

**VOLUME I**

**RESEARCH COMPONENT**

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## **Overview**

This thesis is submitted in partial fulfilment of the requirements for the degree of Doctorate of Clinical Psychology (Clin.Psy.D.) at the University of Birmingham. The thesis consists of two volumes.

### **Volume 1**

This volume comprises three chapters. The first chapter is a systematic literature review evaluating the long-term effects, for children and parents, of group parent training programmes. The second chapter is an empirical study of an uncontrolled, pre, post and follow-up evaluation of the Understanding Your Child's Behaviour (UYCB) group: A parenting group intervention based on the Solihull Approach. The third chapter is a public domain briefing document, providing an accessible summary of the literature review and empirical paper.

## **Volume 2**

Five Clinical Practice Reports (CPRs) are presented in this volume. The first report details the case of a 41 year old woman with bulimia, formulated from cognitive and psychodynamic perspectives. The second report presents a small-scale service-related research project, exploring carers' experiences of the support they received from a Community Mental Health Team (CMHT). The third reports a case-study of a 24 year old woman with a learning disability, presenting with depression and low self-self, formulated from cognitive-behavioural (CBT) and cognitive analytic (CAT) approaches. The fourth report is a single-case experimental design evaluating the effectiveness of a biopsychosocial approach for Trichotillomania (TTM) in a 14 year old boy. The fifth report is the abstract of an oral presentation of the use of a CAT approach with a 90 year old woman suffering from depression.

All names and identifying features have been changed to maintain confidentiality.

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## Contents of Volume 1

### Chapter One: Literature Review

Abstract.....	2
Introduction .....	3
Method.....	7
Search Strategy .....	7
Inclusion Criteria .....	8
Data Extraction.....	10
Assessment of quality.....	27
Results .....	31
Overview of Studies .....	31
Study Outcomes.....	35
Discussion.....	45
Overall Findings .....	45
Limitation and Suggestions .....	49
Clinical Implications.....	51
Conclusion.....	54
References.....	55

### Chapter Two: Empirical Paper

Abstract.....	61
Introduction .....	62
Method.....	67
Intervention.....	67
Fidelity to programme delivery .....	67
Sampling.....	68
Procedure .....	69
Ethics .....	69
Design and Questionnaires .....	69

Data Collection .....	73
Statistical Analysis .....	73
Results .....	75
Participants .....	75
Treatment Fidelity .....	75
Descriptive Data .....	75
Analysis One (pre-post group changes).....	76
Analysis Two (pre, post & follow-up changes).....	78
Clinically Significant Changes .....	82
Discussion.....	84
Limitations.....	87
Clinical Implications.....	89
Conclusions .....	92
References .....	93

## **Chapter Three: Public Domain Briefing**

### **Literature Review**

Background.....	97
Aim .....	97
Method.....	97
Findings .....	98
Conclusion.....	98
References .....	100

### **Empirical Paper**

Background.....	98
Aim .....	99
Method.....	99
Findings .....	99
Conclusion.....	99
References .....	100

## **List of Tables for Volume 1**

### **Chapter One**

Table 1. Data Extraction of Included Studies.....	11
Table 2. Quality Assessment of Included Studies .....	28

### **Chapter Two**

Table 3. Programme Session .....	67
Table 4: Participant Inclusion and Exclusion Criteria.....	68
Table 5: Inter-Class Correlation for CRPS.....	72
Table 6: Inter-Correlation between CPRS subscales and PSI .....	73
Table 7: Pre-Post Changes.....	78
Table 8: Pre-Post-Follow-up Changes.....	81
Table 9: Direct of mean changes in scores across all 3 time-points.....	82
Table 10: Clinically Significant Changes .....	83

## **List of Figures for Volume 1**

### **Chapter One**

Figure 1. Flow chart for inclusion of studies.....	9
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## **Appendices Volume 1**

A: Effective Public Health Practice Project (EPHPP).....	101
B: Outcome Measures used in Included Studies .....	104
C: Fidelity Checklist.....	108
D: Participant Information Sheet .....	116
E: Consent Form .....	119
F: Pre-group Questionnaire Booklet.....	120
G: Post-group Questionnaire Booklet.....	125
H: Follow-up Questionnaire Booklet .....	130
I: Research Ethics Committee Approval .....	135
J: Research and Development Department Approval.....	136
K: Parent Stress Index Attachment Subscale .....	138
L: Participant Demographics Form .....	139



## **Chapter One**

**The long-term outcomes, for children and their parents, of attending a  
group parent training programme:**

**A systematic review of the literature**

## **Abstract**

**Background.** Conduct problems in childhood are both common and costly, and if left untreated may lead to negative implications into later child and adulthood. Group based parenting interventions have been identified as the treatment of choice by the National Institute for Health and Clinical Excellence (NICE) , and short-term benefits of parenting programmes have been consistently reported in the literature. However, in order for such programmes to be truly preventative any immediate gains of the intervention must be able to be maintained over time. This review sought to establish the long-term (one year and over) effects of parenting programmes aimed at targeting conduct problems in children.

