A Comparative Study of Individual Versus Group Interventions for Parents of Hyperactive Children

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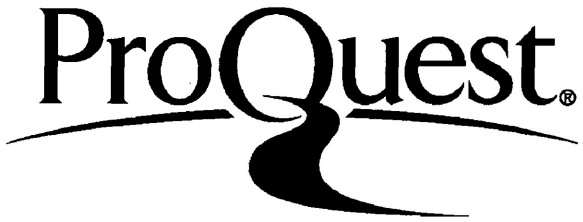

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Abstract

Many treatments including, diets and medication, have been documented as successful interventions for treating hyperactive children diagnosed with Attention Deficit Disorder (A.D.D.).Because compliance and constant monitoring are instrumental in these long term interventions, success is not always the outcome.Furthermore, the A.D.D. child's behaviour can cause a constant strain on the parents. A number of studies have indicated that parents can be helpful co-therapists in treating their children.Not only does the child benefit in this case but, by educating the family on symptomology and providing education to aid the parents dealing with a hyperactive child, stress may decline relieving the tension caused by the interaction of the hyperactive child and the family unit. Studies have additionally indicated, that parents benefit more from small group support than from individual counselling.

Individual counselling was provided at a local children's centre. However, the question of whether or not group counselling was an alternative treatment was investigated in this study. Two experimental groups, one comprised of five to six single parents and the other of five to six two parent couples were compared to the control group consisting of parents who opted for individual counselling.The children's group was used in conjunction with the parenting groups. Strategies in the children's groups were presented at an experiential level understandable to the children. There was no manipulation of the children's group.Both prior to and at the end of the six week program all groups were requested to complete three questionnaires; The Conners Behaviour Checklist (1960), The Achenbach Child Behaviour Checklist (1983) and Barkley's Home Situation Questionnaire (1980) in addition to an evaluation questionnaire to determine whether changes in hyperactive behaviour resulted. Parental groups were provided information and practice in behaviour modification through role-playing techniques and group discussions. T-tests revealed little difference between the control group and those receiving group counselling. This suggests that depending on the number of referrals, group counselling could be somewhat more feasible than individual counselling.

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Introduction

Hyperactivity has become such a predominant childhood disorder that it is almost unnecessary to document it. Indeed, it has been found in both non-psychiatric and psychiatric children. Frazier and Schneider (1975) described hyperactive children as restless and disruptive, requiring continued supervision in order to keep them reasonably calm. Hyperactivity apparently has caused great concern to parents, teachers, practitioners, and therapists, all of whom recognize the hyperactive as children who cannot concentrate for long on any one thing, who over react to external stimuli, and whose demands result in angry, guilty parents. Ross and Ross (1976) describe hyperactive children as those who;

> "consistently exhibit high levels of activity in situations in which it is clearly inappropriate, are unable to inhibit their activity on command, often appear capable of only one speed of response and are often characterized by other physiological, learning and behavioural symptoms and problems." (p.10)

Now referred to as Attention Deficit Disorder (A.D.D.) and soon to be referred to as Attention Deficit -Hyperactive Disorder in the new Diagnostic Symptoms Manual IV, it is speculated to be the underlying cause of noncompliance in some children. A study conducted by Susan Campbell (1975) supported this fact when it was found that hyperactive children were more likely to request help from their mothers and refuse to comply than other groups of children. In a more recent study, Cunningham and Barkley (1979) revealed

that the most commonly used parent rating scales of hyperactivity correlate significantly with noncompliance, while illustrating no significant relationships with measures of activity level or attention span. It is believed that parents are responding to this noncompliance when they seek help. In addressing the need for help, Barkley (1981) contends that A.D.D.is a developmental disorder of early onset requiring long term observation and intervention.

The change in the name of the disorder from hyperactivity to A.D.D. is a reflection of the most recent assumption that constant mobility is not the primary symptom but is secondary to the short attention span and impulsivity. In light of this, at the Canadian Psychological Association in 1972, Virginia Douglas postulated that the major deficiency of hyperactive children was their inability to stop, look and listen, implying that attention is the main discriminant to this disorder.

This has become apparent in various settings. For example, in the home, many hyperactive children experience difficulties that are often evident in their constant inability to complete assigned chores, to listen to directions, to complete homework assignments, to play for extended periods of time without supervision or attention from others, or to watch television at length. Meanwhile,in the classroom, the child is often disruptive, in constant motion and difficult to calm down (Whalen and Henker, 1985).

With the above mentioned problems of A.D.D., the detrimental effects of the disorder are understandable. Parents often report that their children have no friends or that they can only relate cooperatively with younger children (Whalen and Henker, 1985). Whalen and Henker (1985) further expand on the problems these children have in socializing with others reporting that 81% of parents interviewed described their children as disruptive and annoying. Furthermore, Campbell and Paulauskas (1979) report that 80-85% of hyperactive children and only 18-30% of control children were rated high on such behaviours on a behaviour checklist. Also reported in the Whalen and Henker (1985) study was the lack of social skills, which resulted in deviant behaviours escalating rather than subsiding. A final aspect to A.D.D. children's peer relations is that the child's disruptive behaviour often serves as a catalyst, causing others to behave disruptively also (Whalen and Henker, 1985). This is especially evident in the classroom setting.

To further expand on the problems in peer relations with A.D.D. children, Pelham and Bender (1982) conducted a study on 587 elementary school children of whom 52 boys and 12 girls were identified as A.D.D.H. by teachers. These children were evaluated on the Pupil Evaluation Inventory (P.E.I.). Results showed that A.D.D.H. children rated higher on aggression and withdrawal, and lower on likeability illustrating the reasons for their segregation from peer

relations. Indeed, these children frequently maintain their reputation for difficult behaviour even when exposed to unfamiliar people. They are sometimes shy, even withdrawn at first, but once acquainted,their disruptiveness once again surfaces. Paulauskas and Campbell (1979) Ross and Ross (1982) and Waddell (1984) have also found this behaviour to increase with age.

Another characteristic of the A.D.D. child's peer relations is the predictibility of future problems during adolescence and adulthood (Whalen and Henker, 1985). It appears that negative socialization in early childhood continues into adulthood thereby increasing the chances of maladaptive behaviour.

Some final characteristics noted concerning A.D.D. children were aggression and disobedience as well as stubborness, daydreaming and regression which Smith (1986) speculated to be a form of defence for these children. In addition to these various characteristics that have served to distinguish these children from their peers, is the lowered self-esteem that they experience. Whalen and Henker (1985) have reported that although the child may behave inappropriately and often gets into trouble,these behaviours are frequently unintentional. When the child is punished for something s/he didn't mean to do her/his self-esteem is reduced.

The hyperactive child's problem is not her/his own, it is shared by the family members. Campbell, Breaux, Ewing,

and Szumouski (1986, cited in Campbell, Ewing, Breaux and Szumouski, 1986) found that severe family stress, lower social status and conflict in the mother-child relationship by age three were associated with higher scores on inventories measuring hyperactivity. In 1981 Barkley found a higher prevalence of hyperactive children in the lower socioeconomic levels reporting one out of four children as meeting the criterion on the Conner's test (1960). With the potential effect hyperactivity has on the child's development to adulthood it is imperative that some type of intervention be applied to this disorder. Morrison (1980) supports this suggestion with his finding that hyperactivity alone does not produce adult antisocial behaviour but something within the environment which interacts with the hyperactivity and can lead to deviant behaviour. Morrison (1980) speculates that failure of parental control may be one such environmental impetus, encouraging an already abnormally rambuncious child to progress further toward deviant behaviour which will become a permanent adult characteristic. Smith (1986) has found childhood hyperactivity to be an indication of adult alcoholism or behaviour disorders. Furthermore, a link between these hyperactive children and their relatives has also been postulated; suggesting that a genetic factor may be involved. Morrison and Stewart (1971) also found that relatives of hyperactive children were more likely to suffer psychiatric illness, and, most frequently, alcoholism, as

well as a high degree of hysteria and sociopathy. Although the possibility of a genetic factor has not been ruled out, the consistent higher ratio of boys to girls with ADDH certainly indicates the disorder is sex linked (Cunningham, conference 1987). Other studies cited in Mash and Johnston (1983) have looked into the interaction of family members and the problem child. What has been found is that the child's disorder can also be weighing heavily on the family members. The most common problem in these families is the overload of stress. Mash and Johnston (1983) also cite a study in which mothers who interacted little with their child did so as a result of experienced stress and discontent with their parental roles. They concluded that mothers became controlling and stress-filled as a result of difficult interactions with their children although the experiment showed no directionality of the effects.Webster-Stratton (1988) further illustrated a connection between mothers' personal adjustment and their rating of their hyperactive child's behaviour.This she attributed to the mothers perceiving themselves as less competent parents than the fathers since personal adjustment did not appear to be a factor influencing fathers' ratings of their hyperactive child's behaviour..

Lawton and Coleman (1983) found that parents experience stress when faced with having to adjust to actual child rearing responsibilities, particularly when they are uncertain of what is expected of them. This, coupled with

the additional factors of A.D.D. can result in parents changing their parenting behaviours and expectations of their child. Stress at this point could be evident. In a study by Moos and Moos (1983) it was found that the addition of a problem child to a family presents more prolonged stressful situations.

Furthermore, Humphreys and Ciminero (1979) found that children with learning disabilities cause more stress to parents than children with more extensive and obvious handicaps. The parent can adjust to a visible handicap such as blindness or mental retardation but the behaviour of hyperactive children and their attention deficit is not accompanied by physical abnormalities therefore it is difficult for parents to understand the behaviour problem. Furthermore, the attention deficit is not easily diagnosed so it becomes even more frustrating when a child who appears bright and intelligent has such serious difficulties. Mash and Johnston (1983; cited in Margalit and Heiman, 1986) have described parents transactions with learning disabled children to be more stressful and less rewarding than in more extensively handicapped children. There is controversy however, concerning whether or not families of handicapped children in general experience more stress than families who have normal children. It is suspected that the severity of the child's handicap is positively correlated with the levels of stress reported by parents.

From the above it is apparent that something must be done to relieve these children and their families of the constant stresses that each member experiences due to the child's disorder. If left unattended, A.D.D. can continue into adolescence and even adulthood. The unfortunate effects can prove a hinderance to the entire family's interactions.

During the 1950s through the 1970s, in answer to the need for a treatment for A.D.D., experiments were conducted with hyperactive children to determine a cause and hopefully a cure. Today there are many proclaimed cures, but none, as yet, have been found to be a completely effective solution.

Most children are hyperactive for a combination of reasons that may or may not be easy to diagnose. For many of these children there are no organic impairments (Sroufe, 1978). Instead the diagnosis has been derived from their behavioural disorganization and immaturity. As a result, it is suggested that children adopt hyperactive ways of coping with underlying anxiety and distress. For these children drugs may not be as effective as for the 10% of the children who are hyperactive as a result of brain damage. The popular drug remedy for these latter children is Ritalin, a stimulant that paradoxically calms the hyperactive child. The problem with drug use is that it is not always acceptable to parents and many of them will not continue administering it to their children. Furthermore, it is also difficult to regulate since it depends on body weight and metabolic rate. Sroufe (1978) has explained the procedure

for drug therapy which starts the child on minimal strength of medication and then increases the strength gradually until an unmistakable change in behaviour has been noted, ie. a more calm, subdued child. The optimal dosage is between .3 and .5 mg/kg. An increase from this dosage impairs the learning processes. A dosage of .10 mg/kg has an adverse affect on the short term memory (Cunningham, 1987).

Because of the unknown cause and rather chancy treatment, parents have relatively little success in their search for a cure for their child. The child's hyperactive temperament causes more difficulty for parents because it interferes with the unique interaction between parent and child. Susan Campbell (1973) reported several studies on the mother-child interactions of hyperactive children that demonstrated that these children are less compliant, more attention seeking and more in need of supervision than normal children. Drugs may provide a temporary relief by decreasing motor activity and disruptive behaviour,thus improving the chances for more positive interactions between mother and child. Furman and Feigner (1973), however, warn that drugs may only hide the problem and, left uncorrected, the disruptive behaviour will resurface when drugs are discontinued.

Some advantages and disadvantages of Ritalin have been noted. To begin, Ritalin can attribute its popularity to the child's increased accuracy in accomplishing tasks and reduced unnecessary movements and disruptions. Martin,

Welsh, McKay and Bareuther (1984) further note that stimulant drugs increased the attention span, decreased impulsivity and decreased socially maladjusted behaviour. However these drugs purport to reduce some of the symptoms of A.D.D., the effects that they have on the child's development immediately and in later years have been noted. Smith (1986) reports depression, anger and deteriorating self-esteem. Sroufe (1978) reported side effects of loss of appetite, sleeplessness, sadness and irritability.

While drug therapy provides a relatively simple solution to hyperactivity, in that it requires less work from both parent and child than some other interventions, Barkley (1977) postulates that medication has little impact on long term social, academic or psychological adjustment of the child. Recent research (Frances and Jensen, 1985) suggests that stimulant medication reduces parental complaints but that reinforcement for good behaviour is not provided when the child behaves properly, thereby hindering the child's acquisition of more appropriate behaviour.

