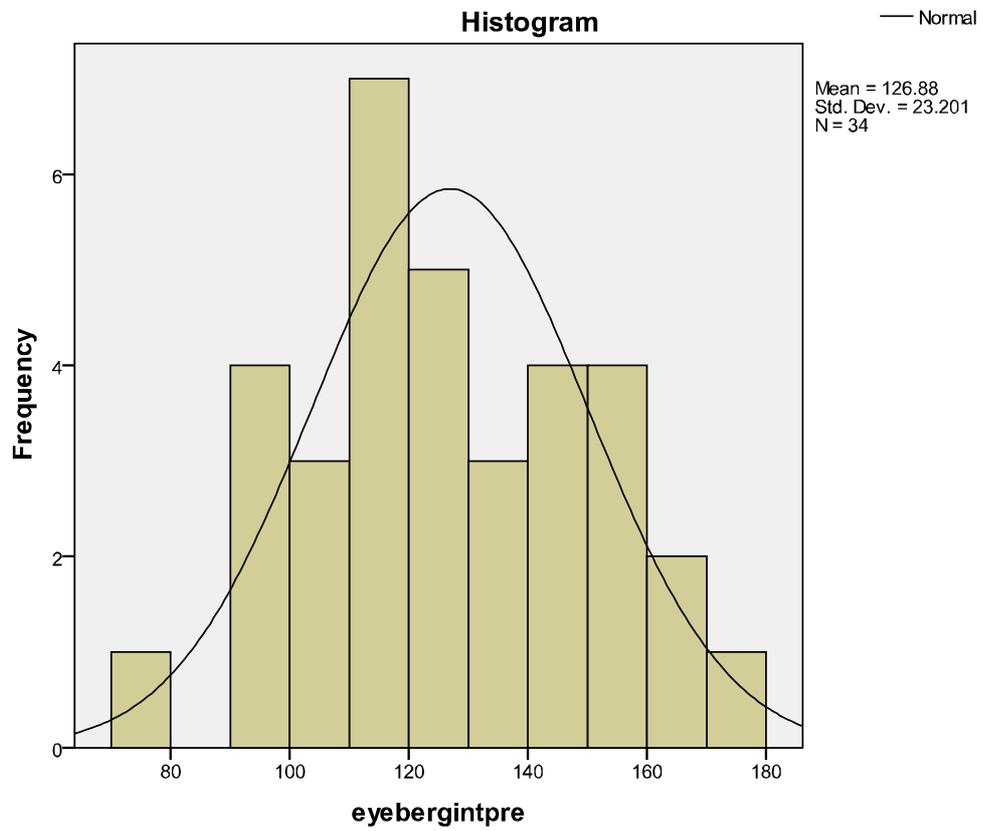
	Kolmogorov-Smirnov ^a			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
Parent Stress Index pre	.083	34	.200*	.981	34	.796
Parent Stress Index post	.136	34	.112	.952	34	.142
Parent Stress Index follow up	.098	34	.200*	.971	34	.479

a. Lilliefors Significance Correction

*. This is a lower bound of the true significance.

Appendix 21

Example Histogram for Eyberg Intensity Pre scores



Appendix 22

Non-parametric Statistical Analysis

The Friedman test was used to compare scores at pre, post and follow up for each measure separately. This allows a main effect over time to be shown (see column chi squared). However, similarly to the parametric repeated measures ANOVA it does not tell you between which time points the difference occurred. Therefore the Wilcoxon signed rank test was used to compare the three time pairs to see where the difference in scores occurred.

	Time 1 mean	Time 2 mean	Time 3 mean	Chi squared	T1-t2	T1-t3	T2-t3
Eyberg Intensity	126.88	101.71	97.71	20.548 Df = 2 P=0.000	Z=4.215 P=0.000**	Z= 4.052 P=0.000**	Z=1.207 P=0.228
Eyberg Problem	12.06	4.12	3.53	35.724 Df = 2 P=0.000	Z = 4.712 P=0.000**	Z=4.722 P=0.000**	Z=1.541 P=0.123
Parent Confidence	43.56	54.65	55.79	43.697 Df=2 P=0.000	Z=5.090 P=0.000**	Z=4.815 P=0.000**	Z=1.113 P=0.266
Parent Stress Index Total Score	87.12	74.97	72.85	19.881 Df=2 P=0.000	Z=4.011 P=0.000**	Z=3.933 P=0.000**	Z=0.973 P=0.331
PSI Parental Distress	30.65	25.79	24.85	17.725 Df=2 P=0.000	Z=3.929 P=0.000**	Z=3.860 P=0.000**	Z=0.788 P=0.431
PSI Parent-child Interaction	23.76	20.79	19.88	10.576 Df=2 P=0.005	Z = 2.469 P=0.014*	Z=2.987 P=0.003**	Z=0.930 P=0.352
PSI Difficult Child	32.79	28.09	28.12	19.910 Df=2 P=0.000	Z=3.202 P=0.001**	Z=3.249 P=0.001**	Z=0.107 P=0.914

** significant at the 0.01 level

*significant at the 0.05 level

Appendix 23

Correlation coefficients for questionnaire pre data using Spearman's Rho

Measure	Eyberg Intensity	Eyberg Problem	Parent Stress Index	Parent confidence
Eyberg intensity	-			
Eyberg Problem	0.637**	-		
Parent Stress Index	0.426*	0.342*	-	
Parent Confidence	-0.508**	-0.241	-0.700**	-

** p < 0.01

*p < 0.05

Appendix 24

MANOVA, repeated measures ANOVAs and post hoc tests for boys

	Time 1 Mean (SD)	Time 2 Mean (SD)	Time 3 Mean (SD)	Main effect over time				
				f	df	sig	partial η^2	Effect size
Eyberg Intensity ##	124.80 (24.75)	102.80 (17.90)	101.47 (25.81)	8.878	2	0.001**	0.388	Large
Eyberg Problem #	10.00 (5.72)	3.33 (3.60)	2.93 (3.77)	18.217	1.224	0.000**	0.565	Large
Parent Confidence ##	42.07 (8.89)	53.33 (6.39)	54.53 (5.96)	37.742	2	0.000**	0.729	Large
Parent Stress total ##	85.67 (18.69)	75.40 (14.58)	76.73 (16.66)	4.727	2	0.017*	0.252	Large
PSI PD##	29.67 (8.01)	24.67 (5.39)	25.60 (6.64)	7.195	2	0.003**	0.339	Large
PSI PCI##	23.73 (8.81)	21.73 (6.18)	21.87 (6.30)	1.189	2	0.320	0.078	Moderate
PSI DC##	32.27 (7.83)	28.80 (7.17)	29.27 (7.15)	2.520	2	0.099	0.153	Large
MANOVA	Wilks $\lambda = 0.148$ F=5.017 (df 14,44), p<0.000** np2 = 0.615 effect size = Large							

N = 15

using Greenhouse-Geisser correction ## using sphericity assumed

*significant at the 0.05 level, **0.01 level

Scales	T1-T2			T1-T3			T2-T3		
	Mean difference	Standard error	Sig	MD	SE	Sig	MD	SE	sig
Eyberg intensity	22.000	5.794	0.006**	23.333	7.133	0.017*	1.333	5.621	1.000
Eyberg Problem	6.667	1.446	0.001**	7.067	1.643	0.002**	0.400	0.631	1.000
Parent confidence	-11.267	1.442	0.000**	-12.467	1.947	0.000**	-1.200	1.284	1.000
Psi total	10.267	3.569	0.037*	8.933	4.030	0.131	-1.333	3.252	1.000
PSI PD	5.000	1.401	0.009**	4.067	1.657	0.084	-0.933	1.089	1.000
PSI PCI	2.000	1.639	0.727	1.867	1.540	0.736	-0.133	1.121	1.000
PSI DC	3.467	1.732	0.195	3.000	1.826	0.368	-0.467	1.447	1.000

N = 15

Adjustment for multiple comparisons: Bonferroni

* significant at the 0.05 level, **0.01 level

Appendix 25

MANOVA, repeated measures ANOVAs and post hoc tests for girls

	Time 1 Mean (SD)	Time 2 Mean (SD)	Time 3 Mean (SD)	Main effect over time				
				f	df	sig	partial η^2	Effect size
Eyberg Intensity #	128.53 (22.45)	100.84 (19.49)	94.74 (24.57)	15.817	1.391	0.000**	0.468	Large
Eyberg Problem #	13.68 (6.54)	4.74 (4.75)	4.00 (5.08)	23.418	1.137	0.000**	0.565	Large
Parent Confidence #	44.74 (8.19)	55.68 (8.95)	56.79 (9.59)	28.974	1.522	0.000**	0.617	Large
Parent Stress total ##	88.26 (19.99)	74.63 (18.07)	69.79 (20.49)	15.226	2	0.000**	0.458	Large
PSI PD##	31.42 (9.96)	26.68 (9.35)	24.26 (10.34)	10.226	2	0.000**	0.363	Large
PSI PCI##	23.79 (8.21)	20.05 (6.05)	18.32 (5.28)	7.264	2	0.002**	0.288	Large
PSI DC##	33.21 (5.85)	27.53 (8.22)	27.21 (9.30)	7.203	2	0.002**	0.286	Large
MANOVA	Wilks $\lambda = 0.210$ $F=5.064$ (df 14,60), $p<0.000$ ** $np2 = 0.542$ effect size = Large							

N = 19 # Greenhouse-Geisser correction ## Sphericity assumed

*significant at 0.05 level, **0.01 level

Scales	T1-T2			T1-T3			T2-T3		
	MD	SE	Sig	MD	SE	Sig	MD	SE	sig
Eyberg intensity	27.684	6.455	0.001**	33.789	8.009	0.002**	6.105	4.146	0.475
Eyberg Problem	8.947	1.893	0.001**	9.684	1.883	0.000**	0.737	0.566	0.629
Parent confidence	-10.947	1.312	0.000**	-12.053	2.160	0.000**	-1.105	1.675	1.000
Psi total	13.632	3.675	0.005**	18.474	3.671	0.000**	4.842	3.029	0.382
PSI PD	4.737	1.302	0.006**	7.158	1.577	0.001**	2.421	1.888	0.648
PSI PCI	3.737	1.565	0.084	5.474	1.619	0.010**	1.737	1.179	0.474
PSI DC	5.684	1.853	0.020*	6.000	1.975	0.021*	0.316	1.471	1.000

N = 19

Adjustment for multiple comparisons: Bonferroni

* significant at the 0.05 level, **0.01 level

Appendix 26

MANOVA, repeated measures ANOVAs and post hoc tests for 2 parent households

	Time 1 Mean (SD)	Time 2 Mean (SD)	Time 3 Mean (SD)	Main effect over time				
				f	df	sig	partial η^2	Effect size
Eyberg Intensity #	129.24 (21.36)	104.71 (16.65)	100.14 (27.45)	16.952	1.480	0.000**	0.459	Large
Eyberg Problem #	12.38 (5.36)	4.57 (4.53)	3.67 (4.61)	26.377	1.117	0.000**	0.569	Large
Parent Confidence #	43.19 (8.71)	54.10 (7.96)	54.52 (7.25)	36.665	1.590	0.000**	0.647	Large
Parent Stress total ##	87.43 (14.32)	74.19 (12.77)	74.29 (15.94)	11.840	2	0.000**	0.372	Large
PSI PD##	30.67 (7.05)	25.24 (5.52)	24.76 (7.21)	12.094	2	0.000**	0.377	Large
PSI PCI#	22.95 (7.76)	19.76 (5.08)	19.62 (5.05)	3.871	1.498	0.043*	0.162	Large
PSI DC##	33.86 (6.20)	28.95 (7.53)	29.90 (8.47)	5.098	2	0.011*	0.203	Large
MANOVA	Wilks $\lambda = 0.234$ $F=5.178$ (df 14,68), $p<0.000$ ** $np2 = 0.516$ effect size = Large							

N = 21 # using Greenhouse-Geisser correction ## using sphericity assumed

*significant at the 0.05 level, **0.01 level

Scales	T1-T2			T1-T3			T2-T3		
	MD	SE	Sig	MD	SE	Sig	MD	SE	sig
Eyberg intensity	24.524	5.050	0.000**	29.095	6.717	0.001**	4.571	4.005	0.801
Eyberg Problem	7.810	1.544	0.000**	8.714	1.624	0.000**	0.905	0.447	0.169
Parent confidence	-10.905	1.110	0.000**	-11.333	1.792	0.000**	-0.429	1.519	1.000
Psi total	13.238	3.188	0.001**	13.143	3.627	0.005**	-0.95	2.463	1.000
PSI PD	5.429	1.013	0.000**	5.905	1.563	0.004**	0.476	1.367	1.000
PSI PCI	3.190	1.549	0.158	3.333	1.528	0.124	-0.143	0.879	1.000
PSI DC	4.905	1.637	0.021*	3.952	1.918	0.158	-0.952	1.266	1.000

N =21

Adjustment for multiple comparisons: Bonferroni

* significant at the 0.05 level, **0.01 level

Appendix 27

MANOVA, repeated measures ANOVAs and post hoc tests for single parent households

	Time 1 Mean (SD)	Time 2 Mean (SD)	Time 3 Mean (SD)	Main effect over time				
				f	df	sig	partial η^2	Effect size
Eyberg Intensity ##	123.08 (26.35)	96.85 (21.05)	93.77 (20.76)	7.738	2	0.003**	0.392	Large
Eyberg Problem #	11.54 (7.96)	3.38 (3.88)	3.31 (4.53)	13.625	1.225	0.001**	0.532	Large
Parent Confidence #	44.15 (8.40)	55.54 (8.04)	57.84 (9.38)	27.718	1.370	0.000**	0.698	Large
Parent Stress total ##	86.62 (25.88)	76.23 (21.53)	70.54 (23.54)	6.833	2	0.000**	0.363	Large
PSI PD##	30.61 (11.96)	26.69 (10.76)	25.00 (11.22)	4.342	2	0.025*	0.266	Large
PSI PCI##	25.08 (9.39)	22.46 (7.32)	20.31 (7.35)	3.999	2	0.032*	0.250	Large
PSI DC##	31.08 (7.37)	26.69 (8.05)	25.23 (7.61)	5.043	2	0.015*	0.296	Large
MANOVA	Wilks $\lambda = 0.137$ F=54.377 (df 14,36), p<0.000** np2 = 0.630 effect size = Large							

N = 13

using Greenhouse-Geisser correction ## using sphericity assumed

*significant at the 0.05 level, **0.01 level

Scales	T1-T2			T1-T3			T2-T3		
	MD	SE	Sig	MD	SE	Sig	MD	SE	sig
Eyberg intensity	26.231	8.335	0.025*	29.308	9.670	0.031*	3.077	6.177	1.000
Eyberg Problem	8.154	2.127	0.007**	8.231	2.158	0.007**	0.077	0.820	1.000
Parent confidence	-11.385	1.803	0.000**	- 13.692	2.530	0.000**	-2.308	1.407	0.381
Psi total	10.385	4.424	0.111	16.077	4.520	0.012*	5.692	4.284	0.626
PSI PD	3.923	1.866	0.172	5.615	1.756	0.023*	1.692	2.214	1.000
PSI PCI	2.615	1.635	0.407	4.769	1.802	0.064	-2.154	1.625	0.629
PSI DC	4.385	2.144	0.190	5.846	1.853	0.025*	1.462	1.727	1.000