**Method.** Seven databases and 4 parent training websites were searched for quantitative research published between 1975 and 2013, of parenting programmes aimed at targeting conduct problems in children which included a follow-up time-point of at least 1 year. In total 1448 studies were screened, of which 19 papers selected for review.

**Results.** Long-term benefits of up to 14 years post-intervention were found in the areas of: child behaviour; parental well-being; and parenting skills, style and competence. However, a number of limitations, in particular the lack of a non-intervention control group for comparison at follow-up, and the fact that most studies included follow-up periods of less than three years, were noted.

**Conclusions** The findings from this review suggest that there are long-term benefits, for children and their parents, of attending a parenting programme. However, follow-up time-points are typically short (< 3 years) and future research is needed in order to be able to establish which groups of parents and children are able to maintain initial positive gains of attending a parenting programme over time, and whether positive findings at follow-up time-points can be truly attributed to the effects of the programmes themselves.

## **Introduction**

Conduct problems in childhood are both common and costly. If left untreated, conduct problems with an onset in early childhood may lead to a diagnosis of Conduct Disorder (CD) or Oppositional Defiant Disorder (ODD), characterised by troublesome, disruptive and aggressive behaviour (DSM-IV-TR, 2000). The prevalence of CD/ODD increases with age, with 7% of boys and 3% of girls aged five to ten receiving a diagnosis, rising to 8% of boys and 5% of girls aged 11 to 16 (National Institute of Clinical Excellence, 2013).

Early onset conduct problems can have significant implications into adolescence and adulthood. A seminal 25-year longitudinal study by Fergusson et al. (2005) sought to establish the association between early untreated conduct problems and a range of later development outcomes (e.g. employment, mental health) with a cohort of 1,000 children in New Zealand. The children included in the study were contacted periodically and data on their educational and social development were collected from a variety of sources including parent and teacher reports, as well as medical and other official records. Results at 25 years showed that, after controlling for confounding variables (such as education and employment status), there was a statistically significant association between conduct problems with an onset in childhood and adverse outcomes in adulthood including poor educational performance, increased social isolation, and increased substance misuse and criminal behaviour.

As well as the impact of conduct problems in childhood on the individual child or adolescent, if left untreated there are significant economic implications for society as a whole. Scott et al. (2001) found that children and young people with conduct problems have increased contact with health, social, specialist educational and criminal justice services. As a result, it has been estimated that the cost of supporting a child with CD/ODD between the ages of 10 to 28 is £90,000 - ten times that of supporting a child without these difficulties (Roberts, 2012). It is therefore not surprising that there has been an increased interest in early interventions targeting conduct problems in childhood with the aim of preventing the development of further difficulties in adolescence and adulthood.

A number of interventions have been proposed to help manage conduct problems in children, including individual behavioural therapy, family therapy, school interventions and, in some cases, medication. In addition, it has been recognised that parents play a fundamental role in shaping their child's development, and poor parenting (e.g. poor parental supervision,

inconsistent discipline, authoritarian parenting style) has been linked to the development and maintenance of conduct problems in children (Farrington, 2009; Morrell & Murray, 2003; Connor & Scott, 2007). As a consequence, a range of parenting interventions have been developed over the years, the most common of which are parent training programmes which are designed to be delivered in a group setting, over a time-limited period (usually between 8-12 weeks). Parent training programmes are underpinned by the theoretical principles of Social Learning Theory (the assumption that a child's behaviour will improve if it is appropriately reinforced), Attachment Theory (the notion that an infant's ability to form strong emotional bond with their care-giver is a fundamental part of their development), and Parenting Styles Theory (the idea that a child's behaviour is directly related to their parent's child rearing practices). The aim of these programmes, therefore, is to utilise the influence parents have on their children, and are based on the premise that modifying parenting behaviour and thinking this will, in turn, change the child's behaviour (Kazdin, 2002).

As well as strategies to manage difficult child behaviour, it has been recognised that parents' own sense of well-being has an impact on their ability to effectively parent and, as such, parenting programmes often include a specific focus on parents developing skills to manage their own stress and anxiety. Parent training programmes have been recommended as the treatment of choice for children identified as being at high risk of developing ODD or CD (e.g. children from single parent families, poverty and low social economic status), as well as those already with a diagnosis (NICE, 2013).

There is substantial evidence supporting the short-term benefits (less than 1 year) of attending a parent training programme across a range of outcome measures, including reductions in parental anxiety, stress and depression, improvements in parenting skills and child behaviour (e.g. reviews by Barlow et al., 2002; Barlow et al., 1999; Bunting, 2004; Gibbs, 2003). However, the value of parent training programmes in achieving their aim of preventing further difficulties in later childhood and adulthood is based on any immediate gains of the intervention being maintained over time. Although there is consensus that long-term follow-up studies are important, at present, longitudinal data are limited, with follow-up time points typically less than 6 months (Kazdin, 2002).

Reviews that have attempted to establish the long-term effects of interventions targeting conduct problems in children have yielded mixed results. Brestan and Eyberg (1998)

reviewed follow-up data of a variety of psychosocial treatments (including parent training programmes) aimed at treating conduct disorders in children and adolescents, and concluded that follow-up effects at 6 months or less were similar to data collected immediately post treatment, but that follow-up data at 12 months indicated the effects of treatment had worn off. In contrast, Durlak and Wells' (1998) review of prevention and promotion interventions for conduct problems found that, although follow-up effects at 6 months or less were similar to the findings of Brestan and Eyberg (1998), at 24 months positive effects continued to be maintained (demonstrated by stability of scores immediately post-treatment at follow-up time-point).