Other alternatives suggested by numerous studies include elimination diets, megavitamins, and sugar restrictions. The Feingold k-p diet (1975) strove to eliminate both natural and artificial foods containing salicylate. However, evidence regarding whether the diet works has been relatively inconclusive. Feingold's original success figures indicated 50% of those involved showed complete remission, while 75% improved enough to discontinue drug therapy

(1975). In his 1976 article, his figures for success were somewhat lower, with a 30-50% range being reported. Martin, Welsh, McKay and Bareuther (1984) state that many parents inquire about diet therapy, which can be helpful to some children but should not be implemented until other forms of intervention have been ruled out and the physician is certain of the effect the diet will have on the child. Approximately 10-20% children will respond to a diet. Varley (1984) has found that megavitamin users have an increased risk of vitamin toxicity, which can lead to bone pain, anorexia, irritability and, in some cases, hepatitis. Arnold (1984) however found no difference between placebo and megavitamin therapy. As for the sugar restriction, a study conducted by Harley (1978) concluded that a sugar restricting diet resulted in only 1 out of 9 children showing hyperactive behaviours while the remaining eight showed no change in behaviours. Further studies by Goyette et al. (1978) supported these findings when eight of sixteen hyperactive children who were following the Feingold diet were given cookies containing additives while the remaining children were given placebos. The study showed no evidence of increases in symptoms of hyperactivity within the two groups. Varley concludes that there is no empirical data base to confirm that a sugar free diet will have any therapeutic effect on hyperactivity. He further postulates that the diet at least makes the parents feel useful and

gives them the impression that they are doing something for their child's disorder.

It is comforting to know that there are now more alternatives available that not only address the behaviour of the child but also look to establish more positive interactions between the child and those around him/her. Behaviour modification is concerned with the behaviours emitted by these children and the consequences of these behaviours. Some of the family problems mentioned earlier are not addressed in drug therapy and are therefore left to dissipate or magnify on their own. With behaviour modification however, these problems are addressed.

During the past fifteen years behaviour therapists have been looking toward parents as assistants in remediation for children with behaviour disorders, such as conduct disorders, noncompliance and deviant behaviours (Griest, Forehand, Rogers, Breiner, Furey and Williams, 1982; Helm and Kozloff, 1986). Authier, Sherrets and Tramontana (1980) have attributed this movement, which has emanated from various disciplines in the social sciences as the latest, potentially most powerful agent of primary and secondary intervention. Parent training has been directed toward numerous childhood disorders (Authier, Sherrets and Tramontana, 1980).

Graziano (1977) has suggested that behaviour therapists are bringing parents in as active participants in their child's remediation, because the parents are the people who

spend the most time interacting with the child. Bradley-Johnson (1982) contend that intense exposure enables the parents to provide constant intervention rather than the few hours a week offered by the therapist. Graziano (1977) has determined that parent training is an effective indirect treatment modality and results in positive changes in the children's behaviour. By providing the parents with useful skills they can be taught to combat problem behaviours themselves which results in savings of time and money. Parenting groups serve as useful devices for reaching parents.

Painter (1985) has stated two reasons for parenting groups. Parents are seen as assets. Parenting groups are more effective than individual therapists in providing support and intervention for parents of problem children. Second, with changes in society parents need help to adapt and to improve parent-child relations. Parent groups serve as a means of disseminating information from child care experts, by providing support and information to parents with particular needs. They are important also in teaching new skills (Graziano,1977). Parents seek information on how to improve familial relationships when they are not satisified with the interactions they are presently sharing with their children. The main reason for parents seeking help from parenting groups is that new methods are provided which may combat problems at home.

Eyberg and Johnson (1974) have found parent training to be extremely successful, noting that twelve of seventeen families studied demonstrated successful treatment outcome when multiple training techniques were used. Horton (1984) notes however, that in many cases the level of parental involvement is a main factor in predicting training success. Some studies have been fortunate enough to be able to include both fathers and mothers in the groups but in most cases mothers were the primary attenders. Moran (1985) has investigated the effect of only one parent being trained compared to both and has found that the effect of the training one parent receives is often passed on to the other parent. When wives attended a program aimed at decreasing stress it was found that their husbands also experienced a reduction in stress as a result of their wives' improved ability to cope. Furthermore, Griest, Forehand and Wells (1981) have indicated that the mental state of the parents influences whether the parents will seek assistance from a parent training group and whether they will remain with the intervention. Griest, Forehand and Wells (1981) as well as McMahon, Forehand and Griest (1981) cite depression as a reason for parental attendance in parent training groups and Cunningham (1987 Conference) noted stress as another factor that increases attendance.

To further support the use of parent training, Pinsker and Geoffray (1981) found that even unskilled people can learn behaviour modification techniques and implement them

after only a short training period and with minimal professional leadership. Behaviour modification techniques have been found to be quite effective. Patterson (1974a; 1974b) and Patterson, Ray and Shaw (1968) report studies in which parents themselves carry out the assigned treatment program with positive outcomes. In many cases parent-collected data has been verified by observations in the home supervised by the therapist (Forehand, McMahon 1981). However, Cagan (1980) notes that merely teaching the parent behaviour modification without hands-on experience in its use with their children is not as effective, since it fails to involve the parent with the child in any significant way.

Parenting programs are beginning to address many child behaviour problems. Patterson (1974) reviewed a study in which seventy-five percent of a group of problem boys decreased aggressive behaviour up to sixty percent.

Various other aspects of parent training groups have also been extensively examined. These investigations range from simply providing information on the child's disorder in comparison to use of actual techniques the parents can use to modify their child's behaviour (Heifetz, 1977); to comparisons of group parent training versus individual parent training in which groups were found to enhance training (Brightman et. al. 1978; Mira, 1970; Kovitz, 1976 citedin Helm and Kozloff, 1986). McMahon, Forehand and Griest (1981) compared two parenting groups; one group was taught behaviour modification skills while the other was

taught, in addition, general principles of social learning. It was found that mothers receiving information on general principles in addition to learning specific skills had a better perception of the child's behaviour and used techniques more effectively than the mothers from the other group.

To be successful, interventions must address all family interactions rather than treating only a few, for both the parental responses to and expectations of the child's behaviour must be changed (Miller and Klungness, 1986). As Barkley (1981) suggests, children affect parents as much as parents affect children. Parents look to parenting groups for improvement in their relationships with their children and as a means of assisting them in adapting to a child with behavioural problems. A number of researchers (Furman and Feighner, 1973; Wiltz and Gordon, 1974; Forehand and McMahon 1981) have advocated the use of parents as co-therapists, using feedback, modelling and instructional materials in the child's natural environment.

Concern has been expressed about the generalizability of parent training programs once parents have been trained. Will they use their techniques on new problem behaviours as they emerge? Turner (1980) proposes that people learn how to be parents as they grow up from observing their own parents' management styles. Therefore parent training groups designed to address child management problems can be considered supplements to, rather than replacements for, the styles and

techniques the parents' already use on their children. If the group training is to be an effective intervention, supplementing existing child management skills, it must be generalizable to individual parents in the home. Studies have shown positive results at follow-up indicating that the ability to learn new or more effective means of child management can be generalized from the group training situation to a practical use in the home (Forehand, Sturgis, McMahon, Aguar, Green, Wells and Breiner 1979; Patterson and Fleishman, 1979). Baker, Heifetz and Murphy (1980) found that the parenting techniques taught in the parenting groups were not only maintained at follow-up but were also generalized to other behaviours not specifically approached in the parent behaviour training group. This study contradicts Johnson and Christensen and Bellamy (1976) who found no such generalization .

Wells, Griest and Forehand (1980) have criticized parent training attempts suggesting that training parents as behaviour therapists does not guarantee that parents will generalize their training from the behaviour modification techniques they received in groups to the management of their own children. Instead, they speculate that changes in child behaviour may be maintained only as long as parents continue to use their skills once training has terminated.

Despite the controversies, one of the main advantages of applying parent-delivered behaviour modification is that parent-child interactions as opposed to therapist-child

interactions allow continuous application of the technique. Miller and Klungness (1980) noted evidence of this in their study when they concluded that parent training in behaviour management was effective in controlling and reducing high levels of stealing in children and adolescents. Another study by Moran (1985) supported the belief that not only the child's behaviour is improved but the family's interactions were also enhanced.

In keeping with this view, Forehand, Rogers, Steefe and Middlebrook (1984) found that the child and parent behaviour change generalizes from the clinic to the home, from treated behaviour to new behaviour problems, from the child identified as the problem to siblings who were not involved in treatment, and for as long as at least three and one half years after treatment has been completed. Furthermore, behaviour modification techniques have lead to improved behaviour in hyperactive children. When applied in the classroom, changes are also evident, although success of the treatment is dependent upon the outcome goal. For example, Sadler, Syden, Howe and Kaminsky (1976) found improvements in child behaviour in general but academic performance was still lacking. This they attributed to the fact that no aspects of the program focused on academic achievement. They further contend that generalizability is dependent on whether efforts are made within the program and maintained after program completion.

Another criticism of group training relates to how the effectiveness of the training is evaluated. In some instances changes in the children's behaviours have been evaluated by the minimally trained co-therapists rather than trained therapists. Still other groups based measures solely on the parental perceptions of change as measured by verbal reports or questionnaires (Tramontana, Sherrets and Authier, 1980). In an attempt to remedy this situation therapists have increasingly relied on reports from parents, teachers and physicians in addition to their own observations of the parent-child interaction. This has increased the accuracy of the assessment since the child is rated by a number of people in different settings which gives a better perception of the child's behavioural difficulties and possible improvements.

Despite some shortcomings, parent training is effective in a remarkably short period of time which commends it's use. The use of traditional long-term psychotherapeutic approaches, on the other hand, could easily result in people dropping out of therapy because they do not see immediate change in the parent-child relationship and view the intervention as too time consuming. Parent training is still controversial, but as researchers investigate factors associated with the success or failure of this type of intervention, more positive outcomes are emerging (Horn, Ialongo, Popovich and Peradotto, 1987).

An even more recent intervention in families with A.D.D. children is to assist and support the parent training groups including the hyperactive child in his/her own group running in conjunction with the parent group, attacking the same behaviour problems but only on a more experiential level. This new addition has sprung from combining the two most popular treatment interventions for treating A.D.D. children; namely, parent training in behaviour modification, and instruction in self-control techniques for children with emphasis on problem solving.

The reason for the emergence of both interventions is the added support each treatment provides the other in the generalizing and maintenance of new, more appropriate behaviours. Horn, Ialongo, Popovich and Peradotto (1987) have found that training parents in behaviour management techniques allows the parents to manage their children on a more cooperative basis. The children are still allowed a certain degree of control over their environment while following the demands of their parents.

The need for family effort in addressing the hyperactive child's problem is apparent, since working with the child alone does not improve generalization or maintenance of new problem solving techniques (Horn, Ialongo, Popovich and Peradatto, 1987). In support of this hypothesis, they suggest that a combined effort by all those involved with the child will maximize the benefits of behavioural modification by providing consistency throughout the child's

environment in addition to support and guidance through instruction in self control techniques.

From the above, a number of conclusions can be drawn. First of all, parent training is becoming a more acceptable method of intervention for a variety of problems. The main philosophy is to help the child, through helping the parent. Parent training programs have been found successful with a number of childhood problems, hyperactivity being one of them.

The basic parent training model focusses on the child as being the main stressor in the family but fails to provide the skills, techniques, and strategies needed for more effective management of the child. However, Pugh (1980 cited in De'Ath, 1982) acknowledges that parents do have skills to improve their parenting but it is because of external pressures and demands that they find it difficult to cope. Well devised groups provide the opportunity for parents to express their fears, inhibitions and stress without feeling like failures.

The present study was designed to examine the effect of the group in providing relief to parents experiencing stress because of their A.D.D. child. Since relatively little information is available on the combined treatment which includes both parents and children, this study attempted to investigate the effects of providing behaviour modification training to parents within a group setting combined with a cognitive behaviour modification group for children. It was

hypothesized that group attendance would prove more effective than the individual counselling normally provided by the institution to parents of hyperactive children since group participants would be receiving the added support of other group members; and that intact families would show the greatest improvement since both parents can be involved in the child management at home. This effect would occur regardless of whether one or both parents actually participated in the parent training groups. It was also hoped that this study would reveal information on what types of individuals are most likely to join groups, information which could prove useful in future planning of group intervention.

METHOD

Subjects

A total of thirty-nine subjects (parents and children) were involved in this study.The families were referred to the Child Development Program of Thunder Bay for counselling. The first experimental group included eight single mothers and their Attention Deficit Disordered children. There were two drop outs in this group midway through the sessions reducing the single parent training group to six single mothers. The second experimental group consisted of three parental couples and two wives from intact families each with their Attention Deficit child. The control group consisted of parents who received individual counselling rather than participating in the parent training groups.

The children participating in this study ranged in age from three to eight years and displayed symptoms of Attention Deficit Disorder. The children attended a children's group held in conjunction to the parents' group. The first children's group consisted of the six children of the single mothers. The second group consisted of five children from the two-parent families while the third group contained four children from families receiving individual counselling.

Parents participating in this study ranged in age from mid twenties to late thirties. Single parents were of the

lower social class and many received additional financial assistance. The two parent families tended to be from the moddle class with both parents working in many instances. The children in this study ranged in age from three to eight years. Some were the only child of their family, most had one other sibling but two children had three other siblings.

The criteria for diagnosis of A.D.D. for the purpose of this study were as follows:

At least six of the following symptoms.

1. Difficulty sitting still,
2. Fidgets with hands,
3. Over-involvement in irrelevant tasks,
4. Frequent change from one activity to another,
5. Difficulty in attending to or maintaining attention to tasks or play activities,
6. Failure to accomplish self-initiated tasks,
7. Inability to follow instructions,
8. Inattentive; fails to attend to activities occurring around him/her,
9. Impulsive; acts before thinking,
10. Forgetful or loses track of thought (DSM III,1980)

In conjunction with these above symptoms, onset occurred before the age of six years and had endured for at least twelve months. Schizophrenia, affective disorder or severe or profound mental retardation was ruled out. Finally, a mean score of at least 1.5 was attained on the Conner's Behaviour Checklist (1960).

MATERIALS

The manual for this study was devised by the researcher. Various other manuals from other programs for children with behaviour problems were used. These are listed in the reference section and also in each session of the manual

(Appendix C). The contents for this six week program were selected according to common parental concerns expressed during interviews and initial referrals to the Child Development Program.

