

## Coping With Conduct-Problem Children: Parents Gaining Knowledge and Control

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*Examined the process of parents' learning to cope effectively with stresses related to their conduct-problem children's behavior by means of a videotape parent training program. Transcripts of 20 intake interviews, 80 group therapy sessions, and 16 therapist consultations with 77 mothers and 60 fathers of conduct-problem children (ages 3 to 7 years) provided the data. These transcripts were analyzed using the constant comparison method. Findings suggested that the process was one of gaining knowledge, control, and competence and was comprised of five phases, which were labeled: acknowledging the family's problem, alternating despair and hope, "tempering the dream", "making the shoe fit", and effective coping. The meaning of the different phases is discussed in light of the theory of stress.*

Approximately two thirds of all children referred to mental health agencies are labeled conduct disorder or oppositional (Kazdin, 1985). Moreover, the prevalence of such disorders is increasing, creating a need for service that far exceeds available personnel and resources. Specific diagnostic criteria have been developed: such children typically exhibit antisocial behavior—that is lying, cheating, stealing, firesetting, fighting, oppositional behaviors, and noncompliance to parental requests—at abnormal rates. The need to help families of conduct-problem children is particularly urgent, for these aggressive children are at increased risk for being abused by their parents (Reid, Taplin, & Loeber, 1981), as well as for school dropout, alcoholism, drug abuse, juvenile delinquency, adult crime, antisocial personality, marital disruption, interpersonal problems, and poor physical health (Kazdin, 1985; Loeber, 1985; Loeber & Dishion, 1983; Robins, 1981). Thus, in the absence of treatment, the long-term outlook for conduct-problem children is poor. In response to the large numbers of children with conduct problems and the shortage of professional manpower, there has been increasing emphasis on training parents to be therapists for their own children. An additional, less circumstantial rationale for such an approach is provided by research indicating that the parents

of conduct-problem children typically lack certain fundamental parenting skills. For example, reports have indicated that parents of aggressive children exhibit fewer positive behaviors, are more violent and critical in their discipline, are more permissive, and often fail to monitor their children's behaviors (Kazdin, 1985; Loeber & Dishion, 1983; Patterson & Stouthamer-Loeber, 1984). Consequently, parent training programs have been developed that focus on teaching parents to use specific reinforcement and nonviolent punishment skills (Forehand & McMahon, 1981; Kazdin, 1985; Patterson, 1984). Reviews of such parent training programs based on one-to-one therapy have generally supported their effectiveness (Kazdin, 1985). In a series of studies (Webster-Stratton, 1981, 1984; Webster-Stratton, Hollinsworth, & Kolpacoff, 1989) we have shown that therapist-led parent group discussion training based on videotape modeling (GDVM) was both cost-efficient and effective in improving parenting attitudes and behaviors, and in reducing child conduct problems. Even an individually self-administered videotape parent training program (IVM) resulted in significant improvements in parent reports and parent-child interactions (Webster-Stratton, in press; Webster-Stratton, Kolpacoff, & Hollinsworth, 1988). In spite of the documented effectiveness of various types of parent training programs, the literature contains little discussion of the actual process of change brought about by such intervention programs. A large body of research to date has been quantitative in nature, focusing on static outcome measures such as reductions in rates of parent critical and physically negative behaviors and reductions in child deviant behaviors. Using such outcome indicators alone does not elucidate

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A more complete description of the parent training program that was the subject of this research, including another paper describing the therapist role, is available from Carolyn Webster-Stratton at the following address.

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the mechanisms or ongoing processes of: What happens when parents' behavior, attitudes, and practices are challenged and modified by a parent training program? There are many questions to be answered concerning the intervention process, such as, what emotional, social, and cognitive changes accompany the parents' efforts to change their parenting practices? What difficulties do parents undergo as they work with the concepts presented in the program? How do these changes occur as they work with the concepts presented in the program? How do these changes affect the family system—that is, what kind of impact does the program have on different family members? Patterson (1984) argued that we need to move beyond the technology in developing an empirical base for parent training. In fact, Patterson and Forgatch (1985) reported one of the first studies to examine the process of parent training. They analyzed the impact of therapist behaviors such as confront and teach on parent noncompliance or resistance. Their study is important in that it analyzes client-therapist interactions, on a moment-by-moment basis; however, it does not help elucidate the parents' cognitions or perceptions of why they resist direct teaching from a therapist. Moreover, such a microscopic approach does not place the clients' responses within the larger context of the ongoing developmental process of change during therapy. The purpose of this study, therefore, was to provide a qualitative analysis of the process of parents' learning to change their parenting approaches and to cope effectively with stresses related to their conduct-problem children's behavior by means of a videotape modeling parent training program. Because we had videotaped all our intake and therapy sessions as well as our consultation sessions, we had a window into the experience of parents who participated in our parent training programs, providing rich data on the intervention process. From these videotapes we analyzed in detail how the parents perceived living with a conduct-disordered child and how they experienced and reacted to the parent training program based on videotape modeling. We sought to determine what their questions, concerns, and unique needs were while participating in the program, and what they felt was missing from the parent training program.

### Method

#### Subjects

The total sample consisted of 77 families with conduct-problem children. Criteria for study entry required that: (a) the child be between 3 and 8 years old; (b) the child have no debilitating physical im-

pairment, intellectual deficit, or history of psychosis, and be receiving no treatment at the time of referral; (c) the primary referral problem be child misconduct that has been occurring for more than 6 months (e.g., noncompliance, aggression, oppositional behaviors); and (d) parents rate their child as having a clinically significant number of behavior problems according to the Eyberg Child Behavior Inventory (ECBI; Eyberg & Ross, 1978).