N = 13

Adjustment for multiple comparisons: Bonferroni

* significant at the 0.05 level, **0.01 level

Appendix 28

MANOVA, repeated measures ANOVAs and post hoc tests for those with siblings

	Time 1 Mean (SD)	Time 2 Mean (SD)	Time 3 Mean (SD)	Main effect over time				
				f	df	sig	partial η^2	Effect size
Eyberg Intensity #	134.20 (27.13)	103.55 (20.60)	104.85 (25.32)	13.380	1.357	0.000**	0.413	Large
Eyberg Problem #	13.90 (7.26)	4.65 (4.43)	4.25 (4.95)	22.318	1.155	0.000**	0.540	Large
Parent Confidence #	44.05 (9.46)	55.55 (8.29)	54.85 (9.63)	30.824	1.285	0.000**	0.619	Large
Parent Stress total ##	89.25 (20.47)	76.00 (18.44)	75.50 (19.95)	12.326	2	0.000**	0.393	Large
PSI PD##	31.05 (10.54)	26.50 (9.50)	26.50 (9.01)	6.877	2	0.003**	0.266	Large
PSI PCI##	23.80 (8.89)	21.10 (6.55)	20.40 (6.46)	3.683	2	0.035*	0.162	Large
PSI DC##	34.45 (6.13)	28.15 (7.75)	28.60 (7.65)	12.354	2	0.000**	0.394	Large
MANOVA	Wilks $\lambda = 0.246$ F=4.653 (df 14,64), p<0.000** np2 = 0.504 effect size = Large							

N = 20 # using Greenhouse-Geisser correction ## using sphericity assumed

*significant at the 0.05 level, **0.01 level

Scales	T1-T2			T1-T3			T2-T3		
	MD	SE	Sig	MD	SE	Sig	MD	SE	sig
Eyberg intensity	30.650	6.497	0.000**	29.350	8.539	0.008**	-1.300	4.425	1.000
Eyberg Problem	9.250	1.901	0.000**	9.650	2.000	0.000**	0.400	0.630	1.000
Parent confidence	-11.500	1.278	0.000**	-10.800	2.170	0.000**	-0.700	1.322	1.000
Psi total	13.250	3.157	0.001**	13.750	3.248	0.001**	0.500	3.014	1.000
PSI PD	4.550	1.230	0.005**	4.550	1.448	0.016*	0.000	1.553	1.000
PSI PCI	2.700	1.510	0.269	3.400	1.317	0.055	0.700	1.112	1.000
PSI DC	6.300	1.611	0.003**	5.850	1.338	0.001**	-0.450	1.270	1.000

N = 20

Adjustment for multiple comparisons: Bonferroni

* significant at the 0.05 level, **0.01 level

Appendix 29

MANOVA, repeated measures ANOVAs and post hoc tests for those without siblings

	Time 1 Mean (SD)	Time 2 Mean (SD)	Time 3 Mean (SD)	Main effect over time				
				f	df	sig	partial η^2	Effect size
Eyberg Intensity ##	116.43 (9.50)	99.07 (15.53)	87.50 (21.32)	16.777	2	0.000**	0.563	Large
Eyberg Problem #	9.43 (3.67)	3.35 (4.09)	2.50 (3.74)	28.452	1.254	0.000**	0.686	Large
Parent Confidence ##	42.86 (7.13)	53.36 (7.40)	57.14 (5.49)	43.449	2	0.000**	0.770	Large
Parent Stress total ##	84.07 (17.46)	73.50 (13.43)	69.07 (17.42)	6.235	2	0.006**	0.324	Large
PSI PD##	30.07 (6.74)	24.79 (4.61)	22.50 (8.21)	9.974	2	0.001**	0.434	Large
PSI PCI##	23.71 (7.83)	20.36 (5.53)	19.14 (5.25)	3.630	2	0.041*	0.218	Large
PSI DC##	30.43 (6.98)	28.00 (7.89)	27.43 (9.55)	1.041	2	0.367	0.074	Moderate
MANOVA	Wilks $\lambda = 0.078$ F=7.368 (df 14,40), p<0.000** np2 = 0.721 effect size = Large							

N = 14 # using Greenhouse-Geisser correction ## using sphericity assumed

*significant at the 0.05 level, **0.01 level

Scales	T1-T2			T1-T3			T2-T3		
	MD	SE	Sig	MD	SE	Sig	MD	SE	sig
Eyberg intensity	17.357	4.732	0.009**	28.929	5.656	0.001**	11.571	4.630	0.080
Eyberg Problem	6.071	1.174	0.001**	6.929	1.184	0.000**	0.857	0.479	0.290
Parent confidence	-10.500	1.478	0.000**	- 14.286	1.662	0.000**	-3.786	1.618	0.108
Psi total	10.571	4.411	0.097	15.000	5.115	0.035*	4.429	3.396	0.645
PSI PD	5.286	1.506	0.012*	7.571	1.869	0.004**	2.286	1.820	0.694
PSI PCI	3.357	1.750	0.232	4.571	2.140	0.157	1.214	1.276	1.000
PSI DC	2.429	2.010	0.746	3.000	2.736	0.878	0.571	1.759	1.000

N = 14

Adjustment for multiple comparisons: Bonferroni

* significant at the 0.05 level, **0.01 level

Appendix 30

MANOVA, repeated measures ANOVAs and post hoc tests for parents above the median age

	Time 1 Mean (SD)	Time 2 Mean (SD)	Time 3 Mean (SD)	Main effect over time				
				f	Df	sig	partial η^2	Effect size
Eyberg Intensity ##	128.47 (22.45)	102.40 (14.89)	93.73 (22.87)	13.366	2	0.000**	0.488	Large
Eyberg Problem #	11.87 (4.91)	4.60 (4.70)	4.2 (5.00)	17.619	1.294	0.000**	0.557	Large
Parent Confidence ##	43.27 (7.70)	53.87 (6.08)	56.20 (6.13)	38.037	2	0.000**	0.731	Large
Parent Stress total ##	87.20 (19.79)	74.13 (14.59)	71.87 (14.21)	7.267	2	0.003**	0.342	Large
PSI PD##	31.80 (8.74)	25.93 (6.26)	24.53 (6.23)	13.375	2	0.000**	0.489	Large
PSI PCI##	23.13 (8.37)	19.27 (5.57)	19.27 (4.38)	3.652	2	0.039*	0.207	Large
PSI DC##	32.27 (7.03)	28.73 (8.05)	28.07 (8.94)	2.338	2	0.115	0.143	Large
MANOVA	Wilks λ = 0.163 F=4.652 (df 14,44), p<0.000** np2 = 0.597 effect size = Large							

N = 15 # using Greenhouse-Geisser correction ## using sphericity assumed

*significant at the 0.05 level, **0.01 level

Scales	T1-T2			T1-T3			T2-T3		
	MD	SE	Sig	MD	SE	Sig	MD	SE	sig
Eyberg intensity	26.07	7.01	0.007**	34.73	8.57	0.004**	8.67	4.91	0.297
Eyberg Problem	7.27	1.76	0.003**	7.67	1.16	0.001**	0.40	0.76	1.000
Parent confidence	-10.60	1.40	0.000**	-12.93	1.78	0.000**	-2.33	1.54	0.460
Psi total	13.07	4.41	0.031*	15.33	5.19	0.031*	2.27	3.20	1.000
PSI PD	5.87	1.42	0.003**	7.27	1.61	0.001**	1.40	1.44	1.000
PSI PCI	3.87	1.98	0.214	3.87	1.75	0.132	0.00	1.10	1.000
PSI DC	3.53	1.79	0.205	4.20	2.63	0.396	0.67	1.73	1.000

N = 15

Adjustment for multiple comparisons: Bonferroni

* significant at the 0.05 level, **0.01 level

Appendix 31

MANOVA , repeated measures ANOVAs and post hoc tests for parents below the median age

	Time 1 Mean (SD)	Time 2 Mean (SD)	Time 3 Mean (SD)	Main effect over time				
				f	df	sig	partial η^2	Effect size
Eyberg Intensity ##	125.63 (24.31)	101.16 (21.40)	100.84 (26.69)	11.669	2	0.000**	0.393	Large
Eyberg Problem #	12.21 (7.47)	3.74 (4.00)	3.00 (4.15)	22.647	1.084	0.000**	0.557	Large
Parent Confidence #	43.79 (9.25)	55.26 (9.20)	55.47 (9.62)	29.647	1.381	0.000**	0.622	Large
Parent Stress total ##	87.05 (19.24)	75.63 (18.04)	73.63 (22.36)	10.846	2	0.000**	0.376	Large
PSI PD##	29.74 (9.44)	25.68 (9.02)	25.11 (10.56)	5.085	2	0.011*	0.220	Large
PSI PCI##	24.26 (8.52)	22.00 (6.32)	20.37 (7.01)	4.055	2	0.026*	0.184	Large
PSI DC##	33.21 (6.60)	27.58 (7.57)	28.16 (8.13)	8.423	2	0.001**	0.319	Large
MANOVA	Wilks λ =0.218 F=4.884 (df 14,60), p<0.000** np2 =0.533 effect size = Large							

N = 19 # using Greenhouse-Geisser correction ## using sphericity assumed

*significant at the 0.05 level, **0.01 level

Scales	T1-T2			T1-T3			T2-T3		
	MD	SE	Sig	MD	SE	Sig	MD	SE	sig
Eyberg intensity	24.47	5.73	0.001**	24.79	7.11	0.008**	0.316	4.55	1.000
Eyberg Problem	8.47	1.75	0.000**	9.211	1.91	0.000**	0.74	0.46	0.389
Parent confidence	-11.47	1.34	0.000**	-11.68	2.24	0.000**	-0.21	1.50	1.000
Psi total	11.42	3.10	0.005**	13.42	3.01	0.001**	2.00	3.21	1.000
PSI PD	4.05	1.26	0.014*	4.63	1.63	0.032*	0.58	1.81	1.000
PSI PCI	2.26	1.30	0.298	3.90	1.59	0.074	1.63	1.20	0.575
PSI DC	5.63	1.82	0.019*	5.05	1.38	0.005**	-0.58	1.26	1.000

N = 19

Adjustment for multiple comparisons: Bonferroni

* significant at the 0.05 level, **0.01 level

Appendix 32

MANOVA, repeated measures ANOVAs and post hoc tests for children above the median age

	Time 1 Mean (SD)	Time 2 Mean (SD)	Time 3 Mean (SD)	Main effect over time				
				f	df	sig	partial η^2	Effect size
Eyberg Intensity ##	135.92 (20.23)	100.08 (19.94)	96.67 (25.56)	24.610	2	0.000**	0.691	Large
Eyberg Problem #	15.17 (7.15)	3.83 (4.00)	3.67 (4.42)	22.503	1.166	0.000**	0.672	Large
Parent Confidence ##	40.42 (9.50)	51.58 (9.43)	53.17 (8.47)	38.525	2	0.000**	0.778	Large
Parent Stress total ##	99.50 (19.57)	84.00 (17.24)	84.00 (19.42)	8.403	2	0.002**	0.433	Large
PSI PD##	35.75 (10.15)	30.50 (9.75)	29.25 (10.01)	5.236	2	0.014*	0.322	Large
PSI PCI##	28.50 (10.03)	22.83 (7.25)	22.83 (7.35)	5.529	2	0.011*	0.334	Large
PSI DC##	35.25 (4.47)	30.67 (5.61)	31.92 (8.44)	2.443	2	0.110	0.182	Large
MANOVA	Wilks λ =0.111 F=5.682 (df 12,34), p<0.000** np2 0.667= effect size = Large							

N = 12 # using Greenhouse-Geisser correction ## using sphericity assumed

*significant at the 0.05 level, **0.01 level

Scales	T1-T2			T1-T3			T2-T3		
	MD	SE	Sig	MD	SE	Sig	MD	SE	sig
Eyberg intensity	35.83	6.84	0.001**	39.25	6.75	0.000**	3.42	4.80	1.000
Eyberg Problem	11.33	2.30	0.001**	11.50	2.38	0.002**	0.17	0.78	1.000
Parent confidence	-11.17	1.54	0.000**	-12.75	1.86	0.000**	-1.58	1.30	0.746
Psi total	15.50	4.65	0.020*	15.50	5.23	0.039*	0.000	2.87	1.000
PSI PD	5.25	1.84	0.047*	6.50	2.55	0.082	1.25	1.93	1.000
PSI PCI	5.67	2.25	0.085	5.67	2.06	0.057	0.00	1.52	1.000
PSI DC	4.58	1.86	0.094	3.33	2.76	0.757	-1.25	1.65	1.000

N = 12

Adjustment for multiple comparisons: Bonferroni

* significant at the 0.05 level, **0.01 level

Appendix 33

MANOVA, repeated measures ANOVAs and post hoc tests for children below the median age

	Time 1 Mean (SD)	Time 2 Mean (SD)	Time 3 Mean (SD)	Main effect over time				
				f	df	sig	partial η^2	Effect size
Eyberg Intensity ##	121.95 (23.65)	102.59 (18.18)	98.27 (25.23)	9.072	2	0.001**	0.302	Large
Eyberg Problem #	10.36 (5.35)	4.27 (4.51)	3.45 (4.67)	21.599	1.188	0.000**	0.507	Large
Parent Confidence ##	45.27 (7.55)	56.31 (6.57)	57.23 (7.80)	32.970	2	0.000**	0.611	Large
Parent Stress total ##	80.36 (15.57)	70.05 (13.93)	66.77 (16.03)	9.975	2	0.000**	0.322	Large
PSI PD##	27.86 (7.22)	23.23 (5.16)	22.45 (7.21)	10.552	2	0.000**	0.334	Large
PSI PCI##	21.18 (6.08)	19.68 (5.18)	18.27 (4.41)	2.998	2	0.061	0.125	Moderate
PSI DC##	31.45 (7.40)	26.68 (8.40)	26.05 (7.74)	7.436	2	0.002**	0.261	Large
MANOVA	Wilks λ =0.238 F=5.406 (df 14,72), p<0.000** np2 =0.512 effect size = Large							

N = 22 # using Greenhouse-Geisser correction ## using sphericity assumed

*significant at the 0.05 level, **0.01 level

Scales	T1-T2			T1-T3			T2-T3		
	MD	SE	Sig	MD	SE	Sig	MD	SE	sig
Eyberg intensity	19.36	5.37	0.005**	23.68	7.45	0.014*	4.32	4.57	1.000
Eyberg Problem	6.09	1.31	0.000**	6.91	1.41	0.000**	0.82	0.49	0.331
Parent confidence	-11.05	1.24	0.000**	-11.96	2.04	0.000**	-0.91	1.53	1.000
Psi total	10.32	3.06	0.009**	13.59	3.34	0.002**	3.27	3.13	0.921
PSI PD	4.64	1.08	0.001**	5.41	1.18	0.000**	0.77	1.52	1.000
PSI PCI	1.50	1.16	0.634	2.91	1.38	0.143	1.41	0.98	0.501
PSI DC	4.77	1.73	0.036*	5.41	1.52	0.006**	0.64	1.31	1.000