Topics covered during the children's sessions were the same for all groups and were similar to the parent training group with material presented at a level they could understand. The children also received a good deal of hands on experience.

The main emphasis of this program was the "Think Aloud" program, the "Turtle Technique" and "emotions". The "Think Aloud" program is a problem solving process in which children learn to go through the following steps verbally when confronted with a problem related to their behaviour:

(1) STOP! What am I supposed to do?
(2) Think of a plan.
(3) Am I following my plan?
(4) How did I do?

This program is designed to slow the children down and to get them to plan ahead and to anticipate the consequences of their behaviour. The children learn to follow this process when cued to do so The parents also learned the technique and used role playing during group to practice helping their children to use the technique.

The Turtle Technique is a relaxation program for children. The children were introduced to this through cues from turtle pictures and a story which is provided in the author's manual.

Time was also spent on emotions and moods with both parents and children exploring the causes and uses of various emotions. Parents were also provided with guidance on disciplining and providing structure and consistency in the home. As the parents were taught strategies like ignoring inappropriate behaviour,when...then rules and time out procedures, their children met separately and played games which enabled them to learn and understand the principles behind these strategies. Specific details are presented in Appendix C.

Three questionnaires were used during the experiment to determine the extent of the child's hyperactivity and behaviour problems.

Conners Behaviour Checklist (1960)

Barkley (1981), has attributed the Conners (1960) as being the most widely used test in detecting hyperactive children with adequate validity and .57 reliability. There are two scales available for use; the Parent Rating Scale and the Teacher Rating Scale. The Parent Rating Scale which was used in this study, is directed toward parents of problem children between the ages of three and seventeen. The Conners Behaviour Checklist (1960) uses a Likert scale of not at all, just a little, pretty much and very much. Scores of 0-3 are assigned respectively to these items. Items are divided into six subscales: Conduct Problem, Learning Problem, Psychosomatic, Impulsive Hyperactive, Anxiety, Hyperactivity Index. Mean scores are calculated

for each category. A mean factor score of 1.5 or higher indicates a problem area. For further information see Appendix D.

Achenbach Child Behaviour Checklist (1983)

The Achenbach Child Behaviour Checklist (1983) is a rating scale designed for use by parents of children aged 4-17. It requires parents to have at least grade 5 reading ability or the therapist to read the questions to the parents. It takes approximately 15-17 minutes to complete the 118 behaviour problem questions which measure parental perception of the child's behaviour on a 3 point Likert scale from 0-2 with higher scores indicating a greater problem. Questions focus on both behaviour problems as well as behavioural assets. Scores from the checklist are then transferred to the Child Behaviour Profile which enables the clinician to review the behavioural syndromes manifested by the child, the specific items rated by the parents, and how the child compares to typical children of the same age and sex. Items are grouped into subscales and tallied to determine a total score. There were four subscales from this checklist that were of interest to this study, namely, somatic complaints, social withdrawal, depression and aggression. The total score for each subscale is mapped on the profile and compared using T scores. A T score higher than seventy indicates a problem area.Based on empirical research, with adequate validity (.34-.88 for males and.44-

.91 for females) and reliability (.84), the Achenbach is considered the best standardized instrument of its time (Buros,1985).

Home Situations Questionnaire

The Home Situations Questionnaire (1980) was devised by Barkley as a measure of hyperactivity. The H.S.Q. consists of 16 general questions regarding situation and behaviour. The parents indicate whether their children have problems in each setting by circling yes or no and then rating the severity of the problems on a 9 point Likert scale. A problem is indicated if 50% or more of the situations are rated 5 or higher. It should be noted however, that studies are ongoing to establish its interparent and test-retest reliability, in addition to investigations on correlations with other rating scales and objective observations of parent-child interactions.

Evaluation form

The evaluation form was revised from an evaluation devised by Eaton et. al. (1980)(Appendix D). The questionnaire consisted of ten questions requiring written responses. The questions focused on the value of the program requesting parents to convey their likes, dislikes, goals future plans, suggestions for program improvement and opinion on the child section in addition to any general

comments they might wish to make. Responses were tallied and qualitatively analyzed.

PROCEDURE

Upon referral from various community sources to the Child Development Program, all parents were given the Conner's Behaviour Checklist (1960), the Achenbach Child Behaviour Checklist (1983) and the Home Situations Questionnaire (1980) to determine the severity of the child's problems. Upon diagnosis, all parents were interviewed by the counsellors and given the choice of joining the experimental group or remaining in individual counselling. Group activity commenced once the appropriate number of parents were obtained for the experimental and control groups, and consent forms (Appendix A) were signed.

The group process continued for six consecutive weeks at the end of which parents were permitted to resume the individual counselling they were receiving from the agency. During the six weeks parents and children attended the sessions at the Child Development Program. For an outline of procedures used with each group see Appendix B. Parents met in a meeting room and were lead by three experienced case workers from the centre. The children met in the playroom at the Centre and were lead by the experimenter and three case workers so that the ratio of leaders to children was approximately one to one. All three groups met at

different times so that there were three six week programs running concurrently.

Upon completion of the program, parents were asked to complete the Achenbach Child Behaviour Checklist (1983), the Conner's Behaviour Checklist (1960) and the Home Situations Questionnaire (1980) for post testing as well as an evaluation form. All tests were collected during the final home visit on the seventh week. Parents were also debriefed at this time and informed of the purpose of the study and predictions. Once information from the results were calculated, the parents were sent brief summaries of the findings. Information was made confidential by assigning numbers to clients names rather than maintaining names on accumulated written information.

RESULTS

Comparison of pretreatment scores for all groups on all three instruments showed no significant differences between any of the groups including the control group. This indicates that pre and post differences in the experimental groups would not be attributable to differences between the groups from the beginning and any differences at post testing between the control group and experimental groups cannot be attributed to already existing differences between the groups.

Dependent t-tests were used to compare pre and post treatment performance means for all treatment groups and the control group for all measures. The results are presented in Tables 1,2,and 3. On the Conners Behaviour Checklist (1960), pre and post treatment scores differed significantly only for fathers of intact families. Here fathers rated significantly fewer problems following the group program (t= 5.00, $p>.038$). Although none of the remaining groups showed significant differences, all post treatment means indicated fewer behaviour problems were indicated.

For the Home Situations Questionnaire (1980) all groups with the exception of fathers of intact families indicated fewer instances in which problem behaviours occurred. They also indicated more problems at post testing although none of the comparisons between means were significant.

Although pre and post treatment scores on the Achenbach Child Behaviour Checklist (1983) showed no significant

differences for any of the groups, it was most interesting to note that all of the groups involved in the group training treatment indicated higher numbers of behaviour problems following the group experience with "mothers" seeing 2.25 more problems, "fathers" 5.66 and "singles" 5.33 more. These compare to a post test decrease of 12.25 for the control group.

Change scores calculated on the Home Situations Questionnaire (1980) and the Conners Behaviour Checklist (1960) showed no significant difference between the combined experimental group and the control group indicating that individual counselling was no more effective than group counselling. Furthermore, when the experimental groups were separately compared to the control group, no significance was found.

However, when these comparisons were made on the Achenbach Child Behaviour Checklist (1983),a significant difference was noted in the number of behaviour problems. Control group change scores were significantly lower than the change scores of the combined experimental groups (t=-2.463, p.>.048). Results are presented in Table 4. When the experimental groups were separately compared to the control, the control group change scores were significantly lower than the change scores of the single parent group (t=-2.911, p.>.026)

Since each measure contains subscales of particular interest to those working with children with Attention

Deficit Disorder, a brief examination of the subscales was made. To begin, pre and post treatment comparisons were completed for the individual subscales on the Conners Behaviour Checklist (1960). As can be seen in Table 5, two subscales show significant differences: the impulsive hyperactive scale and hyperactive index. On the impulsive hyperactive subscale the single mothers and fathers in the two parent families noticed significant decreases in their children's problem behaviour. Decreases noted by mothers and controls were not significant. On the hyperactive index single mothers and the control group parents noticed significant decreases in their children's hyperactive behaviours. Once again, pretest scores for all groups on all subscales were not significant.

The Achenbach Child Behaviour Checklist (1983) contained four subscales of interest to this study; somatic complaints, social withdrawal, depression and aggression shown on Table 5. The only subscale showing significance at post testing was the aggression subscale completed by the control group. This was part of a control group trend indicating fewer behaviour problems in all four subscales. As with the total scale scores reported in Table 3, scores for the three experimental groups on all other subscales, with the exception of somatic complaints for the mother and father groups, showed increases in problem behaviours reported. None of these were significant.

Using pre-post change scores, comparisons were made between all group scores within subscales and control change scores, the only significant difference was in comparison between single mothers and the control group on the aggression subscale (t=-2.371,p>.05). Single mothers rated their children significantly more aggressive than the control group parents on the Achenbach Child Behaviour Checklist (1983). Other group comparisons within the subscales showed no further significance.

The Home Situations Questionnaire (1980) was originally used to provide the experimenter with guidance in choosing situations for roleplaying during the group sessions. It was deemed useful to examine the items on the Home Situations Questionnaire (1980) separately to determine whether any significant change scores within groups occurred in specific situations. Table 7 shows a mean for each situation across groups. A mean rating higher than five implies a problem area. T-tests indicated that there were no significant changes from pre to post testing. Fathers, for example reported increased ratings on six items, mothers on eight, single mothers on four and controls on six.

Of interest in the H.S.Q. data were the situations where the largest number of problems were reported. These were when the parent was on the telephone, when visitors were in the home, and when the child was in public places for all groups at pre testing. However, with only four to six subjects providing statistical data in each group, all

results that have been presented only for descriptive purposes.

Program Evaluation

Home visits were made the week following completion of the group programs to all parents who participated or allowed their children to participate. Post tests were completed in addition to an evaluation of the program. The evaluation questionnaire (Appendix D) was used to provide the Child Development Program of the Regional Children Centre of Thunder Bay with information pertaining to the usefulness of the group parent training program. Although few significant results were found, all parents felt they gained something from the parent training program.

From the thirteen evaluations completed, twelve parents reported that they realized that they could help their children with the Attention Deficit Disorder and the problems that arise from it. Eleven indicated they liked the support of the parent training program. In answer to some of the questions on the evaluation questionnaire, parents reported as follows: nine said they realized they were not alone; six found they were able to discuss their problems without feeling inadequate or judged by others; three obtained information on Attention Deficit Disorder. The timing was least liked by six respondents. With sessions beginning at 6:30 p.m. and ending at 8:00 p.m., parents felt

rushed getting to the Child Development Program on time, and their children were tired by the time they got home after the session. For eleven parents their goal in participating was to gain understanding of Attention Deficit Disorder; for seven it was to learn how to better deal with the problems that arise from it.

When asked what they learned about themselves through group participation, parents listed such things as: realizing the need to be more consistent with their children; four said realizing that by understanding their child's problem they could be more patient eight realized that their own feelings effect how they react to their children. Parents felt they enhanced their parenting skills by:becoming consistent with their children and following through in the area of discipline, using the children's relaxation technique, ignoring inappropriate behaviour, and applying the when...then rule.

One of the concerns that nine of the parents had since the group ended was lack of continuing support. Many parents felt that a longer program would have been more beneficial. They mentioned changes in their children's behaviour and changes in their parenting skills, but many realized that change was a continuing process and that the behaviour problems would not change completely overnight. They felt support from the group would help the process.

With respect to the style and effectiveness of the leaders, twelve parents expressed an appreciation for the

time and care the leaders offered. Other comments were directed to the children's groups. Overall, eight parents found their children more accepting of A.D.D. and more motivated to work on it. The children enjoyed the groups because they were all accepted for who they were and no one received differential treatment. Furthermore, nine parents noted improvement in the children's self-esteem. Eight parents also found that the older children gained more from the group because they could plan ahead.

To summarize, parents found the sessions to be informative and useful. Many reported feeling relaxed and comfortable in the small group setting and stated that the small changes they experienced could be enhanced by ongoing and longer programs.

TABLE 1

Pre and Post Treatment Means for The Conners Behaviour Checklist (1960) for Individual Groups.