Fifty-seven (73.7%) of these families were headed by couples, and 20 (26.3%) by single mothers. The mean age of the mothers was 34.1 years, and that of fathers was 35.9 years. Family social class, as determined by Hollingshead and Redlich's (1958) Two Factor Index, yielded a wide range of social class: Class 5 ( $N = 6$ ), Class 4 ( $n = 18$ ), Class 3 ( $n = 16$ ), Class 2 ( $n = 20$ ), Class 1 ( $n = 17$ ). Study children included 57 boys and 20 girls, with a mean age of 4 years and 10 months. The mean number of behavior problems reported at pretreatment according to the ECBI was 21.3 ( $SD = 5.6$ ), indicating that the children were clearly in the clinical range according to Eyberg and Ross (1978); for their normative sample the mean was 6.8 and the standard deviation was 3.9.

Data were collected from 77 mothers and 60 fathers who had attended our videotape modeling parent training programs. Initially, each couple or single parent underwent an intensive intake appointment with a therapist, lasting 2 to 3 hr. Sixty-eight of the families (68 mothers and 57 fathers) participated in a 10 to 12 week basic GDVM program, with weekly sessions lasting 2 hr. After the basic program was completed, a random selection of 24 of these parents also participated in 14 ongoing group sessions interspersed throughout the remaining 9 months. The remaining 16 randomly selected families participated in a 10 to 12 week self-administered videotape parent training program that included individual consultations with a therapist (IVMC). The purpose of these consultations halfway through the self-administered program and on completion of the program was for parents to ask questions and clarify issues they did not understand. Every intake and group therapy session was videotaped, and the therapist consultations were audiotaped. A random selection of 20 intake sessions, 80 groups sessions, and 16 therapist consultations were reviewed. These transcriptions provided the data for constant comparative analysis.

#### Data Analysis

The constant comparative method developed by Glaser and Strauss (Glaser, 1978; Glaser & Strauss, 1967; Strauss, 1987) as the method of developing grounded theory was used to analyze the data from

the sessions. Through this method, the investigator abstracts qualitative data into concepts and categories. Constant comparison of data units is used to find similarities and variations within categories, link categories in a hierarchical mode, and to form working hypotheses as to the theoretical nature of these links (Lincoln & Guba, 1985).

Transcriptions were entered into a computer and formatted for use with Ethnograph (Seidel, Kjolseth, & Seymour, 1988). In the first phase of analysis, 30 random transcriptions were analyzed separately and subjected to open coding (Strauss, 1987). The data were approached both across consultations and across families. This procedure allowed the investigators to study each family separately across the various therapy sessions as well as to compare and contrast different families' responses as they moved through the different components of the videotape parent training programs. The initial codes identified were the result of breaking the data into small, meaningful units. Each unit of data was coded as a concept, often using the informants' words. These substantive codes were used to organize the data around selected aspects of the process by which parents learned to cope more effectively with their child's conduct problems. In the second phase of data analysis, the initial codes were compared and contrasted to detect similarities and differences among them (Hutchinson, 1986). Codes that represented dimensions of an overriding category were grouped together. Selected categories were subjected to axial coding (Strauss, 1987) to strengthen the density of these categories by "specifying varieties of conditions, strategies and consequences that are associated with the appearance of the phenomenon referenced by the category" (Strauss, 1987, p. 64). Specifically, these categories were analyzed in regard to various points in the videotape training programs, differences in parents' behaviors, and changing consequences as the intervention program advanced. The axial analysis was used to develop and validate the core categories. As these categories were examined more closely, it became clear that the parents described their responses to the therapy program in terms of different phases. Next, a second set of 30 randomly chosen transcripts was analyzed according to the categories and validated to include no new codes. Once the category scheme was finalized, all interviews were coded.

In the third phase of analysis, the relationships among the core categories representing different phases were explored. The analysis that led to the description of a sequential process by which parents learn to cope more effectively with a child who has conduct problems represented the process of "weaving the fractured data back together again" (Glaser, 1978, p. 116).

Guba (1981) and Lincoln and Guba (1985) suggested the term *trustworthiness* to discuss reliability and validity in qualitative research. Four factors are used to assess the trustworthiness of a research project: credibility, transferability, dependability, and confirmability. First, let us consider credibility, which refers to having confidence in the truth of the findings. Glaser and Strauss (1967) stated that the credibility of a qualitative study rests on the overall assessment of how the investigators derived their conclusions. As the first step in assessing the credibility of the conclusions, the reviewer has to ask whether the subjects are appropriate informants for the investigation and whether the data they offer are true representations of the area of concern. In this study the subjects were parents of conduct-problem children and were considered reliable informants for describing the process associated with parent training. The perspectives that these parents provide must be accepted as accurate representations of that realm.

Validity checks were conducted throughout the stages of data collection and data analysis. A first order validity check of the investigators' interpretations was carried out during the collection phase through continuous feedback from the interviewees. Often, in order to clarify concepts or to validate the investigators' perceptions, subjects were asked to explain or comment on other parents' ideas. In a second order validity check, the importance of the various categories of the experience was validated against a standard question, "How is going through the treatment for you, and how are you doing now?"

Transferability is concerned with verification of the amount that the results are context bound (Sandelowski, 1986). The sample consisted of parents of conduct-problem children from different socioeconomic levels, who had children with a variety of behavioral problems and exhibited different approaches to childrearing. Therefore, the subjects, content, and range of data were considered sufficient to provide the basis for assessing relevancy to related context.

Dependability, the third criterion of trustworthiness, was defined by Lincoln and Guba (1985) as the reliability of the conclusions reached by the investigation. In this study, the reliability of the investigator's interpretation and coding of the data was determined by subjecting a random sample of transcripts to analysis by two independent coders who were expert therapists. These coders were asked to review the categories, read the transcripts, and code the data using the derived categories. Approximately 80% reliability was achieved, and any areas of disagreement were discussed and a decision made as to the most appropriate category.

The last dimension of trustworthiness is confirmability. This dimension is defined as the ability of an independent reviewer to conduct a formal audit of the various study procedures (Lincoln & Guba, 1985). In this study one of the investigators served as a reviewer by auditing the various study procedures step by step.