N = 22

Adjustment for multiple comparisons: Bonferroni

* significant at the 0.05 level, **0.01 level

Appendix 34

Repeated Measures ANOVA with between subject factor for child gender

	Between Subject Variable	Time 1 Mean (SD)	Time 2 Mean (SD)	Time 3 Mean (SD)	Test of between Subject Effects				
					f	df	sig	partial η^2	Effect size
Eyberg Intensity	Boys	124.80 (24.75)	102.80 (17.90)	101.47 (25.81)	0.081	1	0.777	0.003	-
	Girls	128.53 (22.45)	100.84 (19.49)	94.74 (24.57)					
Eyberg Problem	Boys	10.00 (5.72)	3.33 (3.60)	2.93 (3.77)	2.675	1	0.112	0.077	Moderate
	Girls	13.68 (6.54)	4.74 (4.75)	4.00 (5.08)					
Parent Confidence	Boys	42.07 (8.89)	53.33 (6.39)	54.53 (5.96)	0.965	1	0.333	0.029	Small
	Girls	44.74 (8.19)	55.68 (8.95)	56.79 (9.59)					
Parent Stress total	Boys	85.67 (18.69)	75.40 (14.58)	76.73 (16.66)	0.092	1	0.764	0.003	-
	Girls	88.26 (19.99)	74.63 (18.07)	69.79 (20.49)					
PSI PD	Boys	29.67 (8.01)	24.67 (5.39)	25.60 (6.64)	0.090	1	0.766	0.003	-
	Girls	31.42 (9.96)	26.68 (9.35)	24.26 (10.34)					
PSI PCI	Boys	23.73 (8.81)	21.73 (6.18)	21.87 (6.30)	0.710	1	0.406	0.022	Small
	Girls	23.79 (8.21)	20.05 (6.05)	18.32 (5.28)					
PSI DC	Boys	32.27 (7.83)	28.80 (7.17)	29.27 (7.15)	0.127	1	0.724	0.004	-
	Girls	33.21 (5.85)	27.53 (8.22)	27.21 (9.30)					

N = 34 (boys =15, girls =19)

* significant at the 0.05 level, **0.01 level

Appendix 35

Repeated Measures ANOVA with between subject factor for presence of siblings

Measure	Between Subject Variable	Time 1 Mean (SD)	Time 2 Mean (SD)	Time 3 Mean (SD)	Test of between Subject Effects				
					f	df	sig	partial η^2	Effect size
Eyberg Intensity	Siblings	134.20 (27.13)	103.55 (20.60)	104.85 (25.32)	6.046	1	0.020 *	0.159	Large
	No Siblings	116.43 (9.50)	99.07 (15.53)	87.50 (21.32)					
Eyberg Problem	Siblings	13.90 (7.26)	4.65 (4.43)	4.25 (4.95)	4.077	1	0.052	0.113	Moderate
	No Siblings	9.43 (3.67)	3.35 (4.09)	2.50 (3.74)					
Parent Confidence	Siblings	44.05 (9.46)	55.55 (8.29)	54.85 (9.63)	0.021	1	0.886	0.001	-
	No Siblings	42.86 (7.13)	53.36 (7.40)	57.14 (5.49)					
Parent Stress total	Siblings	89.25 (20.47)	76.00 (18.44)	75.50 (19.95)	0.699	1	0.409	0.021	Small
	No Siblings	84.07 (17.46)	73.50 (13.43)	69.07 (17.42)					
PSI PD	Siblings	31.05 (10.54)	26.50 (9.50)	26.50 (9.01)	0.678	1	0.416	0.021	Small
	No Siblings	30.07 (6.74)	24.79 (4.61)	22.50 (8.21)					
PSI PCI	Siblings	23.80 (8.89)	21.10 (6.55)	20.40 (6.46)	0.111	1	0.741	0.003	-
	No Siblings	23.71 (7.83)	20.36 (5.53)	19.14 (5.25)					
PSI DC	Siblings	34.45 (6.13)	28.15 (7.75)	28.60 (7.65)	0.635	1	0.431	0.019	Small
	No Siblings	30.43 (6.98)	28.00 (7.89)	27.43 (9.55)					

N= 34 (siblings = 20, no siblings = 14)

* significant at the 0.05 level, **0.01 level

Appendix 36

Repeated Measures ANOVA with between subject factor for number of parents present in household

Measure	Between Subject Variable	Time 1 Mean (SD)	Time 2 Mean (SD)	Time 3 Mean (SD)	Test of between Subject Effects				
					f	df	sig	partial η^2	Effect size
Eyberg Intensity	1 Parent household	123.08 (26.35)	96.85 (21.05)	93.77 (20.76)	1.373	1	0.250	0.041	Small
	2 Parent household	129.24 (21.36)	104.71 (16.65)	100.14 (27.45)					
Eyberg Problem	1 Parent household	11.54 (7.96)	3.38 (3.88)	3.31 (4.53)	0.360	1	0.553	0.011	Small
	2 Parent household	12.38 (5.36)	4.57 (4.53)	3.67 (4.61)					
Parent Confidence	1 Parent household	44.15 (8.40)	55.54 (8.04)	57.84 (9.38)	0.566	1	0.457	0.017	Small
	2 Parent household	43.19 (8.71)	54.10 (7.96)	54.52 (7.25)					
Parent Stress total	1 Parent household	86.62 (25.88)	76.23 (21.53)	70.54 (23.54)	0.021	1	0.885	0.001	-
	2 Parent household	87.43 (14.32)	74.19 (12.77)	74.29 (15.94)					
PSI PD	1 Parent household	30.61 (11.96)	26.69 (10.76)	25.00 (11.22)	0.039	1	0.845	0.001	-
	2 Parent household	30.67 (7.05)	25.24 (5.52)	24.76 (7.21)					
PSI PCI	1 Parent household	25.08 (9.39)	22.46 (7.32)	20.31 (7.35)	0.773	1	0.386	0.024	Small
	2 Parent household	22.95 (7.76)	19.76 (5.08)	19.62 (5.05)					
PSI DC	1 Parent household	31.08 (7.37)	26.69 (8.05)	25.23 (7.61)	2.142	1	0.153	0.063	Moderate
	2 Parent household	33.86 (6.20)	28.95 (7.53)	29.90 (8.47)					

N= 34 (1 Parent Households = 13, 2 parent household = 21)

* significant at the 0.05 level, **0.01 level

Appendix 37

Repeated Measures ANOVA with between subject factor for age of parent

Measure	Between Subject Variable	Time 1 Mean (SD)	Time 2 Mean (SD)	Time 3 Mean (SD)	Test of between Subject Effects				
					f	df	sig	partial η^2	Effect size
Eyberg Intensity	Parents age above median	128.47 (22.45)	102.40 (14.89)	93.73 (22.87)	0.000	1	0.999	0.000	-
	Parents age below median	125.63 (24.31)	101.16 (21.40)	100.84 (26.69)					
Eyberg Problem	Parents age above median	11.87 (4.91)	4.60 (4.70)	4.2 (5.00)	0.232	1	0.633	0.008	-
	Parents age below median	12.21 (7.47)	3.74 (4.00)	3.00 (4.15)					
Parent Confidence	Parents age above median	43.27 (7.70)	53.87 (6.08)	56.20 (6.13)	0.166	1	0.687	0.006	-
	Parents age below median	43.79 (9.25)	55.26 (9.20)	55.47 (9.62)					
Parent Stress total	Parents age above median	87.20 (19.79)	74.13 (14.59)	71.87 (14.21)	0.028	1	0.868	0.001	-
	Parents age below median	87.05 (19.24)	75.63 (18.04)	73.63 (22.36)					
PSI PD	Parents age above median	31.80 (8.74)	25.93 (6.26)	24.53 (6.23)	0.689	1	0.413	0.022	Small
	Parents age below median	29.74 (9.44)	25.68 (9.02)	25.11 (10.56)					
PSI PCI	Parents age above median	23.13 (8.37)	19.27 (5.57)	19.27 (4.38)	0.392	1	0.536	0.013	Small
	Parents age below median	24.26 (8.52)	22.00 (6.32)	20.37 (7.01)					
PSI DC	Parents age above median	32.27 (7.03)	28.73 (8.05)	28.07 (8.94)	0.006	1	0.939	0.000	-
	Parents age below median	33.21 (6.60)	27.58 (7.57)	28.16 (8.13)					

N= 34 (Parent's age above median = 15, Parent's age below median = 19)

* significant at the 0.05 level, **0.01 level

Appendix 38

Repeated Measures ANOVA with between subject factor for age of child

Measure	Between Subject Variable	Time 1 Mean (SD)	Time 2 Mean (SD)	Time 3 Mean (SD)	Test of between Subject Effects				
					f	df	sig	partial η^2	Effect size
Eyberg Intensity	Child age above median	135.92 (20.23)	100.08 (19.94)	96.67 (25.56)	0.299	1	0.588	0.009	-
	Child age below median	121.95 (23.65)	102.59 (18.18)	98.27 (25.23)					
Eyberg Problem	Child age above median	15.17 (7.15)	3.83 (4.00)	3.67 (4.42)	1.316	1	0.269	0.040	Small
	Child age below median	10.36 (5.35)	4.27 (4.51)	3.45 (4.67)					
Parent Confidence	Child age above median	40.42 (9.50)	51.58 (9.43)	53.17 (8.47)	3.376	1	0.075	0.095	Moderate
	Child age below median	45.27 (7.55)	56.31 (6.57)	57.23 (7.80)					
Parent Stress total	Child age above median	99.50 (19.57)	84.00 (17.24)	84.00 (19.42)	11.028	1	0.002**	0.256	Large
	Child age below median	80.36 (15.57)	70.05 (13.93)	66.77 (16.03)					
PSI PD	Child age above median	35.75 (10.15)	30.50 (9.75)	29.25 (10.01)	8.537	1	0.006**	0.211	Large
	Child age below median	27.86 (7.22)	23.23 (5.16)	22.45 (7.21)					
PSI PCI	Child age above median	28.50 (10.03)	22.83 (7.25)	22.83 (7.35)	6.534	1	0.016	0.170	Large
	Child age below median	21.18 (6.08)	19.68 (5.18)	18.27 (4.41)					
PSI DC	Child age above median	35.25 (4.47)	30.67 (5.61)	31.92 (8.44)	4.355	1	0.045*	0.120	Medium
	Child age below median	31.45 (7.40)	26.68 (8.40)	26.05 (7.74)					

N= 34 (Child's age above median = 12, Child's age below median = 22)

* significant at the 0.05 level, **0.01 level

Appendix 39

Repeated Measures ANOVA with between subject factor for child gender, interaction effects

Measure	Between Subject Variable	Time 1 Mean (SD)	Time 2 Mean (SD)	Time 3 Mean (SD)	Test of between Subject Effects interaction time*child gender				
					f	df	sig	partial η^2	Effect size
Eyberg Intensity #	Boys	124.80 (24.75)	102.80 (17.90)	101.47 (25.81)	0.664	1.567	0.484	0.020	Small
	Girls	128.53 (22.45)	100.84 (19.49)	94.74 (24.57)					
Eyberg Problem #	Boys	10.00 (5.72)	3.33 (3.60)	2.93 (3.77)	0.897	1.170	0.365	0.027	Small
	Girls	13.68 (6.54)	4.74 (4.75)	4.00 (5.08)					
Parent Confidence #	Boys	42.07 (8.89)	53.33 (6.39)	54.53 (5.96)	0.016	1.563	0.965	0.001	-
	Girls	44.74 (8.19)	55.68 (8.95)	56.79 (9.59)					
Parent Stress total ##	Boys	85.67 (18.69)	75.40 (14.58)	76.73 (16.66)	1.823	2	0.170	0.054	Small
	Girls	88.26 (19.99)	74.63 (18.07)	69.79 (20.49)					
PSI PD ##	Boys	29.67 (8.01)	24.67 (5.39)	25.60 (6.64)	1.441	2	0.244	0.043	Small
	Girls	31.42 (9.96)	26.68 (9.35)	24.26 (10.34)					
PSI PCI ##	Boys	23.73 (8.81)	21.73 (6.18)	21.87 (6.30)	1.481	2	0.235	0.044	Small
	Girls	23.79 (8.21)	20.05 (6.05)	18.32 (5.28)					
PSI DC ##	Boys	32.27 (7.83)	28.80 (7.17)	29.27 (7.15)	0.777	2	0.464	0.024	Small
	Girls	33.21 (5.85)	27.53 (8.22)	27.21 (9.30)					

N = 34 (boys =15, girls =19)

using Greenhouse-Geisser correction ## using sphericity assumed

* significant at the 0.05 level, **0.01 level

Appendix 40

Repeated Measures ANOVA with between subject factor for presence of siblings, interaction effects

Measure	Between Subject Variable	Time 1 Mean (SD)	Time 2 Mean (SD)	Time 3 Mean (SD)	Test of between Subject Effects Interaction time*presence of siblings				
					f	df	sig	partial η^2	Effect size
Eyberg Intensity #	Siblings	134.20 (27.13)	103.55 (20.60)	104.85 (25.32)	1.389	1.476	0.256	0.042	Small
	No Siblings	116.43 (9.50)	99.07 (15.53)	87.50 (21.32)					
Eyberg Problem #	Siblings	13.90 (7.26)	4.65 (4.43)	4.25 (4.95)	1.300	1.170	0.268	0.039	Small
	No Siblings	9.43 (3.67)	3.35 (4.09)	2.50 (3.74)					
Parent Confidence #	Siblings	44.05 (9.46)	55.55 (8.29)	54.85 (9.63)	1.970	1.540	0.159	0.058	Small
	No Siblings	42.86 (7.13)	53.36 (7.40)	57.14 (5.49)					
Parent Stress total ##	Siblings	89.25 (20.47)	76.00 (18.44)	75.50 (19.95)	0.294	2	0.746	0.009	-
	No Siblings	84.07 (17.46)	73.50 (13.43)	69.07 (17.42)					
PSI PD ##	Siblings	31.05 (10.54)	26.50 (9.50)	26.50 (9.01)	0.996	2	0.375	0.030	Small
	No Siblings	30.07 (6.74)	24.79 (4.61)	22.50 (8.21)					
PSI PCI ##	Siblings	23.80 (8.89)	21.10 (6.55)	20.40 (6.46)	0.148	2	0.863	0.005	-
	No Siblings	23.71 (7.83)	20.36 (5.53)	19.14 (5.25)					
PSI DC ##	Siblings	34.45 (6.13)	28.15 (7.75)	28.60 (7.65)	1.288	2	0.283	0.039	Small
	No Siblings	30.43 (6.98)	28.00 (7.89)	27.43 (9.55)					

N= 34 (siblings = 20, no siblings = 14)

using Greenhouse-Geisser correction ## using sphericity assumed

* significant at the 0.05 level, **0.01 level

Appendix 41

Repeated Measures ANOVA with between subject factor for number of parents in the household, interaction effects

Measure	Between Subject Variable	Time 1 Mean (SD)	Time 2 Mean (SD)	Time 3 Mean (SD)	Test of between Subject Effects Interaction time*number of parents in household				
					f	df	sig	partial η^2	Effect size
Eyberg Intensity #	1 Parent household	123.08 (26.35)	96.85 (21.05)	93.77 (20.76)	0.020	1.555	0.959	0.001	-
	2 Parent household	129.24 (21.36)	104.71 (16.65)	100.14 (27.45)					
Eyberg Problem #	1 Parent household	11.54 (7.96)	3.38 (3.88)	3.31 (4.53)	0.071	1.161	0.827	0.002	-
	2 Parent household	12.38 (5.36)	4.57 (4.53)	3.67 (4.61)					
Parent Confidence #	1 Parent household	44.15 (8.40)	55.54 (8.04)	57.84 (9.38)	0.515	1.570	0.557	0.016	Small
	2 Parent household	43.19 (8.71)	54.10 (7.96)	54.52 (7.25)					
Parent Stress total ##	1 Parent household	86.62 (25.88)	76.23 (21.53)	70.54 (23.54)	0.602	2	0.551	0.018	Small
	2 Parent household	87.43 (14.32)	74.19 (12.77)	74.29 (15.94)					
PSI PD ##	1 Parent household	30.61 (11.96)	26.69 (10.76)	25.00 (11.22)	0.244	2	0.784	0.008	-
	2 Parent household	30.67 (7.05)	25.24 (5.52)	24.76 (7.21)					
PSI PCI ##	1 Parent household	25.08 (9.39)	22.46 (7.32)	20.31 (7.35)	0.453	2	0.637	0.014	Small
	2 Parent household	22.95 (7.76)	19.76 (5.08)	19.62 (5.05)					
PSI DC ##	1 Parent household	31.08 (7.37)	26.69 (8.05)	25.23 (7.61)	0.492	2	0.614	0.015	Small
	2 Parent household	33.86 (6.20)	28.95 (7.53)	29.90 (8.47)					