Group (n)	Pretreatment Mean	s.d.	Post Treatment Mean	s.d	t.	p.
Single Parent n=6	38.83	21.44	34.50	21.30	1.32	.244
Mothers n=4	51.75	17.39	47.75	31.46	0.38	.731
Fathers n=3	51.00	20.22	41.33	19.86	5.00	.038*
Control n=4	44.25	14.10	35.50	11.48	1.68	.191

*p. <.05

TABLE 2

Pre and Post Treatment Means for Total Scores on the Home Situations Questionnaire (1980)

Groups (n)	Pretreatment Mean	s.d	Post Treatment Mean	s.d.	t.	p.
Single Parent n=6	43.00	18.40	42.33	31.58	.08	.936
Mothers n=4	55.75	22.87	52.50	37.32	.41	.711
Fathers n=3	47.33	43.32	52.67	40.20	-1.09	.391
Control n=4	56.75	38.97	46.75	38.92	1.46	.240

TABLE 3

Pre and post Treatment Full Scale Means for the Achenbach Child Behaviour Checklist (1983) for Individual Groups

Groups (n)	Pretreatment Mean	s.d.	Post Treatment Mean	s.d.	t.	p
Single Parent n=6	35.00	25.66	40.33	29.95	-1.41	.217
Mothers n=4	50.75	23.61	53.00	26.91	-0.42	.700
Fathers n=3	48.67	25.72	54.33	22.75	-0.45	.700
Control	48.75	11.09	36.50	11.62	2.54	.085

TABLE 4

Change Score Comparisons Between Combined Experimental Groups and the Control Groups on Three instruments

Instrument	Group: Combined Experimental Group n=13	Group: Control Group n=4	t.	p.
Conners Behaviour Checklist (1960)	-7.861	-10.75	-.499	.635
Achenbach Child Behaviour Checklist (1983)	4.417	-12.25	-2.463	.048*
Home Situations Questionnaire (1980)	- 0.5	-8.75	-1.317	.303

* p.<.05

TABLE 5

Pre and Post Treatment Comparison for all Groups on Subscales of the Conners Behaviour Checklist (1960)

Subscale	Test	Group			
		Single Parents n=6	Mothers n=4	Fathers n=3	Control n=4
Conduct Problem	Pre	7.00	13.25	12.00	10.00
	Post	7.33	10.50	10.33	8.00
Learning Problem	Pre	5.17	7.50	7.00	7.00
	Post	4.67	6.50	5.33	5.00
Psycho-somatic	Pre	1.33	2.00	3.00	0.75
	Post	1.50	1.50	1.33	0.50
Impulsive Hyperactive	Pre	7.83	8.25	8.00	7.75
	Post	5.33*	7.00	7.00*	5.50
Anxiety	Pre	2.33	4.00	3.33	2.00
	Post	2.83	3.75	3.33	3.25
Hyperactive Index	Pre	14.50	19.00	17.67	18.75
	Post	10.50*	14.25	10.33*	11.75*

*p. <.05 between pre and post test scores

TABLE 6

Pre and Post Treatment Group Means on Subscales of the Achenbach child Behaviour Checklist (1983)

Subscale	Test	Group			
		Single Parent n=6	Mothers n=4	Fathers n=3	Control n=4
Somatic Complaints	Pre	1.67	5.50	3.33	5.75
	Post	3.00	4.50	3.00	4.50
Depression	Pre	7.33	11.75	13.67	8.50
	Post	9.17	13.00	15.67	5.75
Social Withdrawal	Pre	4.17	8.25	5.33	4.75
	Post	5.17	9.00	7.67	3.50
Aggression	Pre	21.83	25.25	26.33	29.75
	Post	23.00	26.50	28.00	22.75*

*p. <.05 between pre and post test means.

TABLE 7

Pre and Post Treatment Group Means on sixteen Situations of the Home Situations Questionnaire (1980)

Situation	Test	Group			
		Single Parent n=6	Mothers n=4	Fathers n=3	Control n=4
playing alone	Pre	0.83	1.25	0.00	4.75
	Post	1.17	0.50	0.00	0.00
playing with children	Pre	2.83	3.50	4.33	4.00
	Post	2.83	4.50	5.67	2.75
at meals	Pre	1.67	4.00	2.33	5.00
	Post	2.33	3.50	4.67	4.50
getting dressed	Pre	1.17	5.00	2.00	5.50
	Post	3.33	2.75	3.67	4.00
washing/ bathing	Pre	1.17	2.50	2.33	0.75
	Post	0.50	3.00	4.33	2.75
you are on the phone	Pre	5.33	6.00	3.33	4.75
	Post	4.00	4.00	4.67	5.50
watching television	Pre	1.00	3.25	1.67	1.50
	Post	1.50	3.50	1.67	1.75
when visitors are present	Pre	6.17	4.25	4.00	5.00
	Post	4.83	4.50	4.33	5.75
visiting others	Pre	5.67	3.25	3.67	2.75
	Post	3.50	4.00	3.00	2.25
in public places	Pre	5.83	5.50	4.67	6.25
	Post	4.33	2.75	4.33	5.25
doing chores	Pre	3.83	4.25	5.00	5.75
	Post	4.50	5.00	4.33	3.75
going to bed	Pre	1.67	2.75	3.33	4.25
	Post	2.83	4.25	3.33	4.50
in the car	Pre	1.17	1.75	2.33	2.00
	Post	1.00	1.75	2.00	3.50
with a babysitter	Pre	2.67	1.50	3.00	2.00
	Post	1.33	2.75	1.67	0.00

TABLE 7 (Continued)

at	Pre	3.50	4.00	3.67	3.25
school	Post	2.67	3.75	3.33	2.25
doing	Pre	0.00	3.00	1.67	1.75
homework	Post	0.00	2.00	1.67	0.00

DISCUSSION

The Child Development Program of the Regional Children's Centre of Thunder Bay was interested in implementing group parent training in order to involve more families in the counselling process. This study was concerned with whether group parent training would prove more beneficial than individual counselling for parents of children with Attention Deficit Disorders. Results clearly indicate little support for this hypothesis. There were no significant change score differences between the experimental groups either combined or separately compared to the control group on two measures; namely the Home Situations Questionnaire (1980) and the Conners Behaviour Checklist (1960).

However, the Achenbach Child Behaviour Checklist (1983) illustrated a significant change score difference between the control group and the combined experimental groups. The control group rated their children's behaviours significantly lower than the combined experimental group. Furthermore, when groups were separately compared to the control group, change scores calculated for the single parent group indicated that this group rated their children as more problematic overall than the control group.

Examination of the results on the Achenbach Child Behaviour Checklist (1983) indicate a general trend within the groups. Overall, the control group rated their children more positively than the other groups. On this particular

instrument, each experimental group noted a general increase in their children's problematic behaviour. These increases were not significant except for the single parent group compared to the control group. This explains the significant difference between the combined experimental group and the control group.

It might be concluded from these results that the single parents had a greater difficulty in dealing with their child, especially in the areas of aggression, somatic complaints, social withdrawal and depression. Although single parents rated their child's behaviours more negatively than the other experimental groups, these ratings did not differ significantly in comparison.

Overall the only significant difference between short term group parent training and individual counselling at pre and post comparisons was found on the Conners Behaviour Checklist (1960) completed by the fathers. Dependent t tests indicated no other group differences on the Home Situation Questionnaire (1980) or the Achenbach Child Behaviour Checklist (1983) .

Subscale comparisons on the three measures found the only significant group comparison of dependent t-tests reflected a greater incidence of single parents rating their children significantly more aggressive than the control group on the Achenbach Child Behaviour Checklist (1983). These results further support the contention that single parents had more difficulties than the control group who

were receiving the individual counselling. Furthermore, single parents may have had difficulty in developing the ability to provide more consistency within their family units by using strategies taught in the group to reduce the incidence of aggression in the home. A possible explanation for this is that as a single parent the responsibility of parenting rests solely on the one parent therefore there is no additional support within the family unit.

A dependent t-test on the fathers' group, showed a significant decrease in the their ratings of problematic behaviour on the Conner Behaviour Checklist (1960) . A possible reason for this decrease is that fathers on average may have been reluctant to show a lack of improvement in their child's behaviour and therefore rated the problem behaviours more favorably.

Other significance was noted in comparisons between single mothers and fathers of intact families on subscales. On the Conners Behaviour Checklist (1960) both single parents and fathers of intact families noticed significant decreases in their children's behaviour on the impulsive-hyperactive subscale while single parents, fathers of intact families and the control group noted significant decreases in their children's behaviour on the hyperactive index subscale.

The fact that these two subscales contained significant decreases in responses is not surprising since the parent training program was devised to specifically address the

problems of families of hyperactive children which the questions on these subscales measured. These findings could be indicative of a successful program since decreases in problem behaviours were noted in the areas the program was aimed. True differences in the groups may have been clouded by the inclusion of other behaviours that were not pertinent to this program. Therefore the full scale measure was not adequate to test the effects of this program.

Scores obtained from mothers of intact families showed decreases in the same child behaviours but these decreases were not significant. One might infer that single parent mothers and fathers of intact families are the ones who attend most to their children's behaviour and discipline, therefore noting more changes in their children's behaviours than mothers of intact families. There was one significant finding on the aggression subscale of the Achenbach Child Behaviour Checklist (1983). The control group rated their children less aggressive on the aggression subscale at post testing. This was in fact part of a trend in the control group in that they rated their children's behaviours as less problematic in comparison to the experimental groups.

A significant decrease in problematic behaviours when the child was playing alone was noted on the Home Situations Questionnaire (1980).This decrease was noted when the combined experimental groups were compared to the control group. The control group showed a more significant decline than all three experimental groups combined. Also

interesting was the number of unexpected increases in behaviour ratings from pre to post testing.This may indicate that parents did not learn to use confidently the disciplinary strategies taught to them and could not successfully apply the strategies to decrease the number of aversive behaviours in particular situations. Alternatively, it may be that parents become more aware of behaviour problems because of the emphasis placed on them during the six weeks of group activity. Consequently, the parent would perhaps perceive problems more frequently and experience some frustration with the behaviour thus causing increased scores on the post test.

Despite the relatively minor changes in children's behaviour as measured by parental response to the three questionnaires used, the parent evaluation of the program reveals a somewhat different perspective. Since parents evidently valued the group it is possible that lack of significant findings are the result of problems within the experimental design in revealing what parents apparently found and what statistical data exposed. Certainly, the disparity between the statistical results and program evaluation make certain implications regarding the outcome of this study. Although both the individual and group counselling proved to be effective, parental evaluation might play an important part in deciphering the problem in this experimental design. The most important suggestions are that the group was not long enough, parents failed to learn

the techniques or failed to apply them properly. These possibilities have been explored, not without controversy, in the literature.

One question raised by a number of studies is what effect the parents' beliefs in the program has on the actual outcome of the program. For example, Tramontana, Sherrets and Authier (1980) have stated, "the increased use of parent training programs seems to have been propelled more by a belief in the efficacy of parent education than by actual demonstrations of effectiveness." Although results in the present study are tenuous at best, improvements were seen in targeted subscale behaviours and the lack of differences between the experimental and control groups appears to indicate that both the experimental and control groups are progressing at an equal rate, on the whole, in therapy. Tramontana, also question whether changes in a child's behaviour will be noticeable at the termination of the parents' program. They conclude that parent education programs show some potential as a means of prevention and intervention of problem behaviours in children but, due to the controversial results of many studies, they caution that the effectiveness of parent training programs has yet to be empirically demonstrated.One obvious effect in this study is that although only minor changes occurred in behaviour measured by the other instruments, according to data from the Home Situations Questionnaire (1980), increases in reported problems at least indicate that parents have become

more aware of problem behaviours. This, coupled with the wish for longer follow-up or even training, is strong demonstration for the efficacy of group forms of intervention.

One argument against some studies is the use of parent verbal reports as measurements of changes in child behaviour. Peed et. al (1977) found in their studies that only three out of eight categories of their parent verbal report questionnaires showed any differential responses despite significant changes in both parenting skills and child compliance as measured by experimenter observation. They dispute parental reports as adequate evaluations for parent training programs concluding that,

> " while changes in child behaviours are the ultimate criteria by which the effectiveness of any parent training program must be judged it is important to identify and measure the changes in targeted parent behaviours which are assumed to modify child responding."

Heifetz (1977) proclaimed that parent training courses succeed in encouraging children to do better behaviourally, but he condemned these training courses for not making constructive attempts at evaluating the parents' ability to maintain the learned parenting skills. Too many studies have depended solely on changes in child behaviour as a measure of success of the program. A very important aspect that should be looked at is what the parents have truly gained from the program. It is the parent who will be the leader for the child once the program is over so it is necessary

for the technique covered to be used by the parent in the home situation.From results of this study, it is obvious that parents do value the group program and gain much from them. What seems to be required now is some research which varies content and length of training to determine whether, as suggested by parents in this study, additional training and follow-up, would lead to greater improvements in behaviour.

In addition to the importance of parents acquiring the necessary skills to maintain the desired behaviour in the children, the content or orientation of the program is also important. After reviewing the various orientations of treatment for children with A.D.D.H. in group programs, Whalen et al, (1978) concluded that there was no compelling evidence that psychotherapy was effective. They found that behavioural and cognitive-behavioural programs were more successful but results tended to be limited in duration and scope. In the present study, when cognitive and behavioural techniques were used much of the success and generalizability depended heavily on the parents' ability to understand, learn and use these techniques which was not tested in this study. This suggests that some sort of an evaluation should be made to ensure that parents have adequate understanding and ability to use the strategies illustrated, before the program is over. The fact that many studies did not implement some sort of an evaluation on acquired parental skills through the program may be a major

reason for the confusion in the literature. If the parent does not learn the required parental skills successfully then what has been learned through the program is quickly lost thereby decreasing the effectiveness of the program as an intervention in changing problematic behaviour in children.

Another factor which adds to the controversy in the literature is generalizability. Whether a program has truly been effective should be measured not only on the basis of whether the parent had indeed acquired the desired parenting skills but also on the basis of how well the skills learned in the program worked over time and were used by parents in confronting novel problems. Given that some strategies will be forgotten, a follow-up, as suggested by the parents in this study, would enable the experimenters to focus on forgotten skills and thereby increase the chances of learned techniques generalizing to new behaviours.Furthermore, programs that use the child's reasoning are able to develop more generalizability but the length of the program is very important in altering the child's reasoning ability. Parents in this study complained that they wanted a longer program.

Finally,the method of determining group composition could be a factor of interference with collected data since the participants were nonrandomly appointed to a particular group according to marital status and preference to group or individual counselling. Therefore a difference was already

created in that the control group particpants preferred individual over group counselling.

Although some studies have found serious problems with some of the parent training programs, other studies have proven parent training programs are quite effective. Helm (1987) reviewed a number of studies indicating that the effects of group and individual counselling are very similar. One study in Helm's review reported that little professional time was saved in group training and parents were not as successful in producing and maintaining the desired change in their children. Since programs concentrating solely on the outcome of child behaviour also require longterm and frequent professional input to be effective, parental involvement becomes even more important as a means of combating cost and professional time involvement. If parents are to be used as behaviour modifiers, then they should be tested to ensure that they have acquired the full understanding and the ability to use behaviour modification techniques. In the present study, parents were given ample examples for roleplay and criticism. There were no standardized measures of how well parents incorporated the strategies taught into their own method of parenting.Future research should attempt to assess the skill levels achieved by parents.