**Results**

The scope of the data allows us to describe the process of cognitive, social, and behavioral changes that parents underwent from the initial intake interview to the point at which the program ended, approximately 1 year later. In qualitative research, case material that best explains the phenomena and phases of therapy is presented in lieu of statistics as the evidence or data to support the model. Previous studies (Webster-Stratton, 1981, 1984; Webster-Stratton et al., 1989) have already presented the quantitative evaluation of this videotape parent training program.

During the initial 2 to 3 hr intake interviews, parents described their children's multiple problems and their efforts to handle them. In these interviews, they initially expressed feelings of despair, anger, shame, fear, and helplessness concerning their interactions with their children. As they participated in the videotape training program, their attitude seemed to oscillate constantly between despair and irrational hope. As they gradually came to realize that their children's problems were chronic, and as their anger, guilt, and resistance gradually decreased, most families were able to change their expectations and settle for less than a total recovery of the family and the child. This stage was followed by one in which the parents worked at "fine tuning" or tailoring the program to their own particular needs.

The data suggest that the process of learning to cope more effectively as a parent is comprised of five core phases: acknowledging the family's problems, alternating despair and hope, "tempering the dream," "making the shoe fit," and effective coping (see Figure 1).

**Phase I: Acknowledging the Family's Problems**

It is not easy for parents to admit that they have a child with behavior problems, a child who is different from other children. This difficult admission was the first phase in the process of change in parents' attitudes toward and interactions with their children. A major consequence of this admission—and perhaps the reason behind its difficulty—was that parents had to face their own conflicting attitudes and feelings concerning their children's problems. Three categories of acknowledging the problem were identified in the data: anger and fear of losing control, self-blame and depression, and isolation.

**Anger and fear of losing control.** During the intake appointments and initial therapy sessions, many parents talked about long months during which they waited for their children to get older, in the expectation that things would become easier for them. When things did not improve with time—when, instead, their children became increasingly defiant and noncompliant, a terror at home and at school—they began to realize that their children were different from most other children.

Mother: I remember waiting for him to turn 3 in June. And just waiting for this magical thing to happen, and it never did. It's just been very, very difficult from the very beginning. We're just on pins and needles. [Intake interview]

As parents felt a growing sense of inadequacy about how to handle these misbehaviors, their frustration with the children mounted. Parents talked about how their frustration and anger at their children escalated as they tried to discipline their children without success.

Father: My wife's been at work and comes home and asks, "How'd

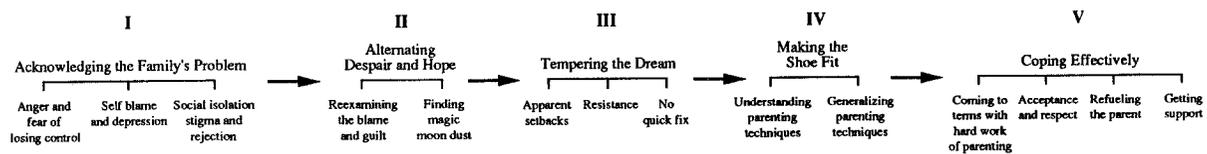


Figure 1. The process of learning to cope more effectively with conduct-problem children.

things go tonight?" I say, "Do the words, 'living Hell' mean anything to you?" That's our sort of little joke. I'm labeling the kids in my mind as never doing what I say and I'm very angry at them. [Intake interview]

Mother: I say to myself, "I'm not going to put up with this shit anymore." And I feel outraged, and it helps because I'm more willing to be the tough guy—but it leaves me a lot angrier. [Intake interview]

Along with the angry thoughts and feelings about their children, parents expressed their sense of being victimized by their children. This sense of being a victim further inflamed their anger. Throughout the program, parents would frequently ask, "Why me?"

Mother: I feel persecuted by the children, especially at night when I first get home from work. Why do they do this to me? I've been fighting the freeways and my job, and now the kids. [Session 8]

Mother: Why is my child so different from others? I feel I'm really in the minority, because of all the mothers I've talked to, and they have never been hit by their child. I can't imagine—I mean it's absolutely unimaginable not to be slapped or kicked by your child—other mothers have never experienced this. I'm a very non-aggressive person. I can't tolerate loud, aggressive people and I just don't associate with them—and I'm living with one! [Intake interview]

During therapy, parents begin to reveal their angry feelings and are then able to discuss their fear of losing control of these feelings when trying to discipline their children.

Father: It's intense—I think I've been able to control it and I start thinking I've got to control myself. You know, I can't! It's like something's boiling inside of me and it's pretty emotional, pretty scary. [Session 6]

Mother: I've never done it, but I've thought of it when I get really, really mad. I've thought of

running and throwing him out the window. But that's just what my head thinks; I've never done that. [Session 13]

**Self-blame and depression.** The parents' anger and loss of control caused them to blame themselves and to feel depressed about these feelings and about their interactions with their children. They tended to evaluate their parenting skills as poor and to see themselves as causal factors in their children's problems.

Mother: Maybe I should just give up because I'm going down in a sinking ship. You were supposed to have all this fun with your kids and be joyful and teach them. [Intake interview]

Mother: I tell myself it is more than I can cope with; you're a no-good mother; everything's out of control. [Intake interview]

**Social isolation, stigma, and rejection.** Another common theme identified throughout various stages of the program was parents' sense of being stigmatized and isolated from other parents with similar aged children.

Mother: I was telling a friend who has daughters about my son, and she said, "What, your son hits you? My daughter's never hit me." I mean, other parents look at me like I just walked off another planet. So I feel very isolated. I feel like no one is like me—no one has my situation. [Intake interview]

Parents felt a lack of connection with and support from other parents with normal children.

The next excerpt is taken verbatim from one of the parent groups talking about what they think would happen if they told their friends what their children are really like.

First Father: You can't tell your friends how you feel about your child—you can't say, "My son is a bastard."