More recent meta-analyses by Grove (2008) and Sandler et al. (2011) have looked at the long-term effects of a wide range of interventions (e.g. family based, school based, residential programmes for adolescents, child coping skills) aimed at reducing adverse effects in children and adolescents (e.g. oppositional behaviour, aggression, delinquency, substance misuse), and have suggested that positive effects may be maintained up to 20 years following intervention. Grove et al. (2008) found the effects of interventions aimed at managing child behaviour problems (including ODD and CD) showed an overall statistically small, but positive effect on long-term outcomes including oppositional and aggressive behaviour. Sandler et al. (2010) looked specifically at preventative intervention studies aimed at targeting behaviour problems in children that were not yet deemed to be clinically significant, with the aim of helping prevent them from becoming so. Their review provided evidence that preventative interventions can be effective in the longer-term (one to 20 years), and significantly, that those interventions that included a behavioural parenting component were linked to improved outcomes, particularly in the areas of youth stress, self-esteem and behavioural disorders.

There are clearly significant, costly implications of untreated conduct problems in children and previous research in this area supports the importance of preventative interventions, in particular those focusing on parenting skills. If parent training programmes are to be successful it is vital that any gains achieved by attending such a programme are maintained over time. The aim of this current review is to look specifically at the long-term (defined as 1 year and over) outcomes of attending a group parent training programme aimed at targeting conduct problems in children. The review includes preventative interventions for children experiencing behaviour problems not yet in the clinical range, as well as

interventions aimed at improving behaviour problems in children already experiencing clinically significant behaviour problems and/or a diagnosis of ODD/CD.

## Method

**Search strategy.** Relevant articles were identified through (1) searching electronic databases; (2) searching parent training websites; and (3) hand searching reference lists of relevant articles obtained.

### (1) Electronic databases

An electronic database search of *PsycINFO* (1987-April Week 1 2013), *Web of Science* (1980- April Week 3 2013), *Embase* (1988- Week 1 April 2013), *Assia* (1987- April Week 1 2013), *Cinahl* (1982- April Week 1 2013), *Social Services Abstracts* (1975-April Week 1 2013), and *Sociological Abstracts* (1952-April Week 1 2013) was undertaken using the following search strategy:

- A. A keyword search was conducted for “parenting programme” **or** “parent training” **or** “family intervention” **or** ((parent\* or family) adj2 (program\* or intervention\* or training\* or educat\* or course\* or group\*)) (all terms exploded)
- B. A keyword search was conducted for “behaviour problem” **or** “behaviour disorder” **or** “conduct disorder” **or** “oppositional defiant disorder” **or** ((Behav\* or conduct\*) adj2 (disorder\* or difficult\* or problem\*)) (all terms exploded)
- C. A keyword search was conducted for “longitudinal study” **or** “follow-up study” **or** “prospective study” **or** ((“long\* term” or longitudinal or “follow-up” or prospective) adj2 (outcome\* or effect\* or evaluation\* or stud\* or finding\*)) (all terms exploded)

Search strategies A **and** B **and** C were combined, resulting in 1153 papers.

### (2) Parent training websites

The following websites were searched for published studies relating to group parenting interventions. It was not possible to apply keyword searches when searching these websites so all relevant abstract articles were obtained for hand screening.

- A. Parent and Family Support Centre- Triple P Evidence Base. Searched on 26/03/13  
<http://www.pfsc.uq.edu.au/research/evidence/>
- B. Incredible Years Library. Searched on 26/03/13  
[www.incredibleyears.com/library](http://www.incredibleyears.com/library)
- C. National Academy for Parenting Research. Searched on 26/03/13

<http://www.parentingresearch.org.uk/Publications.aspx>

D. Research in Practice- supporting evidence-informed practice with children and families. Searched on 26/03/13

<http://www.rip.org.uk/research-evidence/evidencebank>

The website searches resulted in 319 papers.