N= 34 (1 Parent Household = 13, 2 parent household = 21)

using Greenhouse-Geisser correction ## using sphericity assumed

* significant at the 0.05 level, **0.01 level

Appendix 42

Repeated Measures ANOVA with between subject factor for parent age, interaction effects

Measure	Between Subject Variable	Time 1 Mean (SD)	Time 2 Mean (SD)	Time 3 Mean (SD)	Test of between Subject Effects Interaction time*parent age				
					f	df	sig	partial η^2	Effect size
Eyberg Intensity #	Parents age above median	128.47 (22.45)	102.40 (14.89)	93.73 (22.87)	0.888	1.536	0.394	0.029	Small
	Parents age below median	125.63 (24.31)	101.16 (21.40)	100.84 (26.69)					
Eyberg Problem #	Parents age above median	11.87 (4.91)	4.60 (4.70)	4.2 (5.00)	0.079	1.189	0.823	0.003	-
	Parents age below median	12.21 (7.47)	3.74 (4.00)	3.00 (4.15)					
Parent Confidence #	Parents age above median	43.27 (7.70)	53.87 (6.08)	56.20 (6.13)	0.262	1.522	0.710	0.009	-
	Parents age below median	43.79 (9.25)	55.26 (9.20)	55.47 (9.62)					
Parent Stress total ##	Parents age above median	87.20 (19.79)	74.13 (14.59)	71.87 (14.21)	0.078	2	0.925	0.003	-
	Parents age below median	87.05 (19.24)	75.63 (18.04)	73.63 (22.36)					
PSI PD ##	Parents age above median	31.80 (8.74)	25.93 (6.26)	24.53 (6.23)	0.977	2	0.382	0.032	Small
	Parents age below median	29.74 (9.44)	25.68 (9.02)	25.11 (10.56)					
PSI PCI ##	Parents age above median	23.13 (8.37)	19.27 (5.57)	19.27 (4.38)	0.349	2	0.707	0.011	Small
	Parents age below median	24.26 (8.52)	22.00 (6.32)	20.37 (7.01)					
PSI DC ##	Parents age above median	32.27 (7.03)	28.73 (8.05)	28.07 (8.94)	0.505	2	0.606	0.017	Small
	Parents age below median	33.21 (6.60)	27.58 (7.57)	28.16 (8.13)					

N= 34 (Parent's age above median = 15, Parent's age below median = 19)

using Greenhouse-Geisser correction ## using sphericity assumed

* significant at the 0.05 level, **0.01 level

Appendix 43

Repeated Measures ANOVA with between subject factor for child age, interaction effects

Measure	Between Subject Variable	Time 1 Mean (SD)	Time 2 Mean (SD)	Time 3 Mean (SD)	Test of between Subject Effects Interaction time*child age				
					f	df	sig	partial η^2	Effect size
Eyberg Intensity #	Child age above median	135.92 (20.23)	100.08 (19.94)	96.67 (25.56)	2.003	1.573	0.154	0.059	Small
	Child age below median	121.95 (23.65)	102.59 (18.18)	98.27 (25.23)					
Eyberg Problem #	Child age above median	15.17 (7.15)	3.83 (4.00)	3.67 (4.42)	3.624	1.179	0.058	0.102	Moderate
	Child age below median	10.36 (5.35)	4.27 (4.51)	3.45 (4.67)					
Parent Confidence #	Child age above median	40.42 (9.50)	51.58 (9.43)	53.17 (8.47)	0.058	1.564	0.906	0.002	-
	Child age below median	45.27 (7.55)	56.31 (6.57)	57.23 (7.80)					
Parent Stress total ##	Child age above median	99.50 (19.57)	84.00 (17.24)	84.00 (19.42)	0.476	2	0.624	0.015	Small
	Child age below median	80.36 (15.57)	70.05 (13.93)	66.77 (16.03)					
PSI PD ##	Child age above median	35.75 (10.15)	30.50 (9.75)	29.25 (10.01)	0.110	2	0.896	0.003	-
	Child age below median	27.86 (7.22)	23.23 (5.16)	22.45 (7.21)					
PSI PCI ##	Child age above median	28.50 (10.03)	22.83 (7.25)	22.83 (7.35)	1.919	2	0.155	0.057	Small
	Child age below median	21.18 (6.08)	19.68 (5.18)	18.27 (4.41)					
PSI DC ##	Child age above median	35.25 (4.47)	30.67 (5.61)	31.92 (8.44)	0.387	2	0.681	0.012	Small
	Child age below median	31.45 (7.40)	26.68 (8.40)	26.05 (7.74)					

N= 34 (Child's age above median = 12, Child's age below median = 22)

using Greenhouse-Geisser correction ## using sphericity assumed * significant at the 0.05 level, **0.01 level

Appendix 44

MANOVA, repeated measures ANOVAs and post hoc tests for those who score above clinical levels of Parental Distress

Measure	Time 1 Mean (SD)	Time 2 Mean (SD)	Time 3 Mean (SD)	Main effect over time				
				f	df	sig	partial η^2	Effect size
Eyberg Intensity ##	130.89 (19.20)	105.44 (24.02)	101.89 (23.34)	6.168	2	0.010**	0.435	Large
Eyberg Problem #	13.67 (8.54)	4.56 (4.59)	4.44 (5.15)	7.197	1.134	0.023*	0.474	Large
Parent Confidence ##	39.33 (8.66)	50.44 (9.68)	50.44 (8.79)	12.841	2	0.000**	0.618	Large
Parent Stress total ##	107.11 (14.91)	89.22 (17.62)	87.56 (13.37)	14.339	2	0.000**	0.642	Large
PSI PD##	42.11 (5.75)	34.22 (8.54)	34.00 (7.43)	10.119	2	0.001*	0.558	Large
PSI PCI##	28.78 (10.34)	24.56 (8.52)	22.33 (6.98)	3.568	2	0.052	0.308	Large
PSI DC##	36.22 (2.49)	30.44 (4.75)	31.22 (3.53)	8.755	2	0.003**	0.523	Large
MANOVA	Wilks $\lambda = 0.177$ $F = 2.519$ (df 12,22), $p < 0.029^*$ $\eta^2 = 0.579$ effect size = Large							

N = 9 # using Greenhouse-Geisser correction ## using sphericity assumed

*significant at the 0.05 level, **0.01 level

Scales	T1-T2			T1-T3			T2-T3		
	MD	SE	Sig	MD	SE	Sig	MD	SE	sig
Eyberg intensity	25.44	9.58	0.087	29.00	10.81	0.084	3.56	5.88	1.000
Eyberg Problem	9.11	3.36	0.080	9.22	3.33	0.073	0.11	0.99	1.000
Parent confidence	-11.11	1.62	0.000**	-11.11	3.11	0.022*	0.00	2.60	1.000
Psi total	17.89	4.84	0.018*	19.56	3.92	0.003**	1.67	3.23	1.000
PSI PD	7.89	1.80	0.007**	8.11	2.44	0.031*	0.22	1.86	1.000
PSI PCI	4.22	2.69	0.464	6.44	2.48	0.095	2.22	2.16	1.000
PSI DC	5.78	1.68	0.027*	5.00	1.26	0.012*	-0.78	1.53	1.000

N = 9

Adjustment for multiple comparisons: Bonferroni

* significant at the 0.05 level, **0.01 level

Appendix 45

MANOVA, repeated measures ANOVAs and post hoc tests for those who score below clinical levels of Parental Distress

Measure	Time 1 Mean (SD)	Time 2 Mean (SD)	Time 3 Mean (SD)	Main effect over time				
				f	df	sig	partial η^2	Effect size
Eyberg Intensity #	125.44 (24.68)	100.36 (16.55)	96.20 (25.82)	17.913	1.569	0.000**	0.427	Large
Eyberg Problem #	11.48 (5.50)	3.96 (4.25)	3.20 (4.33)	37.115	1.181	0.000**	0.607	Large
Parent Confidence #	45.08 (8.05)	56.16 (6.75)	57.72 (7.15)	51.504	1.576	0.000**	0.682	Large
Parent Stress total ##	79.92 (15.10)	69.84 (12.73)	67.56 (17.99)	8.869	2	0.001**	0.270	Large
PSI PD##	26.52 (5.90)	22.76 (4.84)	21.56 (6.73)	8.129	2	0.001**	0.253	Large
PSI PCI##	21.96 (6.88)	19.44 (4.40)	19.00 (5.40)	4.025	2	0.024*	0.144	Large
PSI DC##	31.56 (7.32)	27.24 (8.42)	27.00 (9.33)	5.118	2	0.010**	0.176	Large
MANOVA	Wilks $\lambda = 0.193$ $F = 7.645$ (df 14,84), $p < 0.000$ ** $\eta^2 = 0.560$ effect size = Large							

N = 25 # using Greenhouse-Geisser correction ## using sphericity assumed

*significant at the 0.05 level, **0.01 level

Scales	T1-T2			T1-T3			T2-T3		
	MD	SE	Sig	MD	SE	Sig	MD	SE	sig
Eyberg intensity	25.08	4.99	0.000**	29.24	6.47	0.000**	4.16	4.13	0.970
Eyberg Problem	7.52	1.21	0.000**	8.28	1.31	0.000**	0.760	0.448	0.309
Parent confidence	-11.08	1.18	0.000**	-12.64	1.67	0.000**	-1.56	1.16	0.570
Psi total	10.08	2.97	0.007**	12.36	3.50	0.005**	2.28	2.87	1.000
PSI PD	3.76	1.04	0.004**	4.96	1.30	0.003**	1.20	1.48	1.000
PSI PCI	2.52	1.22	0.148	2.96	1.28	0.088	0.44	0.83	1.000
PSI DC	4.32	1.65	0.045*	4.56	1.82	0.059	0.24	1.30	1.000

N = 25

Adjustment for multiple comparisons: Bonferroni

* significant at the 0.05 level, **0.01 level

Appendix 46

Repeated Measures ANOVA with between subject factor for clinical levels of Parental Distress

Measure	Between Subject Variable	Time 1 Mean (SD)	Time 2 Mean (SD)	Time 3 Mean (SD)	Test of between Subject Effects				
					f	df	sig	partial η^2	Effect size
Eyberg Intensity	Above clinical level	130.89 (19.20)	105.44 (24.02)	101.89 (23.34)	0.701	1	0.409	0.021	Small
	Below clinical level	125.44 (24.68)	100.36 (16.55)	96.20 (25.82)					
Eyberg Problem	Above clinical level	13.67 (8.54)	4.56 (4.59)	4.44 (5.15)	0.857	1	0.362	0.026	Small
	Below clinical level	11.48 (5.50)	3.96 (4.25)	3.20 (4.33)					
Parent Confidence	Above clinical level	39.33 (8.66)	50.44 (9.68)	50.44 (8.79)	5.790	1	0.022 *	0.153	Large
	Below clinical level	45.08 (8.05)	56.16 (6.75)	57.72 (7.15)					
Parent Stress total	Above clinical level	107.11 (14.91)	89.22 (17.62)	87.56 (13.37)	19.805	1	0.000 **	0.382	Large
	Below clinical level	79.92 (15.10)	69.84 (12.73)	67.56 (17.99)					
PSI PD	Above clinical level	42.11 (5.75)	34.22 (8.54)	34.00 (7.43)	44.339	1	0.000 **	0.581	Large
	Below clinical level	26.52 (5.90)	22.76 (4.84)	21.56 (6.73)					
PSI PCI	Above clinical level	28.78 (10.34)	24.56 (8.52)	22.33 (6.98)	5.607	1	0.024 *	0.149	Large
	Below clinical level	21.96 (6.88)	19.44 (4.40)	19.00 (5.40)					
PSI DC	Above clinical level	36.22 (2.49)	30.44 (4.75)	31.22 (3.53)	2.785	1	0.105	0.080	Moderate
	Below clinical level	31.56 (7.32)	27.24 (8.42)	27.00 (9.33)					

N=34 (above clinical level = 9, below clinical level = 25)

* significant at the 0.05 level, **0.01 level

Appendix 47

Repeated Measures ANOVA with between subject factor for clinical levels of Parental Distress, interaction effects

Measure	Between Subject Variable	Time 1 Mean (SD)	Time 2 Mean (SD)	Time 3 Mean (SD)	Test of between Subject Effects Interaction time*clinical levels of Parental distress				
					f	df	sig	partial η^2	Effect size
Eyberg Intensity #	Above clinical level	130.89 (19.20)	105.44 (24.02)	101.89 (23.34)	0.002	1.556	0.994	0.000	-
	Below clinical level	125.44 (24.68)	100.36 (16.55)	96.20 (25.82)					
Eyberg Problem #	Above clinical level	13.67 (8.54)	4.56 (4.59)	4.44 (5.15)	0.219	1.164	0.679	0.007	-
	Below clinical level	11.48 (5.50)	3.96 (4.25)	3.20 (4.33)					
Parent Confidence #	Above clinical level	39.33 (8.66)	50.44 (9.68)	50.44 (8.79)	0.215	1.564	0.752	0.007	-
	Below clinical level	45.08 (8.05)	56.16 (6.75)	57.72 (7.15)					
Parent Stress total ##	Above clinical level	107.11 (14.91)	89.22 (17.62)	87.56 (13.37)	1.135	2	0.328	0.034	Small
	Below clinical level	79.92 (15.10)	69.84 (12.73)	67.56 (17.99)					
PSI PD ##	Above clinical level	42.11 (5.75)	34.22 (8.54)	34.00 (7.43)	1.526	2	0.225	0.046	Small
	Below clinical level	26.52 (5.90)	22.76 (4.84)	21.56 (6.73)					
PSI PCI	Above clinical level	28.78 (10.34)	24.56 (8.52)	22.33 (6.98)	1.078	2	0.346	0.33	Small
	Below clinical level	21.96 (6.88)	19.44 (4.40)	19.00 (5.40)					
PSI DC	Above clinical level	36.22 (2.49)	30.44 (4.75)	31.22 (3.53)	0.139	2	0.871	0.004	-
	Below clinical level	31.56 (7.32)	27.24 (8.42)	27.00 (9.33)					