First Mother: There's always the fear that if you share with somebody what your child is like, somebody will assume it's your fault, and

- think you screwed up as a parent.
- Second Mother: Or they'll reject you and say, "God, I don't want to hear about this!"
- Third Mother: They may say, "Gosh, my child never does that"—which is such a put down!
- Second Father: Here's another one I've heard. "Oh well, we all have problems." That's like saying, "Well, I'm sorry you're having problems, but it doesn't matter to me."
- First Father: Yeah, it's the indifference that gets to me.
- Third Mother: Well, that sort of comment implies you're supposed to keep a stiff upper lip.
- Third Father: I didn't know it was this dangerous to have a child. I didn't know I had blanks when I went into this war.
- Fourth Father: Well, you know it's hard for me to ask for support sometimes because I might feel like I'm imposing.
- Fourth Mother: One thing I know is that if I tell someone about my problem—you know, talk about how bad my child is—I don't want them to think badly of her, so I'd rather not tell them.

Parents of conduct-problem children felt isolated from other parents, not only because they felt they had not been effective in producing a normal child, but because they thought that if they were honest about their difficulties they would experience rejection or indifference. Or, worse yet, they feared reprisals in terms of the impact this information could have on others' perceptions of and interactions with themselves or their children.

In addition to feeling isolated from friends and other parents, these parents also experienced rejection from teachers. During intake appointments, many of the parents reported that they had been asked by teachers to take their children out of preschools or day care centers. Some families had been asked to leave half a dozen day care centers by the time their children were 5 years old.

- Mother: At 2 years of age he was terrorizing the other children at preschool and we were asked to leave the school with no notice. There I was, scrounging around to find something else, and it's kind of been like that ever since. After the cooperative day care we tried a private preschool. I remember getting a phone call on my answering machine and holding my breath wondering whether the teacher was going to tell me to take him out . . . I would take him to preschool, and I would come back after 3 hours and just the expression on the teacher's face—it was this horrified, painful expression. Then you would hear the reports of how your son had to have two people release him from a choke hold on another child or how he was pouring water on someone's head. [Intake interview]
- Mother: He's 3 years old, and he's always on probation. The teacher just greeted me with one of those really painful expressions I'm so familiar with: "Your son did this." They told me not to bring him back. I was just so embarrassed. [Intake interview]

## Phase II: Alternating Despair and Hope

The second phase was characterized by parents' moving from feelings of blame and guilt to feelings of relief in finding a cure for their children's problems. Two categories were identified in the data as part of alternating despair and hope: reexamining the blame and guilt, and finding "magic mood dust."

**Reexamining the blame and guilt.** As parents participated in the parent training program and learned new parenting strategies such as play skills, effective reinforcement, and nonviolent discipline approaches, their regret and guilt about their earlier lack of parenting knowledge, their previous use of punitive approaches, and their failure to use these new approaches more consistently with their children was a recurring theme.

- Mother: These sessions have helped me feel a whole lot better about having more control about what's going on. I guess my biggest

problem is that I feel guilty when I am not doing the right things and when I am going back to my other habits. I know we're not handling those [behavior problems] right; especially when he starts piling a lot of them at once, I tend to lose it completely and just scream hysterically at him, and spank him, which I don't want to be doing that. [Session 6]

The anger and guilt were attributed to feelings of blame. Parents were initially preoccupied with identifying who should be blamed for the children's problems. Whereas some parents externalized the child's problems and blamed the child's personality, an absent parent, teachers, or society in general, other parents internalized the child's problems and attributed them to their own personal inadequacies and poor parenting ability. As parents participated in treatment and viewed the videotape examples of other parents interacting in different ways with children with different temperaments, they began to reexamine the nature of blame and to understand how children with difficult temperaments required different degrees of parental supervision and different parenting skills in order to be successfully socialized. With this awareness parents were then able to focus more constructively on which parenting techniques would work best to bring out their child's prosocial behaviors and personality strengths as well as strategies to decrease the child's aggression and noncompliance. Thus, the focus of the parents' attitudes gradually shifted from assigning them blame for their children's problems to attempting to understand and manage the problems.

**Finding "magic moon dust."** Although parents first felt guilt and blame about their failure to control their children's misbehaviors, they also expressed feelings of exhilaration and excitement about improving their interactions with their children as they began to learn new parenting strategies.

Mother: He wouldn't go to bed quietly, and the sticker chart took care of that just like that [snapped fingers]. The first day that I used the sticker chart and I started positively reinforcing him, his behavior changed so fast I could not believe it. I also felt the changes in myself and felt great about it. [Session 4]

Father: I have this weird feeling that after 3 weeks in this class my son is instantly better. Through bad habits and exhaustion I was using too much power. So I backed off, and we don't have the power struggles any more. [Session 3]

For most parents, after completing the first four programs on play, learning, praise, and tangible rewards, they experienced a major shift in their perception of their children's behaviors. They began to appreciate and notice their children's positive behaviors and de-emphasize the negative.

Mother: By keeping track of praises I was able to be aware of all the positive things he does. It is so easy to get bent up and think, "He can't do anything right." All of a sudden you start listening to yourself saying, "You did a nice job there. Thank you!" Once I started to be specific in my praises, I noticed how many areas he is really trying to do right. You start thinking, "He's capable. He's probably been doing this a lot longer than I was willing to listen or give him credit for." [Session 6]

Father: Once it got into a more positive cycle and I had more patience because I wasn't getting all this negative stuff all the time, I found myself willing to put up with some shenanigans, not let him get away with it but also not go through the roof because I wasn't at the end of my rope after a day of many positives. [Session 6]

These new parenting techniques were perceived by parents initially as "magic moon dust" that could cure all their children's problems. Often parents experienced some immediate relief as their children made initial improvements, leading them to believe that their children's problems would be easily solved and that these changes in their children's behavior would alleviate other family problems. Thus, parents anticipated a "total cure." In this phase, parents did not consider the possibility that their children's behavior might regress or that improvement might cease at some point. Moreover, parents did not comprehend the long-term commitment and the amount of work that would be necessary to maintain these initial improvements.