(3) Hand searching reference lists

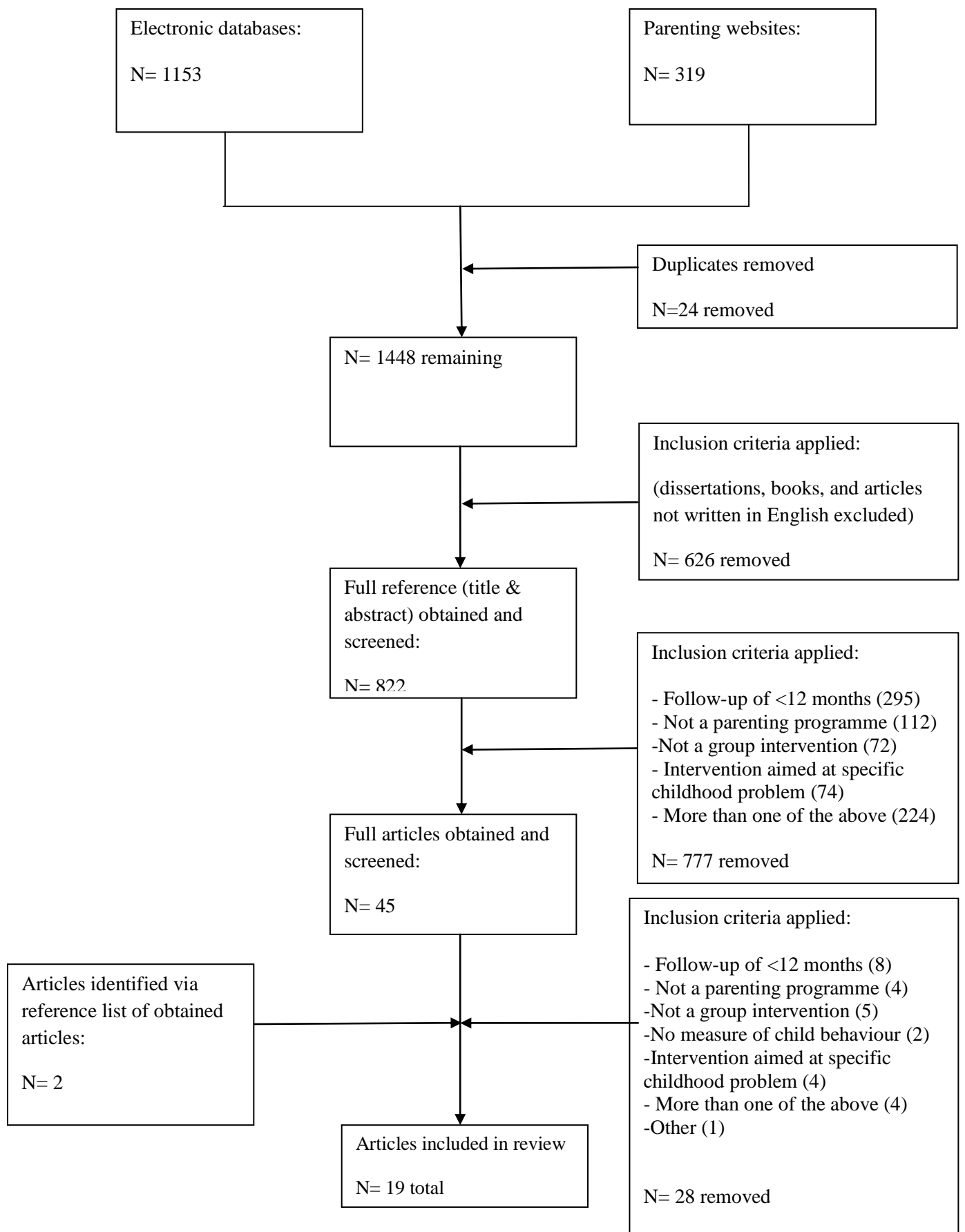
The reference lists of all obtained full articles were also examined to identify any further relevant articles, which yielded a further two papers.

**Criteria for inclusion in review.** Articles generated by the above search strategies were screened based on information contained within the full reference for the article (title, abstract and author). The full text article for all relevant studies were then obtained and further screened. The following inclusion criteria were applied:

- Articles written in English
- Peer reviewed articles
- Studies using quantitative methodology
- Studies with a follow-up time point of 12 months or over
- Interventions delivered in a group setting rather than one-to-one with parent
- Interventions aimed at improving conduct problems in children rather than specific childhood or co-morbid problems (e.g. obesity, sleep difficulties, substance misuse)
- Studies that include at least one standardised instrument to measure child behaviour

Using the above search strategies a total of **19** studies were selected for inclusion in this review. See Figure 1 for a flow chart of the search strategy and the articles included and excluded at each stage.





**Figure 1:** Flow chart for inclusion of studies

**Data extraction.** A data extraction table was created to extract information relating to the study design (number of participants, outcome measures used, length of follow-up), intervention (parenting programme) and outcomes (key outcomes, limitations), from the 19 identified papers (see Table 1).

**Table 1:** Data extraction of included studies (presented in chronological order)

Study  Authors (Year)  <i>County of origin</i>	Study aims	Participant Information (pre group)		Design	Parenting Programme  (see footnote)	Outcome measures  Parent outcomes Child outcomes  (see footnote)	Follow-up (FU)  Time points N Attrition rate	Key findings  Parent outcomes Child outcomes	Limitations
		Parents N Age Gender	Children N Age Gender						
<b>1. Webster-Stratton, Hollinsworth &amp; Kolpacoff (1989)</b>  <i>America</i>	To evaluate the 12 month effectiveness of 3 parenting interventions [group discussion and videotape modelling (GDVM); self-administered video-tape modelling (IVM), and group discussion (GD)] for children experiencing conduct problems.	N= 194  Not Reported (NR)  114 females 80 males	N=114  3-8 years  NR	Randomised Control Trial (RCT)  (Parents were randomly assigned to GDV, IVM, GD or control (CON). CON group went on to receive 1 of the 3 interventions after 4 months).	GDVM, GD, IVM	<i>Parent:</i> PSI, DPICS  <i>Child:</i> CBCL, ECBI, PBQ , PDR	12 months  N=154  20.7%	<i>Parent:</i> Significant reduction in parental stress and observed parenting style (increased praise & decreased critical statements), in all groups. Stability of scores from post-group to FU.  <i>Child:</i> Significant pre to post group increase in pro-social behaviour and decrease in externalising and internalising difficulties in all groups. Stability of scores from post-group to FU in	Lack of CON at FU means it was not possible to ascertain whether reported findings were as a result of the intervention. No included self-report measures of parents' own perceived parenting skills and style.