Another study by Griest, Forehand and Rogers (1982), also supported the use of parent training. Results provided evidence for parent training effectiveness by combining

group training with focuses on parental perception of the child, personal, marital and extrafamilial areas of adjustment. This approach facilitated treatment effects on child deviant behaviour and showed evidence of maintenance of targeted behaviour.

As stated earlier, success of a parent training program is dependent upon the content of the program. Studies have shown that some strategies are more successful in helping parents and their children. In a study similar to this one, Johnson (1981) reported behavioural and reflective treatment of the mother and behavioural treatment of the child resulted in improvement by the child according to parent rating of specific obedience behaviours.Finally, other strategies such as cue recognition and rehearsal have illustrated some potential especially when coupled with social- problem solving training. Overall, cognitive-behavioural procedures have been proven effective especially in improving classroom behaviour. However generalizability needs to be demonstrated before this procedure is of clinical use.

Barkley (1979) stated that generalization would not occur if there was no overlap between strategies covered in the program and the outcome of changes in behaviour. To combat this problem Barkley and Cunningham (1978) suggested combining both behaviour modification and cognitive-behaviour modification to provide maximal benefit by changing the child's problem behaviour patterns in his own

environment. This method was in fact used in this study. Parents were taught behaviour modification techniques in addition to a cognitive-behaviour modification technique of making a plan and planning ahead. From parental comments concerning the effectiveness of the children's group, parents rated the program very effective for children six years and older because they (the children) were able to think ahead and follow a plan where younger children had difficulty following through a plan and needed more assistance.It appears, therefore, that success of interventions involving group as well as individual therapy may be more dependent upon the age of the child than previously recognized.

Although a major short coming of this study was an unfortunately small number of participants which frustrated any attempts at quantitative analysis, there are a few outcomes which may point the way, given further research, to more effective outcomes. Within the children's training groups the one-to-one relationship with the adult trainer and the intensive play training may have been "on the verge" of producing important changes in the children's sense of self-control. This glimmer is evident in the decreases seen in hyperactive-impulsive behaviour and the decrease seen in problem behaviour for children playing alone. It appears important that interventions be applied to children as well as parents to enhance the possibility of positive outcomes.

In terms of the parent groups, although behavioural outcomes with children were minimal, it might be safe to suggest that the parents were most probably sensitized to the behavioural problems of their children and their own child management techniques. Their desire for more training and follow-up indicates this sensitivity. Furthermore, follow-up at a later date also may have provided different findings, as indicated by the parental evaluation of the program when they suggested that the change process was ongoing and behaviours could not be eliminated overnight. A follow up would provide interesting information regarding which techniques parents are able to maintain over time.As Tramontana, Sherrets and Authier (1980) have found, "follow-ups are also obviously important in determining whether or not obtained changes in parent or child are being maintained over time."

Finally, without a no-treatment control group, for comparison it is difficult to separate true treatment change from change due to factors such as practice effects, regression toward the mean or attempts to please the experimenters.However, the purpose of this study was to compare a parent training program to the individual counselling already in practice. Since a few significant differences were noted one can conclude that group parent training may be more cost effective and, depending on the number of families on the referral list, more effective and efficient than individual counselling.

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APPENDICES

Appendix A
Consent Forms

Appendix B
Detailed Outline of Activities in Each of the Children's Sessions

Appendix C
Manual for Both the Children's and Parent's Group Programs

Appendix D
Samples of Instruments Used

Appendix A

Consent Form for Groups with Both Parents and Children Participating.

Consent Form for Parents Whose Children are Participating in the Children's Group.

APPENDIX A

CONSENT FORM

Dear Parent(s):

The Child Development Program would like to thank you for your interest in participating in the parent training groups for parents whose children are considered hyperactive. Your participation is greatly appreciated and will provide the Centre with valuable information that will help it to run groups as a permanent service to other families.

Group participation will involve completion of questionnaires administered during the assessment, and full participation in the parent and children's groups for six consecutive weeks. Data gathered for the purpose of research will be kept confidential by assigning numbers to compiled information rather than the actual names of families.

The group is devised to provide help and support for parents of hyperactive children. In addition to the more popular format of training programs, the agency has included a children's group which will coincide with the parent group. In this group the children will be learning the same techniques as the parents but only through utilizing a combination of creative drama and a variety of play activities. The sessions will be one and one-half hours a week for six consecutive weeks. Group leaders will provide assistance in using the techniques that will be used to help parents and children deal with the hyperactivity.

Group sessions will be substituted for individual counselling for the six weeks but upon completion of the training program individual counselling will be re-instated if desired. Parents not wishing to participate will be provided the individual counselling regardless of their decision on the group sessions.However, your participation will be greatly appreciated as it will help to enhance the service the Centre provides. Thank-you.

I have read and understand the preceding description of the parent training program and take full responsibility for my participation in the parenting group.

Signature _____

Date _____

CONSENT FORM

Dear Parent(s);

The Child Development Program would like to thank you for participating in our program. Your support for our children's program is greatly appreciated and will provide the Centre with valuable information that will help it to run children's groups in the future.

Your participation will involve the completion of questionnaires administered during assessment, and a commitment to seeing that your child attends the group for the six consecutive weeks. Data gathered for the purpose of research will be kept confidential by assigning numbers to compiled information rather than the actual names of families.

While you may continue with individual counselling or any other support systems that have been provided you, your child will be learning some problem-solving and relaxation techniques through creative drama and a variety of play activities. The sessions will be one and one-half hours a week for six consecutive weeks. Group leaders will provide assistance in using the techniques that will be used to help the children deal with their hyperactivity.

Once again, your child's participation is greatly appreciated as it will help to enhance the service the Center provides you.Thank you.

I have read and understand the preceding description of the children's program and take responsibility for my child's participation in the program.

Signature_____

Date _____

Appendix B

Detailed Outline of Activities in Each of the Children's Sessions

Appendix B

Detailed Outline of Activities in Each of the Children's Sessions

**Session #1

Welcome and introduction to children and group leaders, and an explanation of why they are here.

Step one of the bear plan will be covered.

Explanation of the rules of the group, ie. sharing, turn taking and careful play etc.

Craft time- this week we will make bears to stick to the refridgerator.

Songs will be sung to give the children a chance to play around.

Snack time will be used to emphasize stopping and thinking. The children are asked to stop and think of the best way they should go to the snack room.

Quiet time follows with reading stories and doing some relaxation.

Before the children go home they will be given a scribbler with the picture of the bear. They will be asked to color the bear and take it back for everyone to see the next week.

**Session #2

Welcome and review of colored homework.

Puppets will introduce the turtle and role play some situations it is useful in like ignoring inappropriate behaviour.

Craft time will focus on showing the children that we are all different. There are special things about everyone. To explain this the children will make a mask to look just like them.

The children will have some time to sing songs and do some creative movement.

Snack time again provides the chance to think of a plan to get to the snack room.

Quiet time - Stories will be read and relaxation will be practiced.

The children are given a turtle to color for homework this week.

**Session #3

Welcome and review of homework.

The puppets will roleplay ignoring inappropriate behaviour. The children will be asked to help out.

Step two of the bear plan will be introduced. Children will be given practice in making a plan. Games will be played to help them make plans.

The turtle technique is continued from last week to introduce the craft. Tonight the children will be making a turtle collage to help them grasp the idea of the turtle technique.

Once again songs will be sung and some creative movement will be used.

Snack time once again emphasizes stopping and making a plan.

Quiet time will consist of stories and relaxation. The story will emphasize safety and relaxation will help the children to gain inner control.

Children will be given a second bear to do for homework.

**Session #4

Welcome and review of homework.

The puppet show will cover the third step of the bear plan. The children will be asked to follow along the puppets roleplay of a telephone situation.

Turtle game is played followed by copy cat to emphasize body awareness.

This session will also discuss feelings. The children will be asked to identify facial expressions and make faces for different feelings. This is to help them identify others' feelings.

In keeping with the discussion on feelings, the craft will consist of making different faces out of icing paint.

Snack time will be used to emphasize all the steps of the bear plan covered so far. First, STOP what are you supposed to do? Secondly, think of a plan to follow, and third did we follow our plan?

Quiet time will consist of creative movement in which the children will make their bodies look angry, happy sad etc.. We discuss what people do when they are angry and introduce the turtle method as a means of controlling anger. This will be followed by a story and relaxation.

A picture of the third bear will be given to the children to color as homework.

**Session #5

Welcome and review of homework.

Puppets will roleplay specific situations to give the children the chance to follow along, making their own plans.

The turtle game is played along with copy cat to emphasize body awareness.

This week crafts will focus on body awareness. The children will do a number of finger paints. They will also make their own personal books to remind them of what they have learned from the program.

Snack time emphasizing the three steps of the bear plan.

Quiet time will consist of stories and relaxation. The turtle will again be discussed as a means of controlling their own behaviour.

A picture of the turtle will be given as homework to color for the next session.

**Session #6

Welcome and review of the homework.

Puppets will help the children practice their planning. They will introduce the final step of the bear plan "how did I do?" There will be emphasis on the fact that it is okay to make a mistake so long as they try again.

The turtle will be practiced again so that the children will develop an understanding of when it is appropriate to use the turtle.

Craft will be salt ceramics. Children will be allowed to make whatever they choose. They will be encouraged to evaluate how they did when they finish.

Snack time will incorporate the four steps of the bear plan.

Quiet time will consist of stories and relaxation with a final emphasis on creative movement.

Diplomas will be given out at the end of the session to acknowledge the child's work.

The children will be given the final bear to add to their homework scribbler.

Appendix C

Manual for Both the Children's and the Parents' Group Programs

APPENDIX C
MANUAL CONTENTS

ATTENTION DEFICIT DISORDER GROUP

OVERALL OBJECTIVES:

1) To assist parents in viewing their children as people with individual differences that are often very difficult to manage and yet worthy of dignity and worth as human beings.

2) To provide concrete information as the cause, symptoms and current methods of treatment of Attention Deficit Disorder.

3) To provide a supportive environment and a possible future support network for parents who are dealing with very difficult children.

4) To assist parents to begin to develop and apply skills that will enable their child to function better at home, at school and in the community and to assist the family as a whole to function more adequately.

5) To reinforce the concept of long-term management rather than short-term treatment or cure when dealing with Attention Deficit Disorder.

BEFORE GROUP

1) Meet each parent and have a firm committment to follow the program.

2) Have the parents complete the Achenbach, Conners, and the Home Situation Questionnaires.

3) Give parents observation charts to be filled out prior to the first meeting.

4) Discuss with parents how to explain the group to their children.

SESSION #1

Parent Component

Parents are instructed to introduce themselves and to name their child who is participating in the program.

It is emphasized that this group is not a cure. It is designed to give information and to provide some methods that may help with problem behaviours.

It is also important to maintain confidentiality of all participants and to provide input in group discussion. Group cohesion and attendance ia a must. Some of the following expectations will be emphasized; participation, voicing concerns,honour/respecting other members by showing up on time.

Outline of the program and objectives.

Information on Attention Deficit Disorder

Information to include:

1) Definition

The child displays immature behaviour for his/her age. Some signs are not paying attention, impulsivity, and hyperactivity.The signs must be reported by adults in the child's environment,such as parents and teachers. Because the symptoms are typically varible, that is, they are not displayed in all situations, they may not be observed directly, especially in situations where there is one-to-one contact e.g. in a clinic or doctor's office.

2) Criteria

(A) Inattention: At least three of the following;
1. Often fails to finish things he or she starts,
2. Often doesn't seem to listen,
3. Easily distracted,
4. Has difficulty concentrating on schoolwork or other tasks requiring sustained attention,
5. Has difficulty sticking to play activity.

(B) Impulsivity: At least three of the following;
1. Often acts before thinking,
2. Often shifts from activity to another,
3. Has difficulty organizing work (this is not due to lack of intelligence),
4. Needs alot of supervision,
5. Frequently disrupts the class,
6. Has difficulty taking turns in games and group

situations.

(C) Hyperactivity: At least two of the following;
1. Often runs about and climbs on things,
2. Has difficulty sitting still or fidgets too much,
3. Has difficulty staying seated,
4. Moves about alot during sleep,
5. Is always on the go or acts as if driven by a motor.

(D) Symptoms are apparent before the age of six.

(E) Symptoms have lasted for at least twelve months.

(F) Not due to Schizophrenia, Affective Disorder or Severe or Profound Mental Retardation.

RELATED DIFFICULTIES:

1) Poor school achievement and/or learning disabilities
2) Physical and verbal aggression
3) Low self-esteem
4) Poor peer relations.

INABILITY TO CONCENTRATE:

Inability to sustain attention and to inhibit impulsive responding on tasks or in social situations which require focused, reflective and self directed effort.

OCCURRENCE:

Individual symptoms such as overactivity or attention problems are relatively common but the full spectrum of Attention Deficit Disorder occurs in 1 to 4% of school age children and 10 times more often with boys than with girls.

3) Diagnosis: The following are a list of available checklists used in determining the severity of the child's condition.

Conners Child Behaviour Checklist.
Achenbach Behaviour Checklist.
Barkley's Situation Questionnaire.

4) There are a number of speculated causes of A.D.D.. Here is a brief list of the most popular ones.

- Genetic: The family background is the best indication The first step is to eliminate the possibility of neurological problems

- Perinatal factors: Birth factors must also be investigated.
- Neurological insult: The possibility of a physical cause must be checked into.

5) Primary problems:

Teachers and classroom upset
Parental Stress
Inattentive and impulsive behaviours
Babysitting

PLANNING AHEAD

1) Focus in: eye level, eye contact, physical contact

2) Instructions: clear concise, short

3) Prompt child to memorize and review

4) Encourage efforts

5) Pick small areas to see progress

6) Make sure the child is developmentally ready. Allow for individual differences.