**Phase III: Tempering the Dream**

We called the third phase in the process of parents' learning to cope with their children's conduct problems "tempering the dream." In this phase, parents faced the fact that there are no magical solutions and realized that they would need to adjust their hopes and expectations. Two categories were identified in the data as part of tempering the dream: "apparent setbacks" (resistance) and "no quick fix."

**Apparent setbacks.** Soon after the parents started to apply what they were learning in the program, unexpected changes started to take place—changes in the family dynamics, the target child, and the parents themselves. Some of these changes were in conflict with the parents' expectations for the program, resulting in anxiety and anger for some of the parents. Three common themes characterized these apparent setbacks: role reversal within the sibling relationships, conflicting parenting, and children's regression in spite of parents' hard work.

Role reversal was evident when parents reported that as the target children's behavior improved, the behavior of a sibling (mostly the younger child) became more deviant.

Mother: Our younger child, who has always been the one that's hard to get ready for bed, is cooperative lately. Boom! He's the first one ready because he knows if there's extra time, I'll play legos with him. Now the older child, who has always been easy to get into bed, is dragging his feet. Try dragging a chunky 8-year-old up the stairs to bed. [Session 8]

The parents noticed that as they were practicing the strategies taught in the program with the target child, the other children in the family were demanding the same or more attention, thus taxing the already depleted resources and energy of these parents. Conflicting parenting occurred when one partner participated actively in the program while the other parent either did not participate or was critical of the program and invested in maintaining the status quo. These differences in level of participation led not only to debate as to the best way to handle the child's misbehavior but also to conflicts and blame related to the marriage. Thus, at this stage, the program seemed to some parents to result in marital stress. Conflicting parenting was also apparent in single families in regard to either a boy-

friend or grandmother who was not participating in the program.

Mother: Now, what's happening is that he goes to his father's house for 1 or 2 nights a week and his father doesn't reinforce him at all . . . . And I tried to explain to him the sticker charts are not to be used as punishment, and he just sort of "yeah, yeah, yeah, I know this stuff." [Session 8]

Regression, the third type of setback, occurred when the children's behavior seemed to deteriorate in spite of the parents' hard work. In their anticipation regarding the ideal effects of the program on the children's behavior, parents left no room for limited progress or regression in the children's behavior. Therefore, when parents encountered regressions, their reaction was one of disbelief, depression, or even anger.

Mother: In the last 2 weeks, we've had a 75% to 85% regression. Complete—well, almost complete—reversal to where he was before this class began. I'm not certain why. I was really sick; maybe that had something to do with it. All of the sudden, out of the blue, he's had some real bad episodes, and last week it was every day. It's like we've never been in this class. And the time before that—up through Christmas—was wonderful. I mean both of us had to hold him down to get him dressed on Saturday, amidst screaming and kicking and spanking. [Session 9]

Mother: I really feel that I give a lot. I see myself giving a lot of praise, a lot of attention, a lot of the right things. I know a lot of the times that I'm doing the right things, but then I get *so* burned out. I feel like I'm doing *so* much that I know is good, and I'm not getting enough back. Sometimes I get *so* burned out and totally worn out. I'm tired of doing all these right things. I'm just tired of parenting. [Session 9]

These emotions were related to the perceived mismatch between the parents' hard work at imple-

menting the program's strategies and the children's failure to improve. In some cases, as shown in the next example, the parents felt the children actively resisted their efforts to change the family dynamics.

Mother: This morning I told him, "Well, you just did a really good job on your homework, I'm just real pleased, you just got it done, and like now you don't have to run . . ." And he goes, "Yeah, yeah, right, Mom, yeah, yeah, right." And I'm getting mad. Almost a sarcastic feedback, like well, I've heard it several times in the past couple of weeks. It's almost like he's hip to the fact that I am praising him, it's like he doesn't buy it. [Session 6]

**Resistance.** In general, parents did not have realistic expectations concerning the demands the program would impose on them and on their family life. They expressed anger and resistance as they experienced setbacks and changing family dynamics and discovered that favorable changes in their children's behavior could be brought about and maintained only to the extent that parents were committed to implementing the program; to some, this commitment meant an excessive investment of time and energy. Although most parents accepted the philosophy and rationale of the program, during this phase many of them exhibited resistance to parts of the program, especially those that required extra work and were time consuming. Frequently this resistance could be manifested by the parents' failure to complete the weekly homework assignment. When asked about the homework, parents would give excuses such as a lack of time to play with their child or to buy stickers, forgetting what the assignment was, too much stress at home and at work, procrastination, and difficulty being motivated.

Sometimes parents resisted homework assignments involving interactions with their children because they perceived their children as verbally abusive, controlling, and nonreinforcing.

Mother: I find it so hard to find 5 minutes to play with my daughter where I'm not saying, "Put the knife down. Put the hammer down. Don't kill your sister. Don't kill the cat."

Mother: I feel like I am being held hostage some of the times by the kids, with some of the things we've tried. When I was doing the play

time with the kids, I began to feel abused by that I would always be the bad guy, and he would always be doing something to the bad guy. He loves this time, but he orders me around. He is using words, "Do what I tell you," "I am going to decide what we are gonna do today." "I hate you. You are stupid, Mommy, you are not nice." . . . So far the videos said let the child lead the way, and he does not seem to want to do much more than have this real negative interaction. What it does to me is make me not want to do this play time. For me there is no reward. The more I realize the right things to do, the more the wrong things loom huge to me. And I'm, feeling really discouraged by that. [Session 5]

Another area of parent resistance for some parents was substituting Time Out (a method of discipline whereby the child is removed for 5-min to a boring room or chair in a corner) for spanking. Many parents questioned the rationale and effectiveness of Time Out. They found this method to be time-consuming and to minimize their control. These parents would argue that spanking and yelling, in contrast to enforcing Time Out, were expedient as well as immediately effective; spanking and yelling gave them a feeling of maintaining control.