								IVM & GD group on all measures. Further improvements in child behaviour in GDVM group at FU.	
<b>2. Webster-Stratton (1990)</b> <i>America</i>	Three year follow-up to Webster-Stratton, Hollinsworth & Kolpacoff (1989)	N= 194  NR  114 females 80 males	N=114  3-8 years  NR	RCT  (Parents were randomly assigned to GDV, IVM, GD or CON. CON group went on the receive 1 of the 3 interventions after 4 months)	GDVM, GD, IVM	<i>Parent:</i> BDI  <i>Child:</i> CBCL, TRF, PBQ	3 years  N=134  21%	<i>Parent:</i> NR  <i>Child:</i> Stability of scores from post-group to FU in GDVM group regarding child externalising and internalising problems. GD and IVM reported significant escalation in child externalising problems from 1 year to 3 year FU. 1/3 of parents had on-going concerns about their child's behaviour.	Lack of CON at FU. Inconsistency in measures used at 12 month and 3 year FU meant it was not possible to compare outcomes on same measure across time-points. Parental outcomes not reported.
<b>3. Long et al. (1994)</b> <i>America</i>	To follow-up a sample of children whose parents had attended a parent training programme	N=47  NR  NR	N= 47  2-7 years  NR	With-in subjects  Matched comparison included at FU	Helping non-compliant children	<i>Parent:</i> n/a  <i>Child:</i> CBQ, NYS, MAST, RSE, BSI, HDUS, GDS	14 years  N=26  44.7%	<i>Parent:</i> n/a  <i>Child:</i> At FU no significant difference emerged between intervention group	Lack of CON at FU. Small sample size at recruitment and large attrition rate at FU (45%). No information gathered on

	approximately 14 years earlier.							and matched comparison group in the areas of delinquency, relationship with parents, emotional adjustment and academic performance.	events from post to FU to ascertain whether positive outcomes for intervention group are related to having received parenting programme.
<b>4. Bradley et al. (2003)</b> <i>Canada</i>	To evaluate the effectiveness of a 4 session psycho-educational group for parents of children with behaviour problems 1 year post intervention.	N=198 (89= Intervention Group (IG), 109= CON)  NR  NR	N= 198 3-4 years  NR	RCT  (CON lost at FU)	Magic 1-2-3	<i>Parent:</i> PS, BSI  <i>Child:</i> PBQ, PCQ	1 year  N=25  72%	<i>Parent:</i> Significant improvement in IG in regards to parenting style (reduced laxness, over-reactivity and verbosity) from pre to post group. Stability of scores from post to FU. No significant change in 'Hostility' scale of BSI from pre to post group, this was consistent at FU.  <i>Child:</i> Significant changes in all items IG on PCQ showing improvement in child temperament from pre to post	Lack of CON at FU. No included measures of parental well-being. Results based entirely on parental reports. Large attrition rate from pre-group sample at FU (72%), may have impact on non-significant results on some scales of PBQ and BSI.

								group which remained stable at FU. No significant changes on PBQ measures of 'Hyperactivity/Distractible'. This was consistent at FU.	
<b>5. Reid, Webster-Stratton &amp; Hammond (2003)</b>  <i>America</i>	To evaluate the 2 year follow-up effects of interventions aimed at improving conduct problems in a sample of children who met the diagnosis for ODD/CD at the time of recruitment. Parents were randomly assigned to: PT, Parent Training (PT)+Teacher Training (TT), Child Training (CT), CT+TT, or PT+CT+TT, and the effects of each condition were	N=159 (133=IG, 26=CON)  NR  NR	N=159 4-7 years  16 females 143 males	RCT  (CON lost at FU)	Incredible Years (IY)	<i>Parent:</i> PPI, DPICS, CII, BDI  <i>Child:</i> ECBI, TASB, PCSC	2 years  N= 121  24%	<i>Parent:</i> All parent conditions resulted in less negative and more positive parenting post group which was maintained at FU. Mothers' critical statements and feelings of depression post group were found to be predictors of child behaviour outcomes at FU.  <i>Child:</i> Immediately post treatment, all measures indicated statistically significant reduction in conduct problems for all children in all conditions, when compared to CON. Findings	Small CON during intervention phase and CON lost at follow-up. Limited description provided on content of CT and TT