N=34 (above clinical level = 9, below clinical level = 25)

using Greenhouse-Geisser correction ## using sphericity assumed

* significant at the 0.05 level, **0.01 level

Appendix 48

MANOVA, repeated measures ANOVAs and post hoc tests for those on the HHIP

	Time 1 Mean (SD)	Time 2 Mean (SD)	Time 3 Mean (SD)	Main effect over time				
				f	df	sig	partial η^2	Effect size
Eyberg Intensity ##	141.42 (34.49)	110.54 (34.73)	105.29 (29.69)	13.817	2	0.000**	0.375	Large
Eyberg Problem ##	14.92 (6.90)	6.33 (6.67)	5.88 (6.75)	21.801	2	0.000**	0.487	Large
Parent Confidence ##	41.47 (9.02)	55.77 (8.93)	55.67 (7.29)	32.355	2	0.000**	0.585	Large
Parent Stress total ##	101.79 (16.16)	82.04 (18.08)	79.92 (14.78)	15.637	2	0.000**	0.405	Large
PSI PD##	31.75 (8.98)	27.88 (8.57)	26.46 (7.34)	4.172	2	0.022*	0.154	Large
PSI PCI##	28.58 (7.49)	23.46 (7.18)	23.58 (6.13)	7.032	2	0.002**	0.234	Large
PSI DC##	39.08 (9.14)	29.33 (7.05)	29.17 (8.99)	21.494	2	0.000**	0.483	Large
MANOVA	Wilks $\lambda = 0.304$ F=4.652 (df 14,80), p<0.000** np2 = 0.449 effect size = Large							

N = 24 # using Greenhouse-Geisser correction ## using sphericity assumed

*significant at the 0.05 level, **0.01 level

Scales	T1-T2			T1-T3			T2-T3		
	MD	SE	Sig	MD	SE	Sig	MD	SE	sig
Eyberg intensity	30.88	7.83	0.002**	36.13	7.76	0.000**	5.25	6.63	1.000
Eyberg Problem	8.58	1.37	0.000**	9.04	1.79	0.000**	0.46	1.44	1.000
Parent confidence	-14.29	2.25	0.000**	-14.19	2.24	0.000**	0.10	1.57	1.000
Psi total	19.75	4.15	0.000**	21.88	4.61	0.000**	2.13	4.17	1.000
PSI PD	3.88	1.9	0.143	5.29	1.89	0.031*	1.42	1.94	1.000
PSI PCI	5.13	1.47	0.006**	5.00	1.80	0.032*	-0.13	1.37	1.000
PSI DC	9.75	1.76	0.000**	9.92	1.81	0.000**	0.17	1.62	1.000

N = 24

Adjustment for multiple comparisons: Bonferroni

* significant at the 0.05 level, **0.01 level

Appendix 49

Repeated Measures ANOVA with between subject factor for HHIP vs HHGP

Measure	Between Subject Variable	Time 1 Mean (SD)	Time 2 Mean (SD)	Time 3 Mean (SD)	Test of between Subject Effects				
					f	df	sig	partial η^2	Effect size
Eyberg Intensity	HHIP	141.42 (34.49)	110.54 (34.73)	105.29 (29.69)	3.494	1	0.067	0.059	Small
	HHGP	126.88 (23.20)	101.71 (18.55)	97.71 (24.97)					
Eyberg Problem	HHIP	14.92 (6.90)	6.33 (6.67)	5.88 (6.75)	4.487	1	0.039*	0.074	Moderate
	HHGP	12.06 (6.38)	4.12 (4.28)	3.53 (4.51)					
Parent Confidence	HHIP	41.47 (9.02)	55.77 (8.93)	55.67 (7.29)	0.040	1	0.842	0.001	-
	HHGP	43.56 (8.48)	54.65 (7.90)	55.79 (8.16)					
Parent Stress total	HHIP	101.79 (16.16)	82.04 (18.08)	79.92 (14.78)	6.441	1	0.014*	0.103	Medium
	HHGP	87.12 (19.19)	74.97 (16.39)	72.85 (18.95)					
PSI PD	HHIP	31.75 (8.98)	27.88 (8.57)	26.46 (7.34)	0.691	1	0.409	0.012	Small
	HHGP	30.65 (9.06)	25.79 (7.82)	24.85 (8.79)					
PSI PCI	HHIP	28.58 (7.49)	23.46 (7.18)	23.58 (6.13)	6.032	1	0.017*	0.097	Moderate
	HHGP	23.76 (8.35)	20.79 (6.07)	19.88 (5.94)					
PSI DC	HHIP	39.08 (9.14)	29.33 (7.05)	29.17 (8.99)	2.654	1	0.109	0.045	Small
	HHGP	32.79 (6.70)	28.09 (7.69)	28.12 (8.36)					

N= 58 (HHIP =24, HHGP = 34)

* significant at the 0.05 level, **0.01 level

Appendix 50

Repeated Measures ANOVA with between subject factor for HHIP vs HHGP, interaction effects

Measure	Between Subject Variable	Time 1 Mean (SD)	Time 2 Mean (SD)	Time 3 Mean (SD)	Test of between Subject Effects Interaction time*type of intervention				
					f	df	sig	partial η^2	Effect size
Eyberg Intensity ##	HHIP	141.42 (34.49)	110.54 (34.73)	105.29 (29.69)	0.408	2	0.666	0.007	-
	HHGP	126.88 (23.20)	101.71 (18.55)	97.71 (24.97)					
Eyberg Problem #	HHIP	14.92 (6.90)	6.33 (6.67)	5.88 (6.75)	0.071	1.576	0.892	0.001	-
	HHGP	12.06 (6.38)	4.12 (4.28)	3.53 (4.51)					
Parent Confidence ##	HHIP	41.47 (9.02)	55.77 (8.93)	55.67 (7.29)	1.058	1.760	0.344	0.019	Small
	HHGP	43.56 (8.48)	54.65 (7.90)	55.79 (8.16)					
Parent Stress total #	HHIP	101.79 (16.16)	82.04 (18.08)	79.92 (14.78)	1.731	2	0.182	0.030	Small
	HHGP	87.12 (19.19)	74.97 (16.39)	72.85 (18.95)					
PSI PD ##	HHIP	31.75 (8.98)	27.88 (8.57)	26.46 (7.34)	0.113	2	0.893	0.002	-
	HHGP	30.65 (9.06)	25.79 (7.82)	24.85 (8.79)					
PSI PCI #	HHIP	28.58 (7.49)	23.46 (7.18)	23.58 (6.13)	0.710	1.802	0.480	0.013	Small
	HHGP	23.76 (8.35)	20.79 (6.07)	19.88 (5.94)					
PSI DC ##	HHIP	39.08 (9.14)	29.33 (7.05)	29.17 (8.99)	4.127	2	0.020 *	0.069	Moderate
	HHGP	32.79 (6.70)	28.09 (7.69)	28.12 (8.36)					

N= 58 (HHIP =24, HHGP = 34)

using Greenhouse-Geisser correction ## using sphericity assumed

* significant at the 0.05 level, **0.01 level

Appendix 51

Independent T tests for the DC subscale of the PSI

Measure	Time period	Mean for HHGP [n = 34]	Mean for HHIP [n = 24]	T	Sig (2 tailed)
PSI DC	T1	32.79	39.08	-3.027	0.004**
PSI DC	T2	28.09	29.33	-0.628	0.532
PSI DC	T3	28.12	29.17	-0.456	0.650

* significant at the 0.05 level, **0.01 level

Appendix 52

Pilot and Revised Pre Semi Structures Interview Questions

Pilot Pre Semi structured Interview questions	Revised Pre Semi Structured Interview Questions
<ol style="list-style-type: none"> 1. How did you hear about holding hands? 2. What is it about the programme that encouraged you to take part? 3. Are there any aspects of the programme that concern you? 4. What are your main concerns relating to your child? Do these concerns depend on the situation? (do you feel you can manage your child's behaviour in all situations? what situations are difficult? What situations are easy / less difficult) <ol style="list-style-type: none"> a. How confident do you feel to deal with your child's behaviour? (what behaviour is most challenging?) b. How do you cope? What do you do to cope? 5. What are you hoping to get out of this programme? What do you think will be most useful? Are there any risks for you in doing this programme? 6. How do you feel about taking part in the programme? 	<ol style="list-style-type: none"> 1. How did you hear about holding hands? <ol style="list-style-type: none"> a. How did you become involved? 2. What is it about the programme that encouraged you to take part? 3. Are there any aspects of the programme that concern you? 4. What are your main concerns relating to your child? Do these concerns depend on the situation? (do you feel you can manage your child's behaviour in all situations? what situations are difficult? What situations are easy / less difficult) <ol style="list-style-type: none"> a. How confident do you feel to deal with your child's behaviour? (what behaviour is most challenging?) b. How do you cope? What do you do to cope? 5. What activities do you do with your child? (on own/with others) (examples – how frequent?) 6. What do you think you do well? (Feel confident in doing?) 7. What are you hoping to get out of this programme? What do you think will be most useful? Are there any risks for you in doing this programme? 8. How do you feel about taking part in the programme?

Appendix 53

Pilot and Revised Post Semi Structured Interview Questions

Pilot Post Semi structured Interview questions	Final Post Semi Structured Interview Questions
<p>1. Do you feel that the project has been beneficial?</p> <p style="padding-left: 40px;">a. If no what could have been improved?</p> <p>(If not much detail: Do you feel that there has been some progress in your child's play skills/you and your child's interactions/your confidence/your stress levels since the start of the project?</p> <p>- If yes in what ways?</p> <p>- If no has there been any change? How?)</p> <p>2. What part did you like the most?</p> <p>- why?</p> <p>3. Which part did you like the least?</p> <p>- why?</p> <p>4. Which FLIP message was the most useful? (FLI or P - Was labelled praise more or less useful than setting limits and boundaries? Or was following your child's lead most useful?)</p> <p>5. Did you think there was the right number of sessions?</p> <p>- if no , too few or too many?</p> <p>- If too few what else would you have wanted?</p> <p>- If too many what would you have left out?</p> <p>- How many sessions do you think would be useful?</p> <p>- Were the sessions of the right length?...if</p>	<p>1. Do you feel that the project has been beneficial?</p> <p>- For you</p> <p>- For your child?</p> <p style="padding-left: 40px;">b. If yes in what ways, what is it about the programme that brought about change? how would it help others?</p> <p style="padding-left: 40px;">c. If no what could have been improved?</p> <p>(If not much detail: Do you feel that there has been some progress in your child's play skills/you and your child's interactions/your confidence/your stress levels since the start of the project?</p> <p>- If yes in what ways?</p> <p>- If no has there been any change? How?)</p> <p>2. What part did you and your child like the most?</p> <p>- why?</p> <p>3. Which part did you and your child like the least?</p> <p>- why?</p> <p>4. Which FLIP message was the most useful? (FLI or P - Was labelled praise more or less useful than setting limits and boundaries? Or was following your child's lead most useful?)</p> <p>5. Did you think there was the right number of sessions?</p>

<p>no, why not?</p> <p>-Was the content of the sessions/ the information given helpful?</p> <p>- Did you like how the sessions were delivered? The activities?</p> <p>6. Were the other people in the group helpful to your experience?</p> <p>- if yes in what ways did they help? (giving ideas/not feeling on your own)</p> <p>- if no were they unhelpful? Would you have preferred to have the sessions individually?</p> <p>7. how useful was the FSW?</p> <p>8. how useful was the EP?</p> <p>9. Was it useful to have activities to complete between the sessions?</p> <p>- if yes why?</p> <p>- if no why?</p> <p>- are the ideas something you will continue using?</p> <p>- can you identify most useful activity and least useful activity?</p> <p>10. What do you think had the greatest impact on you?</p> <p>11. DO you think the programme would be useful for others?</p> <p>- if yes – would you recommend it?</p> <p>- if no – what changes would you make?</p> <p>12. Are there any other comments you would like us to know?</p>	<p>- if no , too few or too many?</p> <p>- If too few what else would you have wanted?</p> <p>- If too many what would you have left out?</p> <p>- How many sessions do you think would be useful?</p> <p>- Were the sessions of the right length?...if no, why not?</p> <p>- Was the content of the sessions/ the information given helpful?</p> <p>-Did you like how the sessions were delivered? The activities?</p> <p>6. Were the other people in the group helpful to your experience?</p> <p>- if yes in what ways did they help? (giving ideas/not feeling on your own)</p> <p>-if no were they unhelpful? Would you have preferred to have the sessions individually?</p> <p>7. how useful was the FSW?</p> <p>8. how useful was the EP?</p> <p>9. Was it useful to have activities to complete between the sessions?</p> <p>- if yes why?</p> <p>- if no why?</p> <p>- are the ideas something you will continue using?</p> <p>- can you identify most useful activity and least useful activity?</p> <p>10. What do you think had the greatest impact on you?</p> <p>11. Do you think the programme would be</p>
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	<p>useful for others?</p> <ul style="list-style-type: none"> - if yes – would you recommend it? - if no – what changes would you make? <p>12. At the pre interview you said you thought.... would be the most useful. Did it turn out this way?</p> <ul style="list-style-type: none"> - if no why do you think this was? <p>13. At the pre interview you were concerned about... aspect of the programme. Did taking part remove this worry?</p> <p>14. At the pre interview you indicated that</p> <ul style="list-style-type: none"> - you found most challenging/ were most concerned about... has this improved? If so how? - that these concerns remained constant/differed across situations. Has this improved/been maintained? - you were/were not confident in dealing with your child's behaviour. Has this improved/been maintained? <p>15. Are there any other comments you would like us to know?</p>
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Appendix 54

Sample Transcript from Pre Interviews showing Initial Coding

Transcribed Data	Initial Coding (initial theme)
<p>BH: How did you hear about holding hands programme?</p> <p>NL: Through A, umm because she was told about it by S in here and she said oh you'd probably benefit as well from doing this course.</p> <p>BH: Ok so that's XX's mum</p> <p>NL: Yeah XX's mum</p> <p>BH: Ok and so then did you come in and S told you about it?</p> <p>NL: Yeah, A had already put her name down and I came and saw S and said can I put my name down as well, just cos I asked her a bit more about it, but she didn't really know much. That's when she gave me the leaflet.</p> <p>BH: Ok</p> <p>NL: So I thought it might help you know anything has got to be better than nothing</p> <p>BH: Um what is it about the programme that encouraged you to take part?</p> <p>NL: Um the boundaries, mostly the boundaries really, like getting the children to learn their boundaries. Cos you know, his behaviour, sometimes his behaviour's not brilliant especially things like sharing</p> <p>BH: Sharing</p> <p>NL: Yeah, Sharing toys and sort of when you say to him like go and do this and he says no mummy</p> <p>BH: So is it the sort of strategies? Gaining the strategies?</p>	<p>By FSW</p> <p>I put my name down</p> <p>Thought it might help</p> <p>The boundaries (hope for the group) His behaviour's not brilliant (difficulties with child)</p> <p>Sharing toys (difficulties with child) He says no mummy (difficulties with child)</p> <p>Yeah gaining strategies (strategies)</p>