Father: You gain respect out of fear, in many ways. I think all this stuff is good and all that garbage but . . . I don't buy all this stuff. There comes a time when you can't say, "Oh that's great. You threw a ball and broke the window—that's nice." There comes a time when you get hold of that kid and you take it out on him. What I'm basically saying is at first once the kid has gone so far, you can threaten him with the moon falling in and he could care less. What I'm saying is at first if you let him know if he gets out of control then it's not going to be Time-Out or anything else—it's spanking time and that's it! As far as I'm concerned, you can try Time-Out and all this good stuff, but there comes a time when this is it—no

Time-Outs, nothing but the belt!  
[Session 8]

Father: There have been times when spankings have really made a difference for him, and I know it's perverse, but it almost seems to make him feel like he needed something to get him in control. It's kind of like the movies with somebody screaming and carrying on and somebody slaps them in the face and they feel instant relief. I know it sounds bizarre, but it works. [Session 8]

Another example of resistance is provided by parents who perceived the parent techniques as manipulative and devious.

Father: You say to your child, "You were bad so what we're going to do is set up a system. Then when you're good a little bit, we'll give you a reward." It seems like it sets kids up to be bad, so by being good they get something. [Session 6]

**No quick fix.** The combined effect of the setbacks and resistance was apparent in a deterioration of the total cure myth and an evaporation of the magic moon dust phase. Parents gradually came to understand that they could not correct the flaw in their child and that there was no quick fix or cure for their children's problems or for their families as a whole.

Mother: I think we've seen them improve, but it'll vary. If things are going bad, they generally go bad all day. There are some days when nothing works, and I can't say a single positive thing. But there are other days, and more of them when the kids are doing better. You can kind of tell when you wake him up. I'll go wake him up I'll rub his back a little bit. If he wakes up rolls over and hugs me, I know it's a good morning. And if he is, "Leave me alone," it's going to be tough. [Session 13]

Although the children's behavior did improve, as well as the overall parent-child interaction, parents realized that the children's temperaments and associated problems were long term. The chronic nature of the problems exacted a heavy toll from par-

ents, requiring them to monitor the children continuously. This change in parental perceptions of the duration of the children's problems was necessary in order for them to make a long-term commitment to the implementation of the program.

Father: I've had a couple of horrible weeks. It feels like I have to be on all the time. I think I have to be telling myself just try and mellow out, and it's difficult. [Session 8]

#### Phase IV: Making the Shoe Fit

In this fourth phase of learning to cope more effectively with their children's problems, parents became preoccupied with "making the shoe fit"—that is, tailoring the concepts shown in the standardized videotape examples to their own family situations and parenting style. This phase was crucial in determining parents' degrees of success in implementing the program. Data indicated that failure to tailor the program resulted in diminished success with it, because parents' expectations for themselves and for their children were inappropriate. Two categories of making the shoe fit were identified in the data: understanding parenting techniques, and generalizing parenting techniques.

**Understanding parenting techniques.** The analysis indicated that, in general, parents had a good understanding of the rationale for the parenting principles and techniques presented in the videotapes. However, some difficulties were apparent concerning parents' understanding of how to implement specific approaches in a realistic and age-appropriate manner.

For example, the tangible reward program, although highly accepted by most parents, posed difficulties for some parents in terms of the monetary cost of the rewards. Some parents tended to set up unrealistic reinforcement menus involving expensive items that they could not afford; when the child earned the agreed-upon number of points, they could not follow through and thus sabotaged their program. In addition, some parents tended to rely on material items in their reinforcement menus, rather than nontangible inexpensive reinforcements such as activity time with parents or special privileges.

Reinforcement menus were developed by some parents with inappropriate expectations, and without concern for the child's developmental status or the frequency and type of misbehavior. More specifically, parents demonstrated difficulties around the appropriate timing of the rewards (*i.e.*, how long the child should wait before getting the reward), choos-

ing type of behavior to put on the list, and weighing the cost for each behavior (e.g., 2 points = sharing, 5 points = extra reading time, 25 points = visit to the zoo).

Of even greater concern to some of these parents of conduct-problem children was the fact that some children began to use the reward system as a tool in their power struggle with their parents; as a result, parents felt the tangible reward system actually decreased their control. Children refused to do anything without a reward, or took control of the reward system by getting access to the stickers.

Mother: What I am finding is that he is keeping on top of it [star chart] . . . It's like he says, "Well, Mom, I can't even earn a sticker, there is nothing to pick up." He did go a long way, but this is very expensive. I was trying to give so many stickers per dollar value. I don't want him to have to wait so long that he loses interest. I was paying \$50.00 a week. [Session 6]

Another parenting technique that posed difficulties for many of these parents was reducing the number of commands. Difficulties arose around two parental behaviors: stopping chain commands and giving the child an opportunity to comply to a command. Having come to expect their child's noncompliance, parents had compensated with frequent repetitions of their commands—chain commands. They found it difficult to stop this reflexive habit.

Father: I am the kind of person that is very directive. I direct my son in almost everything he does, and so, I am having a hard time dropping down the number of commands. [Session 7]

Issues of parents having unrealistic expectations, failing to consider children's developmental status or type of misbehavior, also arose in regard to implementation of Time Out. For example, some parents had a hard time finding an appropriate place to do Time Out in their home or used this as an excuse to avoid using Time Out with their children. Others overused Time Out and used it for child misbehaviors that should have been ignored or were not really inappropriate given the child's age. Sometimes it was difficult for parents to know which parent strategy (Command, Time Out, Ignore, Consequences, Distraction) should be used given a particular misbehavior or new situation.

**Generalizing parenting techniques.** Data indicated that some parents, in the process of making the shoe fit, had difficulties generalizing the particular parenting techniques shown in the videotape scenarios to other children, other problems, and other settings. They did not readily see how a given parent strategy could be used with different behaviors across different age groups. For example, without help from the therapist, some parents could not generalize the concept of using the ignore technique for tantrums to using it for whining and swearing.

Parents also expressed difficulties understanding how to use the techniques in different settings. They commonly struggled with the use of Time Out and Ignore in public settings, and with more than one child.