LEARNING DISABILITIES

Learning disabilities are defined as handicaps that interfere with learning. It develops from a physical problem within the brain not as a result of:
(1) emotional disturbances
(2) retardation
(3) physical handicaps
(4) poor environment

These four factors may exist with the learning disability but they are not causes.

A learning disability can be mild or severe. It can affect specific abilities such as language, memory, perception control of attention, impulses etc.

There will be a hand out to emphasize the points.

MEDICATION

Medication is one alternative used in the management of hyperactive children. The most common drugs preferred by doctors are Dexedrine and Ritalin. These drugs are stimulants but have a paradoxical effect on hyperactive

children by having a calming and organizing effect. When drugs have been prescribed accurately, marked improvement is noticeable in decreased hyperactivity, increased ability to concentrate, and increased ability to sit still for learning.

It should be pointed out that the drugs themselves do not improve learning but they do control interfering characteristics that hinder learning.

Medication should be carefully and frequently monitored. The optimal dosage is between .3 and .5 mg./kg. There is no evidence of possible drug addiction but there are however a number of side effects such as: supressed growth, abdominal pain, insomnia,anorexia, anxiety, weight loss, nausea, diarehea, dizziness,headache,and rash.

Review the observation charts that were handed out with the questionnaires in the previous week.

The think aloud program will be used to establish guidelines for the group to follow. There will also be homework from this program to ensure proper integration of the techniques at home.
This week the first step of the bear plan is covered. STOP what am I supposed to do? Slows the child down so that s/he can think.Parents are instructed on how to get their child to stop and think.

Inform the parents about the upcoming sessions and provide an outline of the dates and topics of these sessions. Also stress that both parents and children will be assigned homework each week which they are expected to have completed by the following week.

Homework

The parents will be asked to complete a chart to improve listening skills.

Ask the parents to identify two general target behaviours unique to their child. These general target behaviours usually fall under noncompliance, interpersonal problems, and off-task behaviour domains. Help parents think-up specific examples of behaviours that may fall under each of these general target behaviours. Some examples are as follows:

- not minding when they are told, talking back when told to do something, throwing temper tantrums etc.

- arguing, hitting, biting, not taking turns, not sharing,butting into converations, losing temper, etc.

- not completing a task such as homework or cleaning their room due to being distracted, not listening to their parents due to being distracted, etc.

Using these examples, discuss and demonstrate in a step-by-step fashion, how to complete the chart. Identify the behaviour first and then the antecedents, followed by the consequences.

Handouts

American Psychiatric Association, Committee in Nomenclature and Statistics (1980). Diagnostic and Statistical Manual of Mental Disorders (3rd. ed.) Washington, D.C. American Psychiatric Association, 41-45.

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Goals

- Introduction to program
- Set positive but realistic expectations for the program
- Information on Cognitive behaviour modification and A.D.D.
- Planning ahead and child proofing
- Improving listening skills.

Child Session

OVERALL OBJECTIVES:

1) To assist children in seeing that they are individuals with potential; in short, helping to improve feelings of self-worth and self-esteem.
2) To allow children the opportunity to participate in groups under a controlled environment.
3) To provide children with support and understanding of their situation.
4) To help children develop skills that will help them gain control of their hyperactivity and impulsivity.
5) To provide children with a strategy they can use any place,any time own their own.
6) To provide children the opportunity to take some responsibility for their own actions.

There will be a consistent focus throughout the entire six sessions of continual reinforcement and touching to help develop the child's self esteem.

Toys will be available until all the children have arrived.

Introduction to children will start upon arrival of all the children.

The children will be issued name tags to be worn during the session. Each time the child attends a session s/he will receive a sticker outlining the theme of the session. The sticker will be attached to the name tag for all to see.

After each activity a stop sign will be displayed to help the children STOP and think of what they are supposed to do. Once the bears are introduced and the first plan is discussed, each child will have a turn displaying the stop sign. This is to help them interate what they are learning.

Each evening we will begin by singing a song to make the children feel relaxed and welcome;
We are happy to see you here today here today here today. We are happy to see you here today ---------.

This is sung holding hands. It is repeated until all children's names have been mentioned. As each child's name is sung s/he goes to the center of the circle while others circle around him/her.

A puppet show illustrating the purpose and rules of the program will be performed to help the children understand why they are there.

PUPPET #1 — Hey kids! Can you tell me why we are all here today? Pause for children to answer.

PUPPET #2 — I think you've got it! You and your parents have come here because sometimes at home or at school there are problems. The reason that you and your parents have come is so that there will be less problems at home, at school and with our friends. During these groups we will play some games, and have some fun; but the most important reason why you have come is to work on problems so that you can all become better problem solvers.

PUPPET #1 — And you can't forget that we will be playing games, listening to music and books, coloring, cutting, glueing and a lot more.

PUPPET#2 — So, how about it kids, do you all understand why you are here?

PUPPET #1 — Now we are going to talk about group rules.... The first rule is: Stay in the room at all times! We don't want you to get lost! If you have to go to the bathroom, tell one of us and we will help you. You see this picture of the bear? He is here to remind you to STOP and ask someone before you go any where.

PUPPET #2 — The second rule is: Use our inside voices inside the room. Outside voices do not belong in here! We also must remember to use our inside feet so we can be very quiet. In case you forget look up here and see the bear telling you to be quiet.

PUPPET #1 — The third rule is: Listen with our ears. When one of us is giving directions and/or wants your attention. In all the fun that we will be having we don't want to miss something important so we will practice listening because

sometimes we all have problems listening.

PUPPET #2 — The fourth rule is: Work and play with others nicely. We want to make friends while we are here and playing nicely is one way to do that.

PUPPET #1 — The fifth rule is: Treat others with kindness. This is another way to be a good friend.

PUPPET #2 — The sixth rule is: Handle our things with care. If we play rough the toys will break and no one will be able to play with them. Remember kids, if you forget a rule look up at the bears and they will remind you of how you are supposed to behave in this group.

PUPPET #1 — Well, how about it kids, can anyone think of any rules that we have not talked about?

Now I'd like you all to take a look at the picture behind me.Look away up on the board. What is this bear doing? Put up your hand if you can tell me.

That's good!! He has to STOP and think about what he is doing.Now we are going to play a game. Since _____ said the right answer he can help me. Listen Carefully: this is how the game is played. I'm going to tell you to Crawl (tip toe, hop, walk etc.) around the room and when _____ holds up the stop sign I want everyone to STOP and don't even blink an eye.

Okay Now that we had fun playing the game can anyone tell me why the bear had to STOP? That's right he has to <u>think</u> before he does something, just like you had to stop and then think about what I asked you to do next!

Now, to practice what the bear just taught us let's STOP and think about how we are going to go to our seats at the table....

Now let's STOP and listen to what we are supposed to do. Today we are going to make a bear out of pom-poms. First I will Give you the pom-poms. I want you to glue them to this paper. You can have some for the arms and legs too. I will give you eyes, ears,nose and mouth too. So when everyone is sitting quietly we will start.
* Helper can emphasize this by asking the children individually what they are supposed to do.

The idea is to make a bear since the bear plan is what they will be working on to help them learn our strategies.

Snack time will be a part of planning ahead for the children.They will be told of the routine and each session will be consistent with previous ones so that the children can anticipate what activity will follow. Later on the children will be given the opportunity to help out during snacktime.

The first part of the bear plan has been introduced in this session through the puppet show and game. The children will be taught to stop and determine what they are supposed to do. To be able to answer this question they will have to listen carefully. We will also practice reviewing what has been said to us.

After snack time cleanup will follow. Once things are back in order there will be time for stories and songs. Relaxation will also be covered:

We will begin by having the children lie on the floor and do some deep breathing exercises. Take a deep breath in and fill up your bellies. Hold it there (5sec) now blow it out. Repeat a few times.

1) Now I want you to hold your arms out and make a fist. Now feel the tension in your arms. Let your arms fall to the floor as if they are made of stone.... just let them fall .... now relax, just shake them out.
2) Now hold your arms up again and this time I want you to spread your fingers as far apart as possible.... now relax.
3) Now make a muscle hold it as tight as you can. Relax.
4) Push your shoulders back as far as they will go .... Relax.
5) Turn your neck to one side... Relax... Now turn to the other side.... Relax.
6) Open your Mouth as wide as you can hold it there... Relax.
7) Now Stick your tongue out as far as possible..... Relax.
8) Shut your eyes as tight as possible... Relax.
9) Raise your eye brows and wrinkle up your forehead..... Relax.
10) Suck in your bellies as tight as you can and hold it....Relax.
11) Stiffen out your legs stretch them and push them to the floor.... Relax.
* Helpers can lay down beside the child to help him/her remain relaxed. Not all exercises have to be covered at one session judge according to the children's attention span.

GOALS

- Getting to know one other
- Learning the rules of the group and setting limits and controls.
- Turn Taking
- Planning ahead
- Listening skills.

SESSION #2

Parent session

First of all there is a time for questions and discussion.Homework is be reviewed and parents are asked to recall when their homework worked best with the child. Group leaders roleplay some of the positive situations.

CAUSES OF MISBEHAVIOUR

There are four major factors that influence a child's behaviour.

(1) The child's characteristics

(a) Temperament - the child's activity level, general attention span, emotionality, sociability, response to stimulation, and habit regularity.

The more difficult the child is with respect to the above aspects of temperament, the more difficult the relationship is with adults.

Conflicts between parent and child are greatest for the parent who has to place many demands on the child during the day. This will more likely bring out the child's negative temperament which only serves to negate the parents view of the child.

(b) Physical characteristics- The child's physical appearance,motor coordination, strength, stamina, and general physical abilities can influence an initial negative reaction from people.

(c) Developmental abilities- noticeable delays in language development, speech and expression, intelligence etc. often subject the child to ridicule. Delays such as these can also affect the child's ability to understand and comply with parental commands.

2. The Parents' Characteristics

Parents should be informed that their own characteristics play an important part in the development of behaviour problems in their children. Children can inherit their parents' characteristics but more importantly, certain parental characteristics influence the parents' consistency and effectiveness in managing child misbehaviours when it arises.

3. Situational Consequences

The environment affects the parents' abilities to provide consistent and effective guidance for misbehaving children are influenced by the consequences they face; therefore the situation can effect child compliance.

Discussion is to continue to help parents examine why the child is misbehaving. What happens? What does the parent do? For example, misbehaving to get parental attention.

4. Family Stress

There are a number of stressors within the family unit. To name a few;
(a) personal problems
(b) marital problems
(c) health problems
(d) financial problems
(e) stress related to one or both spouse's occupation
(f) problems with relatives and friends
(7) problems created by siblings

With problems such as these, parental tolerance level to misbehaviour is reduced therefore, even small things can appear major. Additional stresses also interfere with consistency and effectiveness of management. Furthermore, stresses tend to make the parent exaggerate the child's problems.

Stresses can also effect the children by heightening the likelihood of the child's displaying negative, oppositional or noncompliant behaviour.

5. The Reciprocal Interaction Among These Factors

Discussion should emphasize that these factors are not mutually exclusive; that is one factor can lead to another which can cause the difficult behaviour.

DEVELOPMENTAL SHIFTS IN SYMPTOMS

1. Infancy

These children may have a history of prenatal and perinatal difficulties. The most apparent symptoms during infancy are active, restless, and irregular in their sleeping and eating patterns, although this is not evident in all cases.

2. Preschool years

During these years, children are even more active and exploratory than is typical for children in this developmental phase.They maybe less responsive to the usual

disciplinary techniques relative to their peers and more likely to engage in dangerous behaviours as a result of their impulsivity.

3. Early School Years

Difficulties in attention and concentration become more apparent as the child enters school and is required to sit for longer periods of time. These children appear to lack the ability to modulate their attention processes and activity level to match the demands of the environment. Specific learning disabilities and poor peer relations will become more problematic and interfere with the proper development of self-esteem.

4. Adolescence

As teenagers, these children may have control of their hyperactivity but the damage from previous years leaves them marked with attention difficulties, impulsivity, and excitability.Problems stemming from the A.D.D. may become more apparent at this time such as poor school achievement, physical and verbal aggression, low self-esteem and poor peer relations.

5. Adulthood

Research indicates that many of the problems associated with A.D.D. continue into adulthood. In addition, other emotional and behavioural difficulties may also be present.

SELF-ESTEEM ISSUES

Parents are brought to awareness of how their child's self-esteem suffers by relating how the parents suffer with poor self-esteem.Discussion focuses on how the "don'ts" interfere with proper self confidence and self-esteem. Some areas to be discussed include:

-A sense of security (child-proofing). This includes a short discussion on safety precautions and keeping the child safe but allowing freedom to explore.

-A sense of identy or self concept

-A sense of belonging and acceptance

- A sense of purpose

-A sense of personal competence

GETTING TO KNOW YOUR CHILD

focus on strengths

provide love and acceptance
demonstrate faith and confidence in your child
have realistic expectations for your child
Explore the beliefs that parents have about their children and themselves as parents. Often parents have negative attitudes about their own ability to parent and their child's ability to perform certain tasks. The goal of this exercise is to help the parents become more realistic about their children and themselves in terms of being able to have some success with this program.

In order to facilitate change in parents expectation and beliefs about their child, it may be helpful to discuss aspects of their beliefs,such as the difference between having unchanging versus changing beliefs about the child. If one has a stable belief, such as " my child will never be a success" it maybe more difficult to fully engage in a change process than if one has a more unstable belief, such as "right now, my child is struggling with school work."

Another important issue to consider is the distinction between global and specific beliefs. Again, if one has the global belief that " my child is doomed to reck every family gathering" it maybe more difficult to focus and develop helpful strategies than if one has the more specific belief of " my child tends to get particularly over excited in family situations with too many other children and too little structure." Parents may be correct in their beliefs about their children but being too global discourages change. It is therefore important that parents adopt a more specific belief.