<p>NL: Yeah, gaining strategies and to get him to do things that I want him to do really without him realising</p> <p>BH: Ok</p> <p>NL: But he's not silly that's the only thing. (laughs)</p> <p>BH: Ok. Are there any aspects of the programme that concern you? Or that you are worried about?</p> <p>NL: No not really</p> <p>B H: Ok do you have any concerns about XX at all?</p> <p>NL: Yes, sleeping</p> <p>BH: Sleeping?</p> <p>NL: Sleeping he's a nightmare, sleeping and eating</p> <p>BH: Sleeping and eating?</p> <p>NL: Yeah, really bad.</p> <p>BH: Is it a case of he won't go to bed? Or once he's in bed he'll wake up? Or..</p> <p>NL: No he'll go to bed, but like lately he's been waking up every hour and it's like, he always been a nightmare from a very young baby, like sleeping so I about a year ago I started doing the controlled crying and they say, cos I was doing an online forum as well, a sleep forum, and they give you a book and you follow all these different things but umm, he did the controlled crying for longer than what they said and it still didn't work, the only thing that helped was he fell asleep quicker but he didn't stay asleep and he kept waking up and wanting milk or.. and then now it's just got to the point.. like a couple of weeks before Christmas he started to sleep through, for the last three of four nights and I thought great but then</p>	<p>Not really (negatives)</p> <p>Sleeping (difficulties with child)</p> <p>And eating (difficulties with child)</p> <p>He's been waking up every hour (difficulties with child)</p> <p>Always been a nightmare (difficulties with child)</p> <p>Controlled crying (strategies tried)</p> <p>Online forum (strategies tried)</p> <p>Kept waking up (difficulties with child)</p>
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<p>Christmas came and he just got worse and made himself sick and so I am going to go and see a health visitor about it later cos its just getting to the point where it's like urghhh ridiculous</p> <p>BH: Yeah</p> <p>NL: It every hour now</p> <p>BH: And of course if he's tired</p> <p>NL: But yeah she's told me she thinks it's night terrors</p> <p>BH: Ok</p> <p>NL: I don't know, you know so she's going to contact me, the thing is I'd love him to sleep through, he's two and a half so he should be sleeping through now and the food thing is, he's a nightmare with food.</p> <p>BH: Ok</p> <p>NL: He does not like it</p> <p>BH: So there are things he doesn't like</p> <p>NL: He just won't even try anything, you can try and put it in front of him but he's mmm. Tasty food. That's why me and A started to have lunch together to get them to eat better, cos obviously its better when he's got his friends around, but he won't eat certain things still but..</p> <p>BH: Ok</p> <p>NL: Terrible</p> <p>BH: What sort of things does he eat? Or like?</p> <p>NL: The only things he'll eat at the moment is um.. he just recently, which I suppose is a break through really, started eating fish, he wouldn't eat fish before, like flipper dipper things, fish fingers and things. He loves peas, he's always been</p>	<p>Just got worse and made himself sick (difficulties with child)</p> <p>It's like urghhh ridiculous (frustrations)</p> <p>She told me she thinks it's night terrors (interactions with professionals)</p> <p>He's two and a half so he should be sleeping through (comparisons)</p> <p>He won't even try anything (difficulties with child)</p> <p>It's better when he's got his friends around (comparisons)</p> <p>Terrible (frustrations)</p>
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<p>quite good with peas, potatoes, he loves carrots,</p> <p>BH: They're good things to like!</p> <p>NL: Yeah yeah but he won't eat meat. Now I'm vegetarian and my husband says it's my fault cos I force my feelings but I always try to put ... and meat ... but he won't eat it, he won't eat beef, he won't eat chicken, and chicken everyone says oh all kids like chicken, but he won't eat it.</p> <p>BH: Ok</p> <p>NL: I try and disguise it but he picks it out. He's terrible.</p> <p>BH: So you said he's better if he's eating with friends?</p> <p>NL: Yeah but he still won't eat chicken or meat with them.</p> <p>BH: Ok</p> <p>NL: He has a sandwich with them</p> <p>BH: So when is it more difficult, if it just him eating or</p> <p>NL: Um no its all the time if we are all sitting together</p> <p>BH: Ok</p> <p>NL: He's always been a bit of a nightmare with eating. It's just infuriating cos everyone else you speak to is like my kids eats this and they sit down nicely to eat their food and he just sits there and then he sees it and then he wanders off and it's like get back and eat it but ... and all he wants to eat is crisps</p> <p>BH: Crisps?</p> <p>NL: Yeah cos I took him to the doctors over it and the doctor said to me don't worry about it, give him crisps you don't see</p>	<p>My husband says it's my fault (self impacting on child)</p> <p>I try and disguise it (strategies tried)</p> <p>It's just infuriating (frustrations)</p> <p>Cos everyone else you speak to is like my kid eats this (comparisons)</p> <p>I took him to the doctors (interactions with professionals)</p>
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<p>adults living of crisps he'll get bored of it soon. But that was a year ago and so</p> <p>BH: He hasn't got bored yet</p> <p>NL: No and he won't eat breakfast, he used to love fruit, he liked bananas and apples and that but now hell only eat grapes. It's just urghhh</p> <p>BH: I can see that it must be frustrating</p> <p>NL: Yeah, it is very frustrating. It annoys my husband as well, cos even though my husband's not there quite a few of the meal times when he is at weekends it's like oh god he doesn't eat anything I don't know why you bother cooking for him you know but I have to try and give him something</p> <p>BH: Yeah it would be easy to give up so it's good that you keep trying</p> <p>NL: But he does like pasta so I suppose that's good but he only likes plain pasta, if I make him a sauce. The annoying thing is hell eat a sauce that my husband's mum gives him which is like a shop bought one but if I make him it he won't eat it yet it tastes better than the shop bought.</p> <p>BH: Ok</p> <p>NL: But he won't eat it for me, But he'll eat it for her, but he won't eat it for me</p> <p>BH: Ok</p> <p>NL: Cos I tried buying the shop bought stuff for him but he won't eat it</p> <p>BH: Ok so is it when he is at his Nan's house that he eats it?</p> <p>NL: Yeah he eats alright. But not always cos they said to me, they had him on Saturday and he wasn't very good with his food then</p>	<p>It's just urgh (frustrations)</p> <p>It annoys my husband as well (others noticed)</p> <p>He doesn't eat anything (difficulties with child)</p> <p>He'll eat a sauce that my husband's mum gives him (comparisons)</p> <p>He wont eat it for me, but he'll eat it for her (comparisons)</p>
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<p>BH: Ok</p> <p>NL: He loves, he'll only eat cucumber or something like that which there isn't any goodness in it. It's just annoying and I think that's all connected with the sleep as well. The food and sleep it's got to be all connected. I mean if you don't eat properly you're not going to sleep properly. Well I don't think</p> <p>BH: Ok</p> <p>NL: It's just annoying</p> <p>BH: So the eating and the sleeping and the things you find the most hard to manage with him?</p> <p>NL: Yeah definitely.</p> <p>BH: Ok</p> <p>NL: Oh and also he does have a few tantrums sometimes as well which they are getting better, because I know they do say that from the age of two and half they do have tantrums but he wasn't, he's not as bad but if you tell him to do something he goes no mummy no mummy, like answers you back and you think do you ignore it or...</p> <p>BH: When he says no what sort of strategies do you use to cope with that?</p> <p>NL: I say to him things like um right you're not going to see XX, or go to XX's house, not going to go to playgroup, not going to have any like your favourite Peppa pig on, so ... but it only works for a certain amount of time</p> <p>BH: Ok</p> <p>NL: And then he starts doing it again. And in the end I just say right televisions off and it doesn't seem to bother him he just goes and finds something else to do but..</p>	<p>It's just annoying (frustrations)</p> <p>Have a few tantrums (difficulties with child)</p> <p>Answers you back (difficulties with child)</p> <p>Not going to see XX (strategies tried)</p> <p>Not going to go to playgroup (strategies tried)</p> <p>Only works for certain amount of time (strategies tried)</p> <p>Televisions off (strategies tried)</p> <p>Doesn't seem to bother him (difficulties with child)</p>
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<p>BH: Ok so what sort of activities do you do with BL?</p>	
<p>NL: Um well I take him to a children's... um a mother and toddler groups</p>	<p>Mother and toddler groups (activities)</p>
<p>BH: Ok</p>	
<p>NL: We do messy Mondays here,</p>	<p>Messy Mondays (activities)</p>
<p>BH: That sounds fun</p>	
<p>NL: (Laughs), and Tuesday he goes to a toddler group, Wednesday he goes to a toddler group and sometimes through the children's centre we do like course like where we do stuff together like making things or activity type things, like six week, the last one was a six week course here where we did autumn scrapbooks, collecting of leaves and things like that and then they had a scrapbook and the one we are doing at the moment over there is story sacks where they do a story and put things in a sack so.</p>	<p>Toddler group (activities)</p> <p>Six week course (activities)</p> <p>Story sacks (activities)</p>
<p>BH: And are these groups where there are quite a few children?</p>	
<p>NL: Umm the one over there is about 6/7 children and messy Mondays has got loads of kids in, like it's really packed and obviously the lent rise on the Tuesdays that's always busy too.</p>	
<p>BH: Ok</p>	
<p>NL: I mean he's quite good at interacting with kids but I mean the only thing like, he's not so bad now, but I did have a problem with him like um pushing kids in the face and like I know they say they do at that age but</p>	<p>Good at interacting (opposite to difficulties with child)</p> <p>Pushing kids (difficulties with child)</p>
<p>BH: Yeah</p>	
<p>NL: He did used to go through a biting phase, he used to bite me,</p>	<p>Biting phase (difficulties with child)</p>

<p>BH: The music</p> <p>NL: Yeah the music and stories</p> <p>BH: Ok and are there any risks you can see about taking part in the programme?</p> <p>NL: No</p> <p>BH: Ok and last one how do you feel about taking part in the programme?</p> <p>NL: Yeah fine, quite excited actually</p> <p>BH: That good</p> <p>NL: Gain more knowledge on everything.</p>	<p>Gain more knowledge on everything (predicting what works)</p>
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Appendix 55

List of Initial Themes

- Other parents
- Professionals as supportive
- Accessing children's centres
- Being understood and listened to
- Difficulties with child
- Strategies tried
- Activities
- Comparisons
- Hopes for the group
- Predicting what works
- Strategies
- Ideas
- Reinforcing previous knowledge
- Child's point of view
- Self confidence
- Child behaviour
- Others noticed
- Interactions with professionals
- Interactions with other children
- Parent confidence
- Parent stress
- Parent-child interactions
- Self impacting on child
- Frustrations
- Consistency
- Flexibility
- Positives
- Negatives
- Structure

Appendix 56

Structure of reviewed themes

Over-arching Final Theme	Initial Themes Formed Sub-Themes (initial themes that have been merged into a different initial theme)
Support	<ul style="list-style-type: none"> • Other parents • Professionals as supportive (accessing children’s centres) • Being understood and listened to
Awareness	<ul style="list-style-type: none"> • Difficulties with child (strategies tried, activities) • Comparisons • Hopes for the group (predicting what works)
New knowledge	<ul style="list-style-type: none"> • Strategies • Ideas • Reinforcing previous knowledge
Reconstructing	<ul style="list-style-type: none"> • Child’s point of view • Self confidence
Changes	<ul style="list-style-type: none"> • Child behaviour (others noticed, interactions with professionals, interactions with other child) • Parent confidence AND parent stress • Parent-child interactions
Interactions	<ul style="list-style-type: none"> • Self impacting on child (frustrations) • Consistency • Flexibility
What worked vs What didn’t	<ul style="list-style-type: none"> • Positives • Negatives • Structure

Parenting Programmes: A Literature Review

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Parenting Programmes: A Literature Review

Introduction

Early childhood can be characterised as a stage in which children show externalising behaviours and disobedience (Côté, et al., 2002). These behaviours generally decrease over the course of natural development as children develop other strategies and relatively few children continue to display such behaviour beyond early childhood (Tremblay, 2000). Nevertheless, behaviour difficulties are one of the most common problems for which parents seek professional advice (Kazdin, et al., 1990) and they are becoming more common (Webster-Stratton & Hammond, 1997), with prevalence estimated at 6.9% of boys and 2.8% of girls aged 5 to 10 (NICE, 2006).

The pre-school years are a crucial stage of development (Nelson & Bosquet, 2000; Thompson, et al., 2003) and behaviour difficulties at this age are associated with significant risks of poor outcomes in the future (Campbell, et al., 2006; Fergusson, et al., 2005; Shepard & Dickstein, 2009; Shortt, et al., 2003; Tremblay, 2006). If behaviour difficulties emerging in early childhood are not addressed promptly they become more resistant to treatment later in life (Loeber & Dishion, 1983). Between 50%-75% of pre-school children who demonstrate behaviour difficulties continue to exhibit challenging behaviour up to 6 years later (DfES, 2003; Nixon, 2002).

The strong link between behavioural issues in infancy and difficulties later in life, together with the long-term cost implications of antisocial behaviour (Schweinhart, et al., 2005), provide the rationale for early preventative action (Nixon, 2002; Shepard & Dickstein, 2009). Prevention and early intervention are priorities in the government's strategy for promoting positive outcomes for children. Support by the recent Labour government was demonstrated by two green papers: Supporting Families (Home Office, 1998) and Every Child Matters (DfES, 2003). Despite rebranding, the focus on early intervention remains a priority for the new coalition government (Teather, 2010).

Parent-child interactions (PCIs) are highlighted as being of particular relevance and it is widely accepted that parenting programmes (PPs) are an effective mechanism for supporting children with behaviour difficulties (NICE, 2006; J. Patterson, Mockford, Barlow, Pyper, & Stewart-Brown, 2002; Scott, et al., 2001; Webster-Stratton, 1984; Webster-Stratton, et al., 1989), as well as being cost effective (Edwards, et al., 2007). It has also been shown that if PPs are implemented during preschool years they are more likely to be successful (Scott, O'Connor, & Futh, 2006) and to have positive long-term outcomes (Schweinhart, et al., 2005).

Three main psychological theories aim to explain the significance of parenting in the context of child behaviour difficulties: social learning theory (Bandura, 1978), attachment theory (Bowlby, 1969) and parenting styles theory (Snyder & Stoolmiller, 2002). Each theory suggests PPs with different foci. Due to the increasingly wide range of evidence-based PPs (Eyberg, et al., 2008), questions about which PPs are the most successful are raised. Is one approach more effective than another? Or is an approach that combines strategies more effective than one using a single approach?

This literature review will discuss relevant theory and demonstrate how different theories promote different styles of PPs. The review will then provide a more specific examination of PPs and their evaluation. I will then show how my research builds on this previous knowledge and offers a unique contribution to the field.

Method

This literature review was conducted in four inter-related stages; an extensive database search, selection of papers, review of papers and following up citations.

The data bases; 'Ebsco a-z', 'psychArticles' and 'pubmed' were used alongside Google Scholar to search for published material. Search terms focused on 'parenting programmes', 'behaviour issues' and 'early years'. This review primarily uses recent articles to ensure that it reflects the present context in which PPs operate. However, to illustrate that the arguments have evolved and developed over time key pieces of older research are also included. To support the academic literature I also searched

for Government documentation, reports from independent organisations and projects currently running in the UK.

Initial database searches returned 139 papers. Google Scholar searches returned thousands of articles and reports. In order to select papers, I focused on those that were more highly cited and which seemed most directly relevant from an initial reading of title and abstract. These included papers that reviewed a PP, discussed methods to improve PPs or looked at supporting theory. The main reason for excluding a paper was that it looked at methods of supporting children with behaviour difficulties other than PPs. The final stage of the process involved checking papers cited by or citing the papers selected at the earlier stage.

This review technique allowed me to gain a broad, current and relevant literature base that reflects a variety of perspectives. It also allowed me to place the argument in a historical context and demonstrate how the topic relates to other areas.

Background Theory and framework

Social Learning Theory (SLT)

Over recent years SLT has become the dominant theory explaining antisocial behaviour (Scott & Dadds, 2009). It offers an explanation of how childhood behaviour difficulties are developed and maintained. Bandura (1978) proposed that behaviour is learnt from appropriate social models, applying these ideas to the development of aggression (Bandura, 1978).