	compared.							remained stable at FU. 2 years post intervention 75% scored within the normal range on ECBI PT & PT+TT predicted significantly better outcomes than other treatment conditions	
<b>6. Nixon et al. (2004)</b> <i>Australia</i>	To evaluate the effectiveness of 2 parent training programmes- Parent Child Interaction Therapy (PCIT) vs abbreviated form of PCIT (APCIT)- for conduct problem preschoolers, at 1 and 2 years post intervention.	N= 54 (17=PCIT, 17=APCIT, 20=CON)  Mean age= 34.73 (SD=4.54)  NR	N=54  Mean age= 3.9 years (SD=0.52)  16 females 38 males	RCT  (Parents randomly assigned to PCIT or APCIT or CON. CON lost at FU)	PCIT	<i>Parent:</i> BDI, PSI, PS, DPICS  <i>Child:</i> EBCI, CBCL,NIMH DISC-IV	<u>1 year</u>  N= 36 (16=PCIT, 20=APCIT)  33.4%  <u>2 year</u>  N=34 (15=PCIT, 19=APCIT)  37%	<u>1 year</u> <i>Parent:</i> Significant reduction in mothers' critical statements from pre to FU in PCIT, but no significant changes shown in APCIT group. 45% of mothers in PCIT showed clinically significant reduction in parental stress, compared to 25% of APCIT.  <i>Child:</i> Both treatment conditions showed statistically significant improvements in child behaviour	Modest sample size, in particular at FU. No CON at FU. Not all measures were re-administered at 2 year FU (e.g. parent measures)

								(decrease in oppositional and deviant behaviours and increase in compliance) from pre to FU.  <u>2 year</u> <i>Parent:</i> No measures included  <i>Child:</i> Results remained consistent with 1 year FU findings.	
<b>7. Stewart-Brown et al. (2004)</b>  <i>United Kingdom</i>	To evaluate the 1 year effectiveness of the IY parenting programme on a sample of parents of children who scored above the median score on a measure of child behaviour at time of recruitment	N= 116 (60=IG, 56=CON)  NR  NR	N=116  Mean age =4.6 years (SD=2.0)  NR	RCT  (CON retained at FU)	IY	<i>Parent:</i> GHQ, PSI, RSE  <i>Child:</i> ECBI, SDQ	1 year  N=47  59.5%	<i>Parent:</i> Change in positive direction from pre to post on measure of parental depression (GHQ), stress (PSI) and self esteem (RSE) which was maintained at FU for IG. Similar findings in CON group.  <i>Child:</i> Significant reduction in hyperactivity and conduct problems pre to post group which was maintained at FU.	Potential contamination effects of CON group. As pre-group scores were not clinically significant there may have been a regression to the mean at FU. Significant attrition rate at FU



								No significant difference between IG and CON.	
<b>8. Scott (2005)</b>  <i>United Kingdom</i>	To see whether there were lasting effects at 1 year following parents of children with conduct problems attending the Basic version of the IY parenting programme.	N= 124 (73=IG, 51=CON)  NR  NR	N=124 3-8 years  NR	RCT (CON lost at FU)	IY Basic	<i>Parent:</i> Not included  <i>Child:</i> PDP, SDQ, PACS	1 year  N=59  52.5%	<i>Parent:</i> n/a  <i>Child:</i> Improvements at post showed that for 2/3 showed at least a modest clinically significant change in child behaviour problems (hyperactivity, antisocial behaviour, emotional problems). Original improvements at post group were found to have persisted at FU, with no loss of effectiveness.	Loss of CON at FU. There may have been a floor effect due to the fact that many of the children pre intervention did not show clinically significant problems (which may account for the 3 <sup>rd</sup> who showed no clinically significant change at post).
<b>9. Gardner, Burton &amp; Klimes (2006)</b>  <i>United Kingdom</i>	To test the effectiveness of the IY parenting programme for reducing behaviour problems in children with clinically significant	N=76 (44=IG, 32=CON)  NR  NR	N=76 2-9 years  20 females 56 males	RCT (CON lost at FU)	IY	<i>Parent:</i> PSOC, PS, BDI  <i>Child:</i> ECBI, Observation	18 months  N=38  50%	<i>Parent:</i> Post group there was a significant decrease in negative parenting style and an increase in positive parenting style that was maintained at 18 month FU. Changes	Loss of CON at FU. Modest sample size, some baseline differences between CON and IG which were not controlled for.

	behaviour problems, 18 months following intervention.							<p>in parenting skills appeared to be key mechanism for change in child behaviour.</p> <p><i>Child:</i> Significant intervention effects shown from pre to post on measures of child behaviour which was maintained at FU.</p>	
<p><b>10. Bywater et al. (2009)</b></p> <p><i>United Kingdom</i></p>	To establish whether the short-term benefits of attending an IY parenting programme were maintained 12 and 18 months following intervention with parents of children scoring above the clinical cut-off on measure of child behaviour at time of recruitment	<p>N=153 (104=IG, 49=CON)</p> <p>NR</p> <p>NR</p>	<p>N=153</p> <p>3-4 years</p> <p>NR</p>	<p>RCT</p> <p>(CON lost at FU)</p>	IY Basic	<p><i>Parent:</i> PS, PSI, BDI, DPICS</p> <p><i>Child:</i> ECBI, SDQ, SCRS, CAPRS</p>	<p><u>12 months</u></p> <p>N=82</p> <p>46.1%</p> <p><u>18 months</u></p> <p>N=79</p> <p>48.4%</p>	<p><u>12 months</u></p> <p><i>Parent:</i> Significant improvements in parenting style, skills and well-being from pre to post group which were maintained at FU.</p> <p><i>Child:</i> Pre to post group scores showed significant improvements in child behaviour, which remained stable at FU.</p> <p><u>18 months</u></p> <p><i>Parent:</i> Findings generally consistent with 12 month</p>	Loss of CON at FU. Very small effect size in regards to parenting style and well-being changes at post and FU time points.