Mother: He usually is just fine, but it's the minute that you get him into a store. Like yesterday at the store, he was going up to people, poking his hand and stopping them from moving, or grabbing them like grabbing women's skirts from behind. And the hard thing in the store you can't take him out and put him in the car for Time Out. [Session 10]

Interestingly, the data suggested that parents had difficulties generalizing the techniques when they were dealing with content areas not directly shown in the videotape scenarios. However, the parent group sharing and problem solving provided a rich array of examples of parents applying the concepts in different situations, which helped enhance parents' understanding of how to generalize the skills learned.

#### Phase V: Coping Effectively

In the last phase of the process, parents began to exhibit effective coping strategies. Parents who reached this phase could laugh at their own vulnerabilities, express empathy for their children's problems, and understand their children's developmental needs. In this phase, parents expressed the foreknowledge that they would survive their children's and their own relapses. They became experts at responding to their children's special needs, which allowed them to act as their children's advocates in the larger community. As they discovered they could cope successfully with the daily hassles of having conduct-problem children, they gained confidence in themselves and their ability to cope with future problems. Five categories of coping effectively were identified in the data: coming to terms

with the hard work, acceptance and respect, refueling the parent, managing the anger and depression, and getting support.

**Coming to terms with the hard work of parenting.**

Parents came to realize that they had high maintenance, temperamentally difficult children. They came to terms with the realistic facts that their children's problems are chronic, characterized by the unpredictable relapses, constant vulnerabilities to changes in the routine, and the emergence of new behavior problems whenever the children entered new settings such as school or new schedules. They faced the fact that these problems require parents to invest an exorbitant amount of time and energy into the hard work of constantly anticipating, monitoring, and problem solving for many years. During this phase, parents were able to manage their anger and grief related to their hoped-for, ideal children, to accept their children's difficulties, to appreciate their children's strengths, and to invest themselves in committed parenting.

Mother: I'm continually watching at home: How can we avoid these problems? How can we avoid the activating event? How can I derail something before it explodes? Okay now, cool it down. They're getting excited. Let's break it up. [Session 15]

Father: He still has these fits, but they are farther apart and less severe—not as violent as they used to be. He relapses, but they're still not like they used to be. [Session 15]

**Acceptance and respect.** In this phase, parents indicated empathy, acceptance, and understanding of their children's particular temperaments and sensitivity to the children's developmental struggles. During this phase the parents accepted the children's needs for independence and for the opportunity to learn from their own mistakes. They also understood the importance of their patience and support in the developmental process of the children.

Mother: In the last 3 weeks I've noticed a synthesis of all the sessions we've had, and me basically changing the way I interact with Hannah in a dramatic way—spontaneously. Now when I interact with her I tend to look at her eyes and I realize I can't

remember my parents ever doing that. I'm giving her more space and time—more room to make mistakes, screw up and make messes. I'm trying to give her more independence, when she wants to do something let her do it, rather than saying, "You're going to spill the milk all over the floor." It's fine if she spills the milk; she'll learn what happens, and we've actually been getting on really well. [Session 20]

Part of gaining this empathy for the children was parents' being able to see beyond their own frustration and anger, to understand the feelings and perspective of the children.

Father: You know, something we haven't talked about specifically in this parenting class, although it is in everything you've talked about, is respecting children and their space in the world. You know they should be treated as equal human beings—it doesn't mean you don't set limits and all that stuff but it means you know that they're human beings and as deserving of respect as you are. [Session 20]

Coping effectively means not only for parents to come to accept and understand their children's temperaments and difficulties, but also to accept their own imperfections as parents. They no longer belittled and berated themselves for their angry thoughts but saw the emotional responses as normal ones and understood the need to keep personal self-control. In the next example, the father is able to stop his angry response, to see his daughter's viewpoint and then to recognize her capacity to help him cope.

Father: I went into the bathroom to get Sara to finish brushing her teeth, and there was a puddle of water on the floor and a roll of wet toilet paper, and I was angry and ready to lose it and said, "This is it!" as I threw the toilet paper. You know what she said? "Dad, don't talk to me like that. You know you can scare me." Normally she would have cried, but now I think she was thinking of my point of view. I said, "You're right, and I'm sorry. I'm real tired and it's

wet in here." I felt saved by her.  
[Session 20]

**"Refueling" the parent.** Along with parents' becoming more knowledgeable and confident in their parenting skills and in their ability to cope with the children's problems, coping parents also indicated the importance of reinforcing and refueling themselves as individuals and couples. As the blame, guilt, fear, and anger subsided and the children's behavior improved, the parents were able to get babysitters so that they could spend time away from their children. Parents expressed the view that taking time for themselves and being with their partners was a refueling process that allowed them to gain a more positive perspective and to maintain the energy they needed to cope with their children's problems

Gradually parents also experienced some refueling through their children. As the parents' efforts began to pay off, parents started to talk about how their children were actually reinforcing them.

Mother: I started in the mornings instead of yelling at them to wake up because I had to go to work and rushing around—I wake them both up by giving them a back rub and then I wake them up real gently and they just love it. Now they come up to me and say, "Mom, we need positive strokes." About 2 weeks ago they came up when I was sitting and started rubbing my arm and said, "You need positive strokes, Mom." So they are reciprocating now, which I thought was real interesting.  
[Session 14]

**Getting support.** During this phase, parents no longer felt isolated and stigmatized because of their parenting of their children's problems, but rather were actively engaged in seeking support. The parents indicated that the parent group provided a safe place where they could be honest and vulnerable about their difficulties. Often to their surprise, they found that the other parents all had had similar experiences and emotional responses. Thus the parent group provided a tremendous sense of connection with other parents.