TURTLE TECHNIQUE

Parents are informed of the turtle technique as a means of relaxation and control for their child. As the children are learning how to do the "turtle" the parents are taught situations where it is useful and how to prompt the child to do the turtle.Group leaders will roleplay situations to emphasize the point.

PAYING ATTENTION

The parents are instructed to take part in an exercise. They are asked to write down five characteristics of a person they dislike the most and five characteristics of a person they like. They are then asked who they most behave like when relating to their child. Time is then spent on the child's reaction to the parents'behaviours. If the parent behaves most like the worst person then the child may retaliate rather than comply.

The objective of the exercise is to improve the quality of parental attention given to the problem child. Too often

good behaviour is ignored while misbehaviour receives the attention albeit negative. While improving parent-child interaction will not improve the problems, it is a necessary first step in the process.

To improve the parent-child relation parents are instructed on how to play with their child without directing, questioning,controlling, criticizing or providing any negative feedback that may cause friction between parent and child.

Play time is referred to as a " special time" between parent and child. The child should be informed that this time will take place every day. The child is permitted to choose the activity so that they come to believe that parents are interested in what s/he wants to do. Parents are encouraged to narrate the child's activity after watching the child for a few minutes. This eliminates the use of intrusive questions or giving commands that take over the child's play. Throughout play parents are instructed to provide positive feedback in a variety of methods,such as verbally, physically (a pat on the back), and appreciation.

If the child misbehaves during "special time" the parents should tell the child that the special time is over until the child can behave properly.

For homework the parents will be asked to spend positive time with their child for 15-20 minutes a day. This is
- to encourage self-expression through fantasy or reality play
- to encourage taking responsibility for one's self ie. to acquire inner controls.
- to communicate acceptance to the child.

The mechanisms for reaching the goals are:
- The empathetic behaviour of the parent
- the generally permissive structure of the session
- the limits of extreme forms of destructive behaviour.

Roleplaying will be used to illustrate positive time with the parent. Parents will then be given a chart on interacting with the child to fill out as part of their homework.

Handouts

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GOALS

- To encourage positive interaction
- awareness of self-esteem
- reinforcing listening skills
- planning ahead.

Children Session

Table toys are available until all the children have arrived.

The name tags will be issued and the children will be given their stickers to put on their tags.

The children will sing "We are Happy to See You Here Today" as their opening song.

Before the puppet show the children will be asked to show their friends the picture of the bear that they colored for homework.Each child, regardless of how well the picture is completed, will receive a star.

The puppet show will follow with a review of the rules and an acting out of not paying attention to the rules.

PUPPET #1	Good evening children! How are you this week? Do you remember what we talked about last week? Can someone raise their hand and tell me?
PUPPET #2	What did we say about staying in the room? What are we supposed to do if we have to to go the bathroom? Remember if you forget, you can always look up at the bears and see what they are telling you.
PUPPET# 1	How should we speak? Do we use our inside voices or our outside voices? What about our feet?
PUPPET #2	Remember what we said about listening? (Puppet #1 is now doing something in the corner and apparently not listening). Puppet #2 turns: Excuse me! But don't you know it isn't very nice to talk while others are talking. You might not hear some very important things if you don't listen. So kiddies, while we are in this room we will have to put our listening caps on. Can you all put your listening caps on now?
PUPPET #1	We are also here to learn to play with others. Can anyone tell me how we should play?
PUPPET #2	It would also be nice if we were careful

with the toys. They can break easily and then no one will be able to play with them.

PUPPET #1 — Now that we've gone over the rules, let's meet our new friend tonight. Look above me. Who do you see up there beside our friend Ralph Bear?

PUPPET #2 — What do you suppose he is going to tell us Here's a hint: When he feels scared or alone or angry he goes into his shell. He tucks his legs, arms and head in. Can any of you be a turtle?

The leaders can read the story about the turtle from the turtle manual.

The craft will follow the puppet show. During this activity the child is told that s/he will be making a mask. The leader will discuss with the child what s/he should do first etc. by walking the child through the plan.

The craft activity gives the children an opportunity to make masks which look just like them. They can use these masks in plays for in-class problem-solving activities.

Let's look at each other. Notice the color of our eyes and hair.Do you see how we are the same/different?
Tonight we are going to make masks that look just like us. I will give you a paper plate you can glue your hair and then color in your face.

Materials Needed:
- paper plates
- yellow chalk or pencil
- yarn in hair colors
- crayons
- popsicle sticks
- glue or paste
- tape and scissors.

STOP make your plan. tell your helper what you are going to do.

STOP in 5 minutes we will be going to snack make a plan of how you are going to go to snack.

Snacktime will focus on practice following a routine and planning ahead. The children will also be asked to help out.

Listening skills are also reviewed this week. The child will be asked to repeat what the leader has said so that the directions are sure to be followed.

The story session will involve listening skills.

This week's relaxation will involve imagery:

I'll give you a few minutes to relax. Spread your arms above your head and stretch! Point your toes and stretch your legs out.Relax.
Now while you are relaxing I'm going to tell you a story and I want you to picture everything in your head. Picture in your head that you are lying outside on a warm summer day. You are lying outside on the grass and looking up at the clouds as they go by.Notice how warm the sun feels....notice how nice and comfortable you feel as you look up at the sky. Imagine the clouds as they float by. I want you all to just there relaxed and picturing that you are outside on a warm summer day, and feeling so nice and comfortable ...as if you didn't have a care in the world.(QUIETfor approx. a minute) Now I'm going to count backwards from three. When I say three I want you to picture this room in your mind without opening your eyes. Two I want you to open your eyes but remain lying down. ONE I want you to stretch and get ready to get up.

Before the children leave they will be given their folders with the turtle in them. They will be asked to color the turtle for homework.

GOALS

- to encourage positive interaction with peers
- improve self-esteem and body awareness
- reinforce listening skills
- planning ahead
- increasing appropriate behaviour in peer interaction.

SESSION THREE

Parent session

Time will be devoted to discussion and reviewing homework.Roleplays are to be done on some of the more difficult situations.

Step two of the bear plan is covered. The parents are instructed on how to prompt and assist the child to make a plan. Roleplays are used to aid the parent in this procedure.

IGNORING INAPPROPRIATE BEHAVIOURS

This week emphasis will be on ignoring inappropriate behaviours of the child. Specific examples will be;

- Ignoring whining
- Ignoring tantrums
- Cognitive coping skills to avoid guilt feelings.

In conjunction with the previous discussion, additional time will be spent on providing safety without giving attention. In other words ignore the behaviour but protect the child. This will also be illustrated through roleplaying.

INCREASING INDEPENDENT PLAY

Parents are encouraged to discuss the types of disruptive behaviour they see in their children. They are also asked to examine what it is they are doing when their children become disruptive. at this time it is pointed out that too often children are ignored when they are playing quietly and not disrupting. Therefore the children learn that by being disruptive they receive parental attention.

For example, the scenerio of children fighting with each other can be used. When the children are playing quietly in the playroom the parents are most likely to be preoccupied with something else but once the children begin to argue, the parental attention is turned to the children. The parent may go to the room and stay there until the children settle back down. This only serves to reinforce the disruptive behaviour.

Parents are introduced to the method of reinforcing nondisruptive behaviour through illustrated roleplays. In the beginning,parents must reinforce independent play frequently and then gradually increase the length of time between reinforcement. When the child disrupts, parents are

instructed to ignore as much as possible. Parents are advised that this procedure is necessary to establish the reinforcer needed to reward nondisruptive behaviour and eliminate disruptive behaviour.

A homework chart will be given to record the parent-child progress.

Handouts

Barkley, R.A. (1987). Paying attention when your child is not bothering you. Defiant Children,New York: Guilford Press.

Camp, B.W. and Bash, M.A. (1981). Think Aloud: Increasing Social and Cognitive Skills- A Problem Solving Program for Children. Champaign: Research Press.

Dinkmeyer, D and McKay, G. (1973). Developing the courage to be imperfect. Systematic Training for Effective Parenting,Circle Pines:American Guidance Services.

GOALS

- Awareness to inadvertent reinforcement
- ignoring inappropriate behaviour
- thinking aloud
- prompting plans.

Children's Session

Play objects will be out until all children have arrived.

The opening song will be sung. "We are Happy to See You Here Today "

Name tags and stickers will be issued.

The children will show their homework books to the rest of the group.

The puppets will provide an illustration of ignoring inappropriate behaviours in others. A child will be chosen to hold the stop sign as an indication for the children to think of a plan for the puppet.

PUPPET #1	Can anyone tell me about this stop sign? Why do you suppose we are using it? Well it is supposed to tell us that we have to <u>think</u> of a plan before we do something.
PUPPET #2	Tonight there is a new bear. Look up behind me. What is this bear doing? That's right, He's scratching his head. That's because he"s thinking. Do any of you scratch your head when you are thinking? What do you suppose he's thinking about? Well he's trying to make a plan.
PUPPET #1	Today my friend and I are going to show you what happens when we don't think. Watch carefully.
PUPPET #2	Calls PUPPET #1 to play with him.(STOP) PUPPET #1, not thinking, bangs into the wall and gets hurt. PUPPET #2 comes out and says See what happens when PUPPET #1 didn't think before he acted? What should he have done?

LEADER: Tonight we will play a game to practice making a plan. I want everyone to line up against the wall. Now you have to make a plan to get to the cupboards. <u>BUT</u> you can't use the same plan as the other children. I have planned to walk across watch me. Now it's ----turn ----- how have you planned to get to the cupboards? (everyone can clap when the task is completed)

The turtle technique will follow the puppet show as a part of creative movement exercise. We will give the children illustrations and get them to react either by pulling the turtle in or letting him remain out.

STOP sign: In a few minutes we will be doing crafts. Here is the plan boys and girls. We are going to glue all different colors of squares on your very own turtles. Then we will add eyes, mouth and a tail.

Snack time will continue emphasizing the bear plan by asking the children to develop a plan for going to the snack room.

The final activity will be our quiet time. This time will involve the relaxation exercises covered in week one and stories until parents arrive.

GOALS

- Relaxation
- Improving listening skills,
- Awareness of safety,
- Planning ahead.

SESSION FOUR

Parent Session

Review homework and discussion of previous lessons. Situations the parents had difficulty with are to be roleplayed to help the parents integrate the theory of the think aloud program.

The third step of the bear plan "how am I doing?" will be introduced. This is a checking system parents can help introduce to the child to enforce following a plan. As the child begins to enact his/her plan the parent is taught to provide verbal cues to check the child's progress. Emphasis can also be made that sometimes plans may not work so we can think of another plan that may work better. It should also be emphasized to the child that if s/he fails to follow the plan s/he can still go back to it.Prompting and reminding children and encouraging them throughout the plan will be emphasized.

ANGER INFORMATION

There is a lecture on anger control since hyperactive children can be rather anger provoking when they are out of control.

What is anger? Anger is an emotional reaction to certain kinds of stress. When we become angry, we loose patience. our blood pressure rises and we act impulsively. There are positive and negative uses of anger. Basically , if we use it constructively, that is, without causing harm, acting on impulse or acting aggressively.

Anger becomes a problem when there are frequent explosions, when the emotion is too intense, when it is long lasting, when it harbors aggression and when it puts strain on friendships and relationships.

Anger is a secondary emotion; it results from other feelings such as frustration, annoyance and irritation, verbal or physical abuse and injustice or unfairness.

Things that influence our moods include how we perceive things and what we tell ourselves. When we feel uptight or tense we can get angry more quickly.

STEPS TO RESOLVE ANGER PROBLEMS

Step One: Understanding

Too often we misinterpret events without developing any understanding of the situation. It is important to evaluate the event and develop a good understanding.

Step Two: Remember step one

After developing an understanding of the situation pick out the components that cause your anger. Keep a record of this to determine patterns and factors such as pressure, longstanding conflicts and insecurities you may not be aware of.

Step Three: Understanding the feelings of others

Put your feelings aside and try to take anothers position in the situation. This helps to develop an awareness of others' feelings and perspectives.

Step Four: Self-talk

Self talk can be used in anticipation of difficult situations,developing coping skills, re-evaluating a situation.

Step Five: Learn to relax

Learn relaxation techniques to help alleviate a build up of tension.

Step Six: Stick with it

The parents are also given an anger inventory to complete. This is private and only used to help parents gain insight into their anger.

Parents are also given an anger script to be completed privately.This emphasizes the influence of significant others on us.

Time will be spent on setting up appropriate expectations for the child. What is the child capable of? How much help or prompting will he require?

Handouts are circulated and homework is explained. Parents are given the same chart as in session #3 to help them map their progress.

Handouts

Bienvenu, M. (1976). Inventory of Anger Communication, Family Life Publications Inc.

Camp, B.W. and Bash, M.A. (1981). Think Aloud: Increasing Social and Cognitive Skills A Problem Solving Program

for Children. Champaign: Research Press.

Lafavore, M. and Kennedy, T. (1987). I live my kids, I hate my kids. Children, 28-32.

National institute of mental Health (1985). Plain Talk About Dealing With the Angry Child. D.H.H.S. Publication No.(A.D.M.) 85-871.

Policoff, S. (1987). Are you hungry or angry? Weight Watchers Magazine, March. 60-62.

Ranger, T. (unpublished). Anger. Sudbury Algoma Hospital: Sudbury

GOALS

- To establish congruency between parental verbal and nonverbal cues,
- Setting realistic expectations for the child,
- Planning ahead, a collaboration of the first three steps in the bear plan.

Children's Session

Play materials are available until all the children have arrived.

The name tags and stickers are distributed.

The opening song "We Are Happy to see You Here Today" is sung.

The children will show their coloured bear and receive their star.