								findings, however there was a small but significant negative change in measure of parenting from 12 to 18 month FU  <i>Child:</i> Consistent with 12 month findings  <i>Other:</i> Modest but steady decline with contact with primary care services from pre to post and 12 and 18 month FU	
<b>11. Drugli et al. (2010)<sup>1</sup></b>  <i>Norway</i>	To investigate whether effects of attending PT or PT+CT were maintained at 1 year FU as well as predictors of non-response at FU. Children were selected on the basis that they were experiencing clinically significant behaviour	N= 127  NR  NR	N=127  Mean age= 6.6 years (SD=1.3)  26 females 101 males	RCT  (parents were randomly assigned to PT or PT+CT or CON)  (CON lost at FU)	IY	<i>Parent:</i> PPI, PSI, BDI  <i>Child:</i> KIDDIE-SADS, ECBI, CBCL, PBQ	1 year  N=88  30.7%	<i>Parent:</i> Significant improvements in parental style and well-being from pre to post were maintained at FU. Number of mother receiving treatment for psychosocial problems at FU was higher in non-responding (those children who did not show clinically significant changes in child behaviour)	Highly selected clinical sample included in study may mean that results cannot be generalised to other populations of children experiencing behaviour problems. CON lost at FU. Limited statistical power due to small sample size.

	problems at time of recruitment.							<p><i>Child:</i> Although all children fulfilled criteria for ODD/CD before treatment on 34% still received diagnosis at FU. Having contact with child protection services was found to predict treatment non-response at FU.</p>	
<p><b>12. Hautmann et al. (2009)</b></p> <p><i>Germany</i></p>	To determine the effectiveness of PEP 1 year following intervention for children displaying externalising symptoms.	<p>N=270</p> <p>Mean age= 36.4 years (SD=5.2)</p> <p>270 females 0 males</p>	<p>N=270</p> <p>Mean age= 6.5 years (SD=2.0)</p> <p>70 females 200 males</p>	With-in subjects	PEP	<p><i>Parent:</i> SEFS, PSBC</p> <p><i>Child:</i> CBCL, SCL-ADHD, SCL-DBD</p>	<p>1 year</p> <p>N=101</p> <p>62.6%</p>	<p><i>Parent:</i> Statistically significant increase in self-reported parenting competencies following intervention. A further significant increase in parent competency was shown between post intervention and FU time-points.</p> <p><i>Child:</i> Statistically significant decrease in child behaviour problems immediately following</p>	With-in subjects design employed is less rigorous than RCT. Data gathered exclusively via mothers' self-reports. Significant drop-out rate from post group to FU.

								intervention. No significant change from post to FU, indicating stability.	
<b>13. Drugli et al. (2010)<sup>2</sup></b> <i>Norway</i>	Follow-up to Drugli et al. (2010) to assess the findings 5-6 years post intervention.	N= 127 NR NR	N=127 Mean age= 6.6 years (SD=1.3) 26 females 101 males	RCT (parents were randomly assigned to PT or PT+CT or CON) (CON lost at FU)	IY	<i>Parent:</i> PPI, PSI, BDI  <i>Child:</i> KIDDIE-SADS, ECBI, CBCL, PBQ	5-6 years N=59 53%	<i>Parent:</i> High levels of maternal stress and depression were linked to poorer child behaviour outcomes.  <i>Child:</i> Consistent with 1 year FU findings, although all children qualified for a diagnosis of ODD/CD, at 5-6 year FU 2/3 no longer fulfilled the criteria for such a diagnosis.	Significant attrition rate (53.5% of original sample lost). Small sample size led to limited statistical power of reported findings. No CON for comparison at FU. No measure of significant factors between 1 year and 5-6 year FU that may have impacted on findings.
<b>14. Hahlweg et al. (2010)</b> <i>Germany</i>	To evaluate the 2 year effectiveness of the Triple-P parenting programme for parents of children with child behaviour problems (as identified by	N= 280 (186=IG, 94=CON) 22-47 years NR	N=280 Mean age=4.5 years (SD=1.0) 136 females 144 males	RCT	Triple-P (Standard Version)	<i>Parent:</i> PS, PPQ, Parent-Child Interaction Task,  <i>Child:</i> CBCL, C-TRF	2 years N=274 (184=IG, 90=CON) 2.1%	<i>Parent:</i> IG reported significant reductions in dysfunctional parenting style (e.g. reduced laxness and verbosity) at post intervention, which was maintained at FU.	Sample may not be a true representation of the target population as only 1/3 of eligible parents decided to participate in the parenting programme. For