Father: Out of all the thousands of people you meet from day to day and you have dealings with them, I feel very fortunate to have this class and this group of people

that has really enlightened and enriched my life. And, ah, it's going to make me a better person from knowing everyone here.  
[Session 14]

Father: Even when this program is finished, I will always think about this group in spirit. [Session 24]

Mother: Well, this class has really made such a huge difference in my life, you know to the point of, I would say, making it or breaking it. I don't know where the boys and I were headed. . . . I was at the point of saying, "I can't deal with them" and telling my ex-husband, "You can have them." The class and the sharing—I'm just so thankful. [Session 12]

Mother: This group's all sharing—and it's people that aren't judging me, that are taking risks and saying, "Ellen, have you tried this? Or considered you are off track?" You know we're all putting a lot into this, and my feeling is, the more we as individuals put into it, the more we get out of it. It's the turning point—every class has been building stronger and stronger. I know we're going to make it—I'm going to make it—the boys are going to make it. The three of us are going to live happily ever after—we're going to have our problems. [Session 18]

## Discussion

### The Process of Change

In summary, the process experienced by the parents who were enrolled in this videotape parent training program was one of gradually gaining knowledge, control, and competence to cope effectively with the stresses evolving from having a conduct-problem child. Initially, parents had to acknowledge that their children had behavior problems that they did not know how to handle. They expressed feelings of anger, fear of loss of control, guilt, and blame at not being able to interact more effectively with their children. Once they began to implement the principles and strategies presented in the program, they moved from despair into a second phase characterized by feelings of enormous relief and the belief that the program would provide an easy solution for their children's

and families' problems. Parents were engaged in emotional regulation, coping strategies and, especially, positive reappraisal (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986). They perceived the problem to be less severe than they had thought, and believed they understood how to cope with it easily.

A third phase, involving limited improvement or regression in the children's problems, conflicting family dynamics, resistance, and a realization of the substantial amount of work needed for long-term improvement, served as cues from the environment that parents needed to reconstruct their view of reality. As Folkman and Lazarus indicated, "the extent to which cognitive coping strategies work depends in part on how much distortion or reality is involved, and whether or not the cognitive construction is likely to be challenged by the environment" (1988, p. 966). These continuous environmental challenges tempered the parents' unrealistic expectations for the program and allowed them to refocus their energies on acquiring the new parenting strategies.

As parents moved into the fourth phase, they worked hard at adapting the techniques taught in the program to their own situations and needs. Their coping strategies involved the problem-solving techniques of gathering more information and planning what they needed to do (Folkman & Lazarus, 1988). Although they experienced difficulties applying some of the parenting strategies, parents were able to gain knowledge and control by using the problem-solving techniques.

In the last phase, parents expressed empathy and acceptance of their children's problems and affirmed their ongoing commitment to maintaining progress. Although they still reverted to earlier phases and experienced some relapses and feelings of anger and self-blame from time to time, they had learned to expect these as normal reactions and as clues to the need for helping their children learn how to handle problems. Once parents gained confidence in their knowledge and felt a sense of competence, they were able to cope more effectively by learning to utilize a support system and to refuel themselves. With greater personal resources and a sound support system, they reappraised their difficulties evolving from having conduct-problem children. This time, however, their positive reappraisal was the result not of unrealistic expectations but of their own effective coping skills and their recognition of their children's long-term, ongoing needs for a social environment that acknowledges the children's abilities to behave appropriately.

This qualitative analysis confirms our prior quantitative analyses, which indicated that treated parents' attitudes toward parenting and behaviors toward their children became more positive

posttreatment in comparison to those of control families (Webster-Stratton et al., 1988). The proposed model also supports the work of Chamberlain, Patterson, Reid, Kavanagh, and Forgatch (1984), who reported that parent resistance peaks midway through treatment just as we found in Phase III of the model. In fact, they reported that 72% of families showed moderate to high levels of resistance during most phases of treatment. However, what is new from these data regarding the notion of resistance is that resistance seems to develop as a result of parents' having unrealistic expectations regarding the commitment and energy needed to implement and maintain treatment procedures (lack of a quick fix) and as a result of their anger, frustration, and pain over having to deal continually with children who are aversive and nonreinforcing despite their best efforts. This information has implications for therapists to anticipate this process and be empathic, warm, and reflective, allowing parents to talk about these setbacks and angry and hopeless feelings. It is certainly clear from Patterson and Forgatch's (1985) study that further teaching and confrontation will only inflame the resistance. It could be hypothesized that therapist lectures may serve to give parents the erroneous message that there are easy cures, which the families know by this time not to be the case.

This study has several limitations, which also lead to suggestions for further research. First, the study presents the unilateral point of view of the parents and does not analyze the therapist's perceptions or reactions to this therapy process; nor does it attempt to discern what the therapist or parent group can do to move parents successfully through these phases. Clearly, most parents will exhibit resistant behaviors; however, whether they will increase their resistance or will move on to another phase will depend in part on the therapists' approach. Further, research needs to analyze qualitatively the therapists' perceptions and behaviors when confronted with the resistant, angry, or depressed parent during the process of parent training. Another limitation of this study is that it is impossible to tell from this kind of research what percentage of families work through all five phases of treatment or what percentage of time families spend in a particular phase. It would also be helpful to know the characteristics of families that remain fixed in the earlier phases versus those that successfully cope with their children's problems. One final limitation of the study is that it is unknown whether the same therapy model would hold true for a different type of parent intervention program that perhaps was not as lengthy or did not use videotapes. Further therapy process research is needed to confirm and elaborate on this proposed model.

It is our contention that through qualitative analyses we can begin to move into another stage in the understanding of parent training procedures for families with conduct-problem children. The qualitative approach is not meant to replace the use of a quantitative database for evaluating the eventual outcomes of parent training programs but rather represents another lens through which to view the ongoing process of change for parents who are participants in treatment. Instead of relying only on observable deviant behaviors of the parent or child as indicators of treatment success or failure, qualitative methodology allows us to develop therapy process models and to understand better the reasons why a family might succeed or fail in treatment. The qualitative approach serves the additional purpose of ultimately leading to further clarification of the multiple goals and important outcomes in treatment. This study suggests that we need to broaden our perspective in terms of goals for parent training programs and utilize treatment outcome measures such as reductions in parents' anger and depression levels, increases in social support systems, improved sibling relationships, and overall improvements in family coping and problem-solving abilities.

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