The basic principles of SLT revolve around reinforcement. If a child receives an immediate reward for their behaviour, they are more likely to repeat the behaviour. However, if the child receives a punishment for their behaviour, or the behaviour is ignored, they are less likely to repeat the behaviour (Hogg & Vaughan, 2002).

A further major component of SLT is modelling. Modelling is the 'tendency for a person to reproduce the actions, attitudes and emotional responses' of another (Hogg & Vaughan, 2002, p. 447). Children will readily imitate the actions of others even if the action is aggressive (Bandura, Ross, & Ross, 1963). This imitation of behaviour can occur if the behaviour is live, on television or in videogames (Bandura

& Walters, 1963; Huesmann & Miller, 1994; Sheehan, 1983). In families where the child displays antisocial behaviour, parents were also participating in this behaviour (G Patterson, 1982).

These processes of reinforcement and modelling can explain how an inappropriate behaviour is acquired and maintained. If a parent responds to a child's behaviour by letting the child have their own way, this reinforces the negative behaviour. Patterson (1982) described this cycle as a 'reinforcement trap'. When the parent gives in the child is learning that aggression is effective in getting their own way. However, there is then a tendency for the parent to become more and more aggressive in order to get the child to comply. The parent is then also learning that aggression works. A second 'reinforcement trap', outlined by Snyder and Stoomiller (2002), suggests that when children engage in more inappropriate behaviour they are less likely to be reinforced for positive behaviours. By only noticing and responding to inappropriate behaviour parents are reinforcing this cycle. These ideas of reinforcement links SLT with Parent-Child Interactions (PCIs).

If behaviour is learnt, as proposed by SLT, then it should be possible to change the behaviour by altering the reactions to the behaviour. Miles and Carey (1997) suggest that infants must learn not to associate desirable outcomes with inappropriate behaviour and learn to associate these outcomes with pro-social behaviour. A large range of effective PPs and interventions have evolved from this SLT approach (e.g. Sanders, 2008; Webster-Stratton & Reid, 2003). The principles are clear and provide an explicit structure to be followed.

However, even successful SLT based PPs often fail to improve the situation for all families (McIntyre & Phaneuf, 2008; Scott & Dadds, 2009) with between a quarter and a third of families not benefiting. This suggests that there needs to be something else within the intervention. SLT describes certain parental behaviours as being rewarding, for example granting attention, and others as punishing, for example time-outs. However, SLT fails to offer an explanation for why these behaviours are categorised this way. Therefore when attention from a parent fails to reinforce positive behaviour SLT cannot explain it. SLT also focuses on observable behaviour, rather than the internal thought processes. It focuses on what the parent

is doing rather than why they might be doing it. Two theories that may offer some additional explanation are attachment theory and parenting style theory.

Attachment theory

Bowlby's (1969) attachment theory offers an alternative explanation of the origins of early childhood behaviour difficulties. He claims that a child needs to develop a relationship with a primary care-giver in infancy for normal social and emotional development. How the parent responds to the child and the extent to which they provide a sense of emotional security and protection from harm leads to particular patterns of attachment. The pattern of attachment then leads to the development of an internal working model which the infant uses to guide their expectations in later social situations. Four patterns of attachment were identified; secure, avoidant, anxious (Ainsworth, Blehar, Waters, & Wall, 1978) and disorganised attachment (Carlson, Cicchetti, Barnett, & Braunwald, 1989).

Attachment patterns are associated with particular behaviour shown by the child. They have been shown to be significant for children's outcomes. Secure attachments seem to allow infants to develop into socially competent individuals (Berlin, Cassidy, & Appleyard, 2008). Insecure attachments have been linked with poor achievement, less successful social interactions, less secure relationships in adulthood (Sroufe, 2005) and behaviour problems in children (Belsky, Woodworth, & Crnic, 1996; Brumariu & Kerns, 2010; Fearon, et al., 2010; Greenberg, Speltz, Deklyen, & Endriga, 1991; Lyons-Ruth & Block, 1996; Lyons-Ruth, Easterbrooks, & Cibelli, 1997; McCartney, et al., 2004; Moss, et al., 2006). However, 'Early attachment experiences do not shape subsequent development in a fixed deterministic manner, so that insecure attachment is not synonymous with disturbance, nor is secure attachment a guarantee against disturbance.' (Scott & Dadds, 2009, p. 1443).

Mesman et al (2008) proposed three ways in which insecure attachments could lead to the development of behaviour difficulties. The first suggests that if infants have developed a negative internal working model due to unresponsive or insensitive parenting they will view adults as unreliable. This can result in oppositional behaviour and reactive aggression. The second views the behaviour difficulties as a

strategy that the infant uses in order to gain attention from the care-giver and so elicit an attachment. The third proposal suggests that the attachment pattern influences a child's socialisation. A secure attachment results in a child motivated to comply with requests, whereas an insecure attachment results in a child not motivated to comply. Non-compliance is then seen as a behaviour difficulty.

Bowlby originally proposed that attachment patterns were stable and persistent throughout development. Therefore although attachment theory could explain why certain parental behaviours may not be rewarding in SLT approaches, it raises the question of how PPs can have an impact for children who have already formed insecure attachments. However, ideas about attachment stability have been modified and attachment patterns are seen as less fixed and irreversible. Schaffer (2003) proposes that the stability of attachment appears to be linked to stability in conditions. Belsky et al (2006) support this proposal and suggest that attachment patterns can be altered with changes in the quality of care-giving. Therefore, if a PP can increase the levels of parenting sensitivity and responsiveness (Bakermans-Kranenburg, Van IJzendoorn, & Juffer, 2003) outcomes for children can be improved.

The main difference between attachment-based PPs and SLT-based PPs is the acknowledgment that parent-child interactions (PCIs) are not solely about rewards and punishment. There is an emotional significance of having someone respond to the child's needs and who can be relied upon. Bakermans-Kranenburg et al (2003) reviewed 81 studies that looked at attachment-based PPs. They found improvement in levels of parenting sensitivity and responsiveness in most cases. However, Scott and Dadds (2009) argue that attachment-based interventions may not be as successful with older children. Instead they promote the idea that interventions that combine elements of both attachment theory and SLT will be the most successful.

Parenting style theory

A parenting style is a psychological construct that represents strategies a parent uses to raise their child. Cultural and situational factors such as how they were raised themselves are likely to have impacted on a parent's beliefs about parenting.

These internal thought processes can then influence the parenting style they demonstrate.

Baumrind (1971) proposed three categories of parenting style: authoritative, indulgent or authoritarian. These categories are conceptualised along two scales; responsive vs. unresponsive and demanding vs. undemanding. A fourth category, neglectful parenting, was added by Maccoby and Martin (1983).

Each parenting style is characterised by different parent behaviours and strategies. Authoritative parenting, using appropriate praise but also imposing consistent boundaries and discipline, tends to result in children with higher self-esteem and an ability to regulate behaviour. Indulgent parenting, accepting children's behaviour and not requiring any regulation, tends to result in children who show impulsive behaviour. Authoritarian parenting, using restrictive limits while displaying lower emotional responsiveness, tends to result in low self-esteem and social competence. Neglectful parenting, providing for basic needs but often dismissive and emotionally uninvolved, tends to result in insecure attachment and internalizing or externalizing behaviour difficulties (Aunola, Stattin, & Nurmi, 2000; D. Baumrind, 1966; D Baumrind, 1971; Simons & Conger, 2007; Snyder & Stoolmiller, 2002).

A meta-analysis by Hoeve et al (2009) found that combinations of authoritarian and neglectful parenting were the best predictors of delinquency. Parenting that uses psychological control has been linked to high levels of externalising behaviour (Aunola & Nurmi, 2005) and lower emotional regulation (Manzeske & Stright, 2009) in children. Walton (2010) demonstrated that maternal warmth is an important factor for children to show regulated behaviour.

Baumrind (1971) described parenting styles as stemming from the parent's behaviour. This would suggest that if a PP could alter the behaviour of the parent then outcomes for the child would improve. However, this leaves out the vital influence of the child on the relationship. It seems more likely that parenting is a two-way relationship between the child and parent(s) (Gallagher, 2002) and that it can be influenced by the temperament of both the parent and child, as well as

cultural and situational factors. This shifts the focus away from the parent towards PCIs.

Parent-Child Interactions.

A common theme from the above three theories is PCIs. There is a strong theme in the literature focusing on the relationship and interactions between the parent and child, rather than on the behaviour of either (Barlow & Schrader-MacMillan, 2009; Barlow & Svanberg, 2009; Kennedy, Landor, & Todd, 2010).

All three theories offer explanations of how negative PCIs develop. SLT emphasises parental use of inconsistent discipline that reinforces challenging behaviour. Attachment theory stresses the importance of the child's internal working model and PCIs in the first years of life. Parenting styles research focuses on the beliefs held by parents about how a child should be parented and the strategies that grow out of these beliefs.

Just as each theory provides an explanation for negative PCIs, each provides a view of how positive PCIs could be achieved. SLT encourages the use of successful discipline techniques, attachment theory highlights the level of parental responsiveness and sensitivity and parenting styles emphasises parental behaviour to include high levels of warmth.

However, it is likely that all three explanations contribute to the development of negative PCIs. This suggests that an intervention that combined elements of all three theories would be the most effective in developing positive PCIs (Scott & Dadds, 2009). Recent research indicates that PPs are most effective when they address both the quality of the parent-child relationship, including parental sensitivity, and use positive structured discipline strategies (Bakermans-Kranenburg, et al., 2003; Kaminski, Valle, Filene, & Boyle, 2008; Scott, et al., 2006).

These three theories can be understood in the context provided by the ecological model (Bronfenbrenner, 1977). It provides a useful framework through which to explore the complex nature of parenting. The eco-systemic levels illustrate how

factors that influence parents and child are entwined in a hierarchy (figure 1 and table 1).

Figure 1:

Bronfenbrenner's Model of the Ecology of Human Development

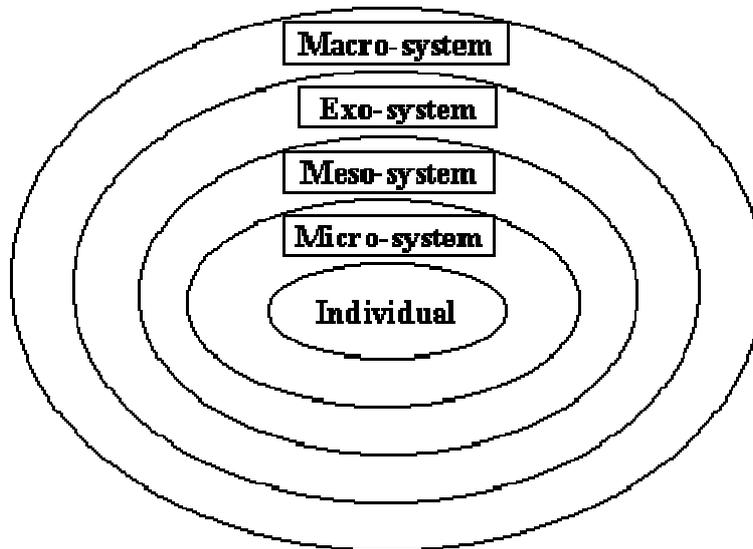


Table 1: The eco-systemic levels of family dynamics.

Micro-system	Individual differences of the parent and child e.g. child temperament, parenting styles, roles and interactions of the individuals.
Meso-system	The relation between two or more settings in which the individual participates e.g. work and home.
Exo-system	Settings which impact on the individual but are normally outside their control e.g. local community or church.
Macro-System	Wider political, social and cultural influences. Impacts on lower levels due to how it shapes values, laws and customs.

PPs with PCIs as their focus concentrate on the micro-level. However, due to the interconnectedness between and within levels, family dynamics and PCIs are influenced by changes at a variety of levels. These complex interactions link to the ideas discussed above about the bi-directional nature of parenting styles (Gallagher, 2002; GR Patterson, DeBaryshe, & Ramsey, 1989).

The literature proposes that holistic services which support all levels of the ecological model would be the most beneficial. However, in practice most services available to families focus on the micro and meso-levels. Clinically developed, evidence-based PPs often do not take the outer levels into account, leading to the criticism that they cannot be successfully transported to a community setting (Phillips, et al., 2008) where these higher levels can be influential.

Combining ideas from the three theories outlined above and targeting multiple levels of the ecological framework are important. In order to build on these insights it is important to review the literature on existing PPs.

Current evidence base on parenting programmes

This section begins by reviewing the basic idea of PPs and laying out the major themes, ideas and limitations, drawing on academic literature, independent evaluations and Government funded research. I will then consider two specific PPs and several current UK projects before demonstrating how my work will build on existing knowledge and make a contribution.

PPs are accepted as being one of the most effective and successful methods of supporting behaviour difficulties (Barlow & Stewart-Brown, 2000; Barrett, 2010; Butt, 2009; Dretzke, et al., 2009; Hallum, et al., 2004; Moran, et al., 2004; NICE, 2006; J. Patterson, et al., 2002; Scott, et al., 2001; Webster-Stratton, 1984; Webster-Stratton, et al., 1989; Webster Stratton & Hammond, 1999). However this general acceptance of PPs is fairly recent. Historically a medical model identifying a process of assessment, diagnosis and treatment (Harris & Enfield, 2003) was standard. It considered the child's internal processes to be responsible for producing the

inappropriate behavior (Alexander & Malouf, 1983). The shift in thinking towards a social model saw the 'fault' or difficulty not within the child but with the system or situation in which the child operates (Harris & Enfield, 2003).

The move towards a social model, combined with increasing political interest in PPs (Barlow & Stewart-Brown, 2001) called for an examination of how parenting skills could be improved (Maccoby & Martin, 1983; Olds, Henderson Jr, Phelps, Kitzman, & Hanks, 1993). This resulted in a wealth of new academic research, government funded work, independent evaluations and recommendations and a growing number of evidence-based programmes (Eyberg, et al., 2008). The evidence base for PPs' effectiveness is constantly being updated and questioned.

Generally, PPs are effective at treating behaviour difficulties (Barlow, et al., 2007; Barlow & Stewart-Brown, 2000, 2001; Barrett, 2010; Butt, 2009; Dretzke, et al., 2009; Graziano & Diament, 1992; Hallum, et al., 2004; Kane, et al., 2007; Moran, et al., 2004; Nixon, 2002; Reyno & McGrath, 2006), with findings beginning to be replicated for ethnic minorities (Barlow, et al., 2004) and teenage parents (Coren, et al., 2003). Improvements have been shown in parent and child behaviour and communication, increased parental self-esteem, improved parental attitudes towards their children and decreases in maternal depression and parental stress (Barlow, et al., 2002; Dretzke, et al., 2005; Graziano & Diament, 1992; Kane, et al., 2007; Reyno & McGrath, 2006).

Despite the generally positive conclusions sources raise questions across three themes; the lack of research on how PPs are successful, the maintenance of positive effects over time and the age of children being supported.

The first theme highlights the shortage of information on how PPs are helpful or what elements are important (Barrett, 2010; Butt, 2009; Moran, et al., 2004). This is particularly important given that even the most successful of PPs do not improve the situation for all families (Butt, 2009; McIntyre & Phaneuf, 2008; Scott & Dadds, 2009). Earlier sources raise this theme as an area for further investigation. While

more recent work demonstrates some interesting contributions in this area (Barrett, 2009; Kane, et al., 2007; Reyno & McGrath, 2006).