	parents)							<i>Child:</i> Significant reductions in child externalising behaviour (e.g. aggression) were reported post intervention and remained stable at FU for two parent families but in single parent families there were a decline in child behaviour from post group to FU.	some of the sub-group analyses (e.g. single parents) statistical power was reduced.
<b>15. Malti, Ribeaud &amp; Eisner (2011)</b>  <i>Switzerland</i>	To establish the effectiveness of 2 universal programmes, PATHS (school based intervention) & Triple-P (group parenting programme), at reducing externalising problems in children, 2 years following intervention	N=1361 (360=PATHS, 339=Triple-P, 306=PATHS + Triple-P, 356=CON)  NR  NR	N=1361  4-5 years  NR	RCT  (Parents randomly assigned to PATHS or Triple-P or PATHS + Triple-P or CON group)	Triple-P (Standard Version)	<i>Parent:</i> n/a  <i>Child:</i> SBQ (all scales)	2 years  N=1135 (311=PATHS, 271=Triple-P, 254=PATHS + Triple-P, 299=CON)  16.2%	<i>Parent:</i> n/a  <i>Children:</i> Parent and teacher ratings of child externalising behaviours showed greatest decline in PATHS group at post and FU in the areas of aggression and impulsivity. No clear benefit of programme participation on pro-social behaviour. Higher levels of baselines	Limited outcome measures used. No measure of parenting skills and style and parental well-being. Diverse sample means social dynamics may have made it difficult to implement Triple-P successfully. Results may have been biased due to only replying on teacher reports of child

								child behaviour problems correlated more highly with intervention effects	behaviour.
<b>16. Reedtz, Handegard &amp; Morch (2011)</b>  <i>Norway</i>	To evaluate whether a short-term parenting programme for children with child behaviour problems that did not yet fall within the clinical range was effective 1 year post intervention.	N= 187 families (89=IG, 97=CON)  NR  NR	N=199  Mean age=3.88 years (SD=1.38)  77 females 122 males	RCT	IY Basic	<i>Parent:</i> PSOC, PPI  <i>Child:</i> ECBI	1 year  N=113 families (67=IG, 46=CON)  39.6%	<i>Parent:</i> There was a significant improvement parenting style (e.g. reduction in harsh discipline) at post intervention for both IG and CON, although these changes were larger for IG.  <i>Child:</i> There was a significant improvement in child behaviour (reduction in internalising and externalising behaviours) in IG post intervention, which was not present in CON. However, at 1 year FU these differences between groups were not present.	Children who scored highly on ECBI pre group (and therefore had the most potential to change) were excluded from the study. Significant attrition rate from pre to post intervention, and at FU.
<b>17. Webster-Stratton,</b>	To examine the long-term (8-12 years) efficacy	N=78  NR	N=78  3-8 years	With-in subjects	IY	<i>Parent:</i> Parent Interview,	8-12 years  N=66	<i>Parent:</i> Observed mother-child coercion was found	FU sample does not include CON for direct

<b>Rinaldi &amp; Reid (2011)</b> <i>America</i>	of IY, delivered as a preventative intervention for pre-school children who displayed signs of ODD/CD	NR	NR			PSI, DPICS  <i>Child:</i> SUASA, RCMAS, CDI, SPP-A, EDS, ECBI, CBCL	13.6%	to be a predictor of negative outcomes (delinquent acts) at FU  <i>Child:</i> At FU, 10% of the young people were in the clinical range on internalising behaviour, 23% had engaged in major delinquent acts, 46% reported some substance misuse. These findings were in-line with published age-related norms.	comparison. Sample includes wide age range so some adolescents may not yet be showing conduct problems that may develop in later adolescence. No data collected on interventions received by young people and their families during the FU period that may have significantly impacted on the findings shown at FU.
<b>18. Posthumus et al. (2012)</b> <i>The Netherlands</i>	To evaluate the preventative effects of IY parenting programme for parents of preschool children at risk of developing ODD/CD, 2 years post intervention	N=181 (71=IG, 110=CON)  Mean age=36.08 years (SD=5.07)  NR	N=181  Mean age=4.23 years (SD=0.24)  60 females 121 males	Case control	IY	<i>Parent:</i> PPI, DPICS  <i>Child:</i> CBCL, ECBI	2 years  N=139 (70=IG, 69=CON)  26.6%	<i>Parent:</i> Significant improvements in both observed and parent-rated parenting skills (e.g. reduction in critical statements in increase in labelled praise) in IG when compared to CON from pre to post group, and these findings were maintained at FU.	Participants were not randomly assigned to groups which may have increase bias due to high educational level of parents who participated in IG, which means that findings may not be generalisable. Relatively modest sample size.



								<i>Child:</i> No differences between IG and CON on parent reported behaviour problems were obtained both post group at 2 year FU, this is in contrast to the observed changes in child behaviour in IG but not in CON at both post and FU time-points	
<b>19. Roberts et al. (2012)</b>  <i>United Kingdom</i>	To evaluate the effects of the IY Basic (for parents of children behaviour problems) 2 years post intervention	N= 90  NR  NR	N=90  1-12 years  NR	With-in subjects	IY Basic	<i>Parent:</i> GHQ, semi-structured interview  <i>Child:</i> ECBI	2 years  N=57  36.7%	<i>Parent:