The puppet show this week will concentrate on the third step of the bear plan.

PUPPET #1 — Hi there! How are you all this week? Do you see that we have another new bear up on the board this week? Can anyone tell me what he is doing? Do you think he is following his plan? How do you know? Well I think he is because he's got a smile on his face so he must be happy.

PUPPET #2 — ------ can you think of a plan to use if your mom was on the phone? Let's act it out. ------ you can be the mother and ----- you can be the child. Now remember your plan.

The leader continues to ask the child about his plan. If there is any indication of a slip up the leader can emphasize that it's O.K.to make a mistake so long as you go back to your plan.)

Following the puppet show the children will be engaged in the turtle game to emphasize its uses i.e. ignoring inappropriate behaviours of others, a means of control or simply relaxing.

Before the children do their crafts they will be engaged in a discussion about feelings. This will be tied in with this week's bear plan by getting the children to notice how their plan makes others around them feel.

The goal of this discussion is that children generally understand that pleasant feelings are more desirable than unpleasant feelings; but impulsive children often have a hard time using how others feel to help them decide on a particular course of action when faced with a problem situation.

Who can tell me about feelings? Can you see a feeling? Can someone point to a feeling?

1) We can't see a feeling- a feeling is something inside a person.
2) How do we find out what a person is feeling if we can't see a feeling?
   a) We can tell what a person is feeling inside by seeing what they look like on the outside.
   b) We can also find out by listening to what a person says and how a person says it.
   c) Another way to find out is by asking the person, "How do you feel?"
3) Everyone has feelings.Some feelings are good feelings and some are "not so good" or "bad" feelings. Everyone has both kinds of feelings.
4) Feelings Change. No one feels the same way all the time. When we change feelings, we wear or put on different faces. Sometimes we feel sad or not very happy, but then we try to do something to end up feeling good. For example,if we are feeling bad, we can use our problem solving plan to help us feel better.

Identifying Facial Cues:

Now I am going to hold up some pictures. What I want us to do today is look at each picture very carefully. Then we will decide whether the person in the picture is feeling good or feeling bad.Then I will ask you to try to tell us what it is about the picture that makes you think the person is feeling "good or bad."

* Hold up the feeling pictures one at a time. Then solicit one child to answer whether the person in the picture is feeling good or bad. Then ask the other kids in the group whether they agree with the first response. When disagreements arise point out that sometimes it is hard to tell what a person is feeling by just looking at him or her.If this occurs ask what they could do to be sure they know what the person was feeling. (Answer:ask). Finally, have the children explain what it is about the picture that makes them think the person is feeling bad or good, and then separate the pictures into "good feeling piles" and "bad feeling piles."

This week the children will be asked to make a back to back face with a happy face on one side and a sad face on the other side.This they can hang on their bedroom door knobs or from their ceilings as a mobile.
Materials needed are:
construction paper cut into circles with holes punched out
string
wire or stick to hang the faces on
icing paint-
   mix 1 1/2 c. sugar

1 c. salt
4 c. cold water
4 c. flour
whip up mixture divide and add temper paint or food coloring. Fill squeeze bottles.

The children will be invited to go for snack and they will be asked to think of what they are supposed to do. Once they return to the room they will be asked to evaluate whether everyone followed the plan or not. If someone failed to follow the plan the children will be asked to list some things the child could have done that would have made a good plan.

After the snack the children will be engaged in a creative movement exercise that will require them to make their bodies look angry, happy ,sad etc. and as a second edition they will be asked to guess what different children are projecting.

We will also discuss what people do when they are angry, and introduce the turtle plan as a method of controlling their anger. The next lesson from the turtle manual will be covered which emphasizes the turtle as a relaxation method. This will be followed by a quiet story before the children leave.

The children will be given their scribblers with their new bear in it. They will be told to color at home and be prepared to show the others next week.

GOALS

- Continued emphasis on self-esteem.
- How it feels to do something well.
- Realizing your own abilities,
- Recognizing how others feel.
- Evaluating plan.

SESSION FIVE

Parent Session

Review homework and discussion. One of the difficult situations is roleplayed.

Discipline:
- Using time-out when it isn't possible to ignore a behaviour.
- Roleplaying as an illustration of time-out.
- Planning ahead examples of Babysitter and supermarket through roleplaying.
- Using the when - then strategy.

The final step of the bear plan is introduced. Parents are encouraged to help their child evaluate whether the plan worked or not. Leaders roleplay some situations to emphasize the importance of evaluating the plan.

In addition to problem solving strategies, parents are introduced to the when... then rule. For example, when you clean up your toys then you can have a snack.

Parents can exercise this practice by listing the things the child has to do like taking the garbage out, getting ready for bed, doing his/her homework or cleaning his/her homework, or cleaning his/her room. Then on the opposite side the parent is to write down what the child likes to do, such as have a snack before bed, watch T.V., play ball etc. This will aid the parent in making when... then rules.

Although the problem solving techniques, positive time, and when... then rule are meant to be more effective forms of discipline, there are situations in which noncompliance may result in more disciplinary measures. This program recommends Time-Out from positive reinforcement. We recognize that the child is being positively reinforced some how for his/her noncompliance. There are a number of things to consider when using time-out:

- The child should be informed of the time-out procedure before it is ever implemented.

Be sure that the request is short, and clear as to exactly what is expected of the child. Do not ask a question, make a suggestion, or plead when something is requested. If the child does not follow through with the initial request, prompt the child to use a plan. If the child then utilizes a plan, and comes up with a solution to follow the initial request, the interaction is stopped and the child is praised for using a plan. If the child is not utilizing a plan and is not following through with the request, then the child

should be given a warning. The warning should outline clearly to the child what will happen if s/he does not comply. It is usually in the formate, "If...Then."After this warning the child should be given five to ten seconds to devise a plan or comply to the request.

If after the warning time the child does not comply, s/he is immediately placed in the area designated for time-out. If the child is disruptive inform the child that time out does not start until s/he is quiet. Each time the child becomes disruptive inform the child that the timer is set back to the starting point. Time out is usually for three to five minutes. If the child is extremely disruptive it may be necessary to take away future privileges.

When time out is completed have the child comply to the request.If still resistent the child must go through the time out procedure again.

Homework involves the completion of a planning chart and practicing the last step of the bear plan.

Handouts

Camp, B.W. and Bash, M.A. (1981). Think Aloud: Increasing Social and Cognitive Skills- A Problem Solving Program for Children. Champiagn: Research Press.

Cunningham, C.E. (1987). Systems Oriented Parent Training Manual. Hamilton: Chedoker McMaster (unpublished).

Rubin, B. (1987). Paying attention is much more difficult for some kids. Today's Health, 13-14.

Smoller, J. (1987). The etiology of childhood. Networker, (Mar.- Apr.) 69-71.

GOALS

- Establishing a discipline routine,
- Planning ahead in specific situation,
- Taking some responsible for the child's plan.

Children's Session

Toys will be available until all children have arrived.

Name tags and stickers will be issued for the children to wear.
The opening song is sung.

The children will show their homework and receive their stickers.
The puppet show will put emphasis on specific situations to help the children make plans.

PUPPET #1 Hello boys and girls, remember me? I'm Ralph bear's friend. Ralph is not with us tonight because our old friend the turtle is back. Can any of you think of a reason for him to be here today? Well it is important that we know when to use the turtle. Can any of you think of when we should use the turtle?

Let's play a game. I will give you some make-believe stories and if you think you should do the turtle I want you to ..... (Do the turtle!). If you do not think you should use the turtle just sit there. Ready? Here's the first one:

You are at your best friend's birthday party and playing games.It is really exciting to have so many of your friends together at a party. You begin to run around the room eventhough your mother said not to. What do you do, the turtle or something else?

Some of the tough boys in the school playground decide they are going to gang up on you. The first boy kicks you.. What do you do?

One of the children in your class is teasing you. The others are busy working but this one won't leave you alone. What do you do?

While Mom is on the telephone you are supposed to watch your baby brother in the play room. Your baby brother is getting into Mom's knitting which means that both of you will be in trouble. What do you do?

You finish your work in school; the first one done! But there is nothing to do. It's boring to have to sit there. You need something to do. What can you do?

Now that we have finished that game and you all know when to use the turtle, let's roleplay to show that we know what

Ralph bear has taught us. The puppets will roleplay a mother and child going to the supermarket so watch carefully because you might have to help out.

PUPPET #1 — Son, we are going to the supermarket, can you think of a plan to use while we are there?

PUPPET #2 — Well, I know that I shouldn't run away from you while we are shopping, and I shouldn't keep asking for treats. You like it when I Hang on to the side of the cart.

PUPPET #1 — That sounds like a very helpful plan. I'd appreciate your help.

LATER: Well we are ready to go, can you remember your plan? Kids can you help us make up a plan?

PUPPET #2 — Yes, I said I would stay with you and hang on to the cart. I won't keep asking for treats.

PUPPET #1 — Great! Thanks for your help.

LATER: PUPPET #2 starts asking for treats. Have a child display the sign and get the children to talk about what is happening.

PUPPET #2 — Mom can I please have a chocolate bar? Or maybe a bag of chips?

PUPPET #1 — Son I think you have forgotten a part of your plan. Can you remember how you were going to help out? Kids do you remember?

PUPPET #2 — Oh yes, I said I wouldn't ask for treats.

PUPPET #1 — I'd like it if you could follow that rule.

PUPPET #2 — O.K. I'll try again.

PUPPET #1 — Thank you son I know you are trying.

PUPPET #2 — Now boys and girls, we are going to go quietly to our tables to plan a craft. When we finish we will see how we did.

Before the children begin their crafts they are engaged in a game similar to Simon Says. Each child is addressed individually and given instructions like "When you touch your nose, Then you can sit down." This is to help the children get the concept of the when then rule in which their parents will be asking them to do something before they get to do what they like to do.

The children will work on their crafts.This week they will make finger paints this will focus on improving body awareness and self-esteem. The children will also make their own personal books to remind them of what they have learned from the program.
The children will have their snack. Some children will be asked to help out and the bear plan will be stressed as a way to help them get organized. "What am I supposed to do?"

After snack the turtle game will be played followed by copy cat to focus on body awareness.

Relaxation and story time will follow the games. This week we will use the imagery relaxation from week two. For the final activity we will read stories.

Children will be given their books to take home and color the bear.

GOALS

- Developing self-esteem,
- Planning ahead for specific situations,
- Relaxing
- Peer interaction.

SESSION SIX

Parent Session

Review of homework and discussion of working out the problems on their own. Where do we go from here.

Filmstrip on A.D.D.

The leaders roleplay situations that bring parents difficulty like compliance in public, telephone interuptions, planning ahead for a visitor etc. Parents are asked to help out in these roleplays.

Following the roleplays, the parents are invited to discuss any other concerns that haven't been addressed or some issues that may not be clear to them.

Evaluation and closure.

Setting up appointments for home visits and distrubuting the post tests to be completed for the home visit.

GOALS

- Integration of bear plan
- Setting rules with choices
- Evaluation

Children's session

Toys are available until all the children have arrived.

Name tags and stickers are issued.

The opening song is sung.

The children will show their colored bears and a discussion will follow to help them integrate all four steps.

The puppet show will concentrate on one example of planning(babysitter) and then the puppets will talk about it being the last night and what the children can expect from now on.

PUPPET #1	Well kids, tonight is our last night. How do you feel about that? Some of you may be sad because we've done so much work together and now you are going to be on your own. But your mom and dad have been working too and they will help you to STOP! THINK, make a PLAN and see if it WORKS.
PUPPET #2	What were some of the fun things we did? Can you remember all the lessons?
PUPPET #1	Now we are going to act out when a babysitter comes to look after you while your mom and dad go out.
PUPPET #2	Sometimes Mom and Dad have to go out and they get a babysitter to look after us. How should we behave? Can you set up a plan? Watch us, I'll be the mother and my friend will be the son.
PUPPET #1	Now son, I have to go out this evening and the children will sit with you. What are some things you could do this evening?
PUPPET #2	Well mommy, I know I should behave so I will go to bed at 7:00 and make sure my toys are picked up and have a bath.
PUPPET #1	Yes, that is very good son, I'd appreciate it if you could do that.

At this time the puppet misbehaves. Have the children display the stop sign and promote discussion from the children on what the puppet should be doing.

PUPPET #1	Hi Dear! I'm home. How did your plan work?
PUPPET #2	Well I needed some reminding from the children but I followed my plan and did what I said I would.
PUPPET #1	Well children how did he do? Did he follow his plan?

The children will again practice the turtle so that they will be able differentiate appropriate from inappropriate use.

Following the turtle the children will make a craft to take home. This week the children will make salt ceramics of their choice.

mix in a pot: 1c. salt, 1/2 c. corn starch, 3/4 c. cold water,food coloring (optional) mix 2-3 minutes over moderate heat until bread dough consistency. Allow to cool, knead and wrap well.

Snack time will follow the craft activity. Since this is the last night there is a special celebration.

While half of the children are completing their books from last week or are working on their salt ceramics, the other half can make the snack. Since it is a celebration the children are helped to make an easy snack like rice crispy squares. When the first set of children are finished the others can have their turn.

Diplomas will be issued to the children before they leave to go home.

Appendix D

Samples of Instruments Used

Appendix D Instruments used in this study

EVALUATION

1. What did you like most about the parent training program?

2. What did you least like about the parent training program?

3. What did you hope to accomplish by being in the group? Do you feel you reached your goals?

4. What is the most important thing you learned about yourself from this program?

5. What is the most important thing you learned about parenting your child?

6. What do you still wish to learn or work on now that the program is over?

7. What suggestions do you have to improve this program for other parents?

8. Please comment on the style and effectiveness of the program leaders.

9. Please comment on any concerns or observations you had regarding the children's group.

10. Are there any other comments you wish to make?