After reviewing studies that attempt to identify variables that might predict, or explain, how successful a PP might be Reyno and McGrath (2006) conclude that socioeconomic status and maternal depression are the only two factors that impact negatively on outcomes of PPs. On the other hand Kane et al (2007) review qualitative studies and conclude that parents find the increase in knowledge and skills important and also benefit from the support from other parents. Barrett (2009) suggests that matching parents to specific programmes, assessing the needs of the family prior to starting a programme and reflecting on progress throughout the programme may be methods to improve outcomes of PPs. Despite these suggestions Barrett questions whether some parents might need something in addition to a PP. It has also been suggested that active participation (Orrell-Valente, et al., 1999), and intervention format and intensity (McIntyre & Phaneuf, 2008) also impact on outcomes. It seems that the optimum design of a PP can vary from family to family. It might be that the key to a successful PP is flexibility.

On the second theme of maintenance, the sources do not present a united front. The majority of academic review papers demonstrate that maintenance is rarely achieved (Barlow, et al., 2005; Eyberg, et al., 1998; Nixon, 2002). However, Reyno and McGrath (2006) suggest otherwise. On closer inspection the references cited by Reyno and McGrath range in date from 1985-1995. This raises the question why these papers were not reported by Nixon and Barlow. The still contentious nature of this topic calls for future work to be clear when reporting on maintenance.

The final theme examines the age of children being supported; which varies from study to study. Academic and independent reviews and government funded work all report the striking finding that despite research and background theory indicating that early intervention and prevention is advisable for supporting children with behaviour issues there remains a scarcity of well designed outcome studies that have focused on pre-school children (Barlow, et al., 2007; Barrett, 2009; Butt, 2009;

Moran, et al., 2004; Sampers, et al., 2001). The majority of work on antisocial behaviour in children focuses on children aged 7 or over (Nixon, 2002).

Despite this lack of research many PPs claim that they are suitable for use with pre-school children or offer an adapted version for younger children. However, Sampers et al (2001) questions whether this is appropriate. Shouldn't PPs be designed with the developmental stage of the child as a specific focus, rather than just differentiated?

Recent work has taken these questions on board and has started to examine the effectiveness of PPs for pre-school children (Barlow, et al., 2005; Reyno & McGrath, 2006). However, due to the limited number of studies with this age range further research is needed to draw firm conclusions.

As well as identifying key themes the range of sources also attend to the methodological limitations in this area. It has been suggested that evaluations are often methodologically flawed (Barrett, 2010) and Nixon (2002) highlights difficulties with study design, sampling and establishing causation.

Study design focuses on whether it is possible to compare papers that employ different underlying approaches. In most cases reviews sidestep this issue by outlining that they intend to use papers from one tradition. For example Nixon (2002) takes a positivist approach and focuses on work that uses Randomised Control Trials (RCTs), which they argue allows their work to be generalised, while Kane et al (2007) use a meta-ethnographic approach, which they argue allows the interpretive nature of qualitative data to be kept. However, each tradition is subject to limitations. The positivist approach has been criticised for reducing social situations to a set of events and not considering the viewpoints of individuals (Robson, 2002). However, while the interpretive approach allows rich information to be collated and a 'thick description' (Geertz, 2003) to be drawn, it also incorporates a reduced ability to compare and generalise findings.

I argue that more than perspective is needed to gain a broad understanding of the area without ignoring a whole body of work. Over the past decade there has been emerging recognition that evidence-based practice needs to consider findings from qualitative studies as well as RCTs (Dixon-Woods & Fitzpatrick, 2001). This will ensure that conclusions consider both outcomes and user concerns (Dixon-Woods, Agarwal, Young, Jones, & Sutton, 2004). This is particularly important as the focus moves towards community work.

Sampling can raise several limitations. The first relates to size while the second relates to the details provided. The academic reviews cited criticise individual papers for using small samples which minimise the ability to generalise conclusions. However, the reviews also use small numbers of articles when examining the wider area (Barlow, et al., 2005; Kane, et al., 2007; Nixon, 2002). Considering the increasing number of articles in this area it seems limiting to only report on a few, particularly if data used in the studies comes from the same source as in Kane et al (2007).

Data related to the sample is often incomplete or unclear (Moran, et al., 2004; Richardson & Joughin, 2002). If information such as demographics, route of referral and type of behaviour difficulty vary, or are not specified, can outcomes be compared? It might be that one of these factors is having an impact. Uncertainty about sample specifics could result in questions such as: do PPs work equally well for all ages? Do PPs work equally well with a range of behaviour difficulties? Do motivation levels vary depending on route of referral? Do PPs work equally well for all referral systems? The need for future work to be specific about the samples they employ is clear.

A final limitation highlighted focuses on establishing causation. Behaviour difficulties do not happen in isolation (Emerson, 2003), making it difficult to know what PPs are having an impact on. In community settings it is also difficult to isolate a group of people taking part in a PP from other influences. This means that something else may have caused any positive change. This is often addressed by using control groups. However, if maintenance is being explored control groups are often not

possible due the ethical issue of withholding the PP from the control group for a long period.

I suggest that the reviews and other papers themselves are subject to further limitations. They have a tendency to focus on papers that use a range of professionals to deliver the interventions, work mainly with mothers and focus mainly on clinical settings (Barlow, et al., 2007; Kane, et al., 2007; Nixon, 2002). These points raise questions about whether findings can be generalised. There is also a tendency for papers to claim positive impact of PPs based on results which demonstrate lower levels of anti-social behaviour. However, the absence of anti-social behaviour does not necessarily mean increased pro-social behaviour. Do PPs need to incorporate both?

A final limitation to be discussed is the nature of the papers cited. Academic papers are assumed to present an unbiased account of a situation. However, some of the papers cited above have been written by authors who have an affiliation with a particular PP (Webster-Stratton & Reid, 2008) or have been funded by organisations with an interest in outcomes (Hallum, et al., 2004; Moran, et al., 2004). This raises questions about the reliability of the work. However, the fact that these papers provide similar results to papers written by independent bodies (e.g. Barrett, 2010; Scott, et al., 2006), along with the fact that authors such as Stephan Scott write for both academic and political reasons, minimises such doubts.

Despite the limitations outlined above, and the discussions on the quality of the sources used, it is important to remember that developments have also been made within this area (Barrett, 2009; Eyberg, et al., 2008). Recent studies have employed larger samples, used multiple methods of reporting on behaviour outcomes and had an increased focus on maintenance (Eyberg, et al., 2008).

Even with these significant developments further work is needed in order to draw firm conclusions and fill gaps in knowledge. Suggestions for future work have included: focusing on comparative studies of PPs, gaining better qualitative data (Barrett, 2010; Moran, et al., 2004) and evaluating PPs out of the clinic setting (Eyberg, et al., 2008). Eyberg, (2008, p. 234) concludes that we have moved “beyond

the question ‘does treatment work?’ and should instead focus on “‘For whom does this treatment work?’” and “‘How does this treatment work?’”

Individual Parenting Programmes

In order to build on the more general view it is important to be familiar with specific PPs and their strengths and weaknesses. I will focus on two particular PPs while briefly mentioning others. Incredible Years (IY) and Parent-Child Interaction Therapy (PCIT) were both selected because Eyberg (2008) identified them as ‘probably efficacious’. IY has also been identified as the most commonly used PP in the UK (Barlow, et al., 2007). While IY is closely associated with the SLT approach, PCIT attempts to combine ideas from several theories.

Incredible Years:

The IY programme (Webster-Stratton & Reid, 2003) is a series of “programs designed to reduce children’s aggression and behaviour problems and increase social competence” (Eyberg, et al., 2008, p. 227). There are three discrete programmes aimed at parents, teachers and children. The PP is the most commonly used in the UK (Barlow, et al., 2007) and focuses on building positive PCIs and supports parents in learning child-led play skills and implementing effective discipline.

A strong evidence base has shown IY to have a positive impact that is maintained (Hutchings, et al., 2007; Reid, Webster-Stratton, & Baydar, 2004; Scott, et al., 2001; Webster-Stratton, 1990, 1998). There is also some preliminary evidence showing that IY is effective with children showing ADHD symptoms and developmental delay (Hartman, Stage, & Webster Stratton, 2003; K. Jones, Daley, Hutchings, Bywater, & Eames, 2007; McIntyre, 2008; Scott, et al., 2001; Webster-Stratton & Reid, 2008).

IY seems to be successful for several reasons; it targets pre-school children before behaviours become entrenched and it intervenes ‘in multiple areas and settings through parent, teacher and child training’ (Webster Stratton & Herman, 2010, p. 37). Having different strands allows it to be tailored to the individual family.

However, it raises questions such as which element is having the biggest impact? Reid et al (2003) suggest that targeting more levels of the ecological model by using the PP in combination with the teacher programme improves long term maintenance. However, Derosier and Gilliom (2007) compared different combinations of IY support and found no difference in outcome. These differing views suggest that more evidence is needed to draw firm conclusions.

As with other PPs the research into IY suffers from some of the limitations discussed above, particularly those concerned with sampling. In addition the majority of outcome measures used parent report. Parents' expectations of the PP may bias their responses. Without independent observations to corroborate the findings any conclusions must be treated cautiously.

Despite IY being one of the most prominent SLT-based PPs it does not improve the situation for everyone (McIntyre & Phaneuf, 2008; Scott & Dadds, 2009). IY has been shown to be most beneficial when mothers' levels of criticism are low (Reid, et al., 2004) and when parents are highly critical after IY, positive maintenance is diminished (Reid, et al., 2003). I suggest that these findings indicate the need to incorporate a focus on attachment.

Parent-Child Interaction Therapy

The second PP to be examined is one that aims to use an interactive approach and incorporate ideas from a range of psychological theory.

PCIT is 'a short-term, evidence-based intervention designed for families with children between the ages of 2 and 6 who are experiencing a broad range of behavioural, emotional and family problems' (Herschell, et al., 2003, p. 9). It is made up of two discreet phases incorporating ideas from both attachment theory and SLT. Parents are taught strategies to help them establish positive nurturing patterns and consistent contingencies for the child's behaviour. The two phases attempt to alter the parenting style of the parent (Berkovits, et al., 2010).

PCIT has been shown to be effective using a large number of measures (Berkovits, et al., 2010; Eyberg, et al., 2001; Eyberg, et al., 2008; Pade, et al., 2006) and when delivered by a range of professionals (Berkovits, et al., 2010). These findings have been replicated across different cultures (Capage, Bennett, & McNeil, 2001; Querido, Warner, & Eyberg, 2002; Werba, et al., 2006), with both mothers and fathers (Schuhmann, et al., 1998) and with group versions and shorter versions of PCIT (Berkovits, et al., 2010; Pade, et al., 2006). Positive effects have also been shown to generalise to other children in the family (Brestan, et al., 1997).

The preliminary research on PCIT indicates several factors which are important for success: therapist style that balances positive feedback and constructive advice (Herschell, et al., 2003) and including both parents and children in the PP (Pade, et al., 2006). The order of the two phases does not impact on outcomes which allows the programme to be adapted to the needs of the parent (Eyberg, et al., 2001). Pade (2006) suggests that future work should compare group versus individual formats of PCIT.

Despite this preliminary data being positive PCIT still suffers from the range of criticisms outlined previously including cultural bias (Eyberg, et al., 2001), a tendency to use parents who self referred (Berkovits, et al., 2010) and disagreements over maintenance (Eyberg, et al., 2001; Funderburk, et al., 1998; Pade, et al., 2006).

The ability to generalise to community settings is the biggest criticism aimed at PCIT. Most research has been carried out in clinic settings at great expense. Replication in the community would not be possible due to cost (Herschell, et al., 2003; Pade, et al., 2006; Schuhmann, et al., 1998). Would positive results be found with a limited budget?

PCIT has been reviewed alongside a range of PPs (Eyberg, et al., 2008; Herschell, et al., 2003). Thomas et al (2007) conclude that PCIT is superior to Triple P. However, they suggest that the observation methods used to evaluate PCIT are more likely to notice change than the methods in Triple P research. They also note that

independent observations did not differ significantly between the two PPs, but that parents viewed PCIT more favourably.

Sampers et al (2001) state that although IY has more empirical support than PCIT, PCIT provides more therapist contact with the parents in a more holistic approach focused on the relationship between parent and child. They argue that this makes it more suitable for the developmental stage of pre-schoolers. However, they question PCIT's cost effectiveness and query the lack of follow-up data.

These unanswered question and the fact that other papers conclude that more research is needed before a decision can be taken about which PP is superior (Lindsay, Strand, Cullen, Band, & Cullen, 2010) suggest the need for further work.

Current projects

There are many projects running in the UK to evaluate PPs (e.g. Broadhead, Hockaday, Zahra, Francis, & Crichton, 2009; Rait, 2011), and examine their cost effectiveness (e.g. CWDC, 2010; Edwards, et al., 2007; Lindsay, et al., 2010).

A particularly influential project is the Parenting Early Intervention Evaluation (Lindsay, et al., 2010). This is a Government funded scheme examining five evidence-based PPs, including IY, that have been rolled out across Local Authorities. The final report is due in spring 2011 but initial results indicate maintained positive outcomes from all PPs, with only small differences between them. They also conclude that the PPs are all cost effective but that IY is the most expensive. Although this project is useful when designing my own study one important difference is that this work looks at supporting children aged 8-13.

This project, along with other reports, suggests that there are many adapted PPs being used across the country (Bohr, Halpert, Chan, Lishak, & Brightling, 2010). One such initiative is the Scallywags project in Cornwall (Broadhead, et al., 2009). This project works with children aged 3-7 and takes a multi-agency approach, supporting the child in school and working with parents at home. An initial pilot indicated positive outcomes and parent perceptions which have been maintained for the majority of children. This project continues to run and has been reviewed in several

academic papers (Broadhead, et al., 2009; Frampton, McArthur, Crowe, Linn, & Lovering, 2008; Lovering, Frampton, Crowe, Moseley, & Broadhead, 2006). It demonstrates that an adapted PP can be run successfully in a community setting. However, the PP was only one element of the Scallywags project. Which raises the question 'can a community based PP be successful on its own?'

Conclusions

This review has identified several trends in the recent literature: towards an integration of various theoretical approaches, towards PPs delivered in the community and towards differentiation of PPs by age group and other factors. These trends are clear even though there remain debates, for example between those who strongly advocate SLT and those who advocate a more inclusive approach.

The impact of this review is threefold. In theoretical terms, the review has alerted me to the importance of taking account of a variety of approaches which identify different mechanisms underlying the operation of PPs. In structural terms, the review has alerted me to the importance of seemingly minor details of the structure and implementation of PPs that can have a major effect on parent and child perceptions. In research design terms, the review has alerted me to the value of adopting a variety of measures of efficacy, both quantitative and qualitative, and being sensitive to parental opinions, in ways that allow my research to be compared with the existing literature.

Building on the identified trends in the literature, my research proposes to contribute by studying a particular PP delivered in the community to pre-school children. The particular PP (Holding Hands) aims to work within a wider range of levels from the ecological model, and has already been run successfully with individual parents and children in their own homes (Rait, 2011), and therefore offers interventions with multiple tiers in order to cater for individual's needs (McIntyre & Phaneuf, 2008). In the current climate of decreasing resources and increasing accountability for impact, it has been questioned whether the programme would be effective when delivered to groups of parents in a children's centre. My study will allow questions such as 'which is the better way to run the programme?' to be

answered. It will also add to the growing evidence about ‘what works best for whom and under what circumstances’ (Moran, et al., 2004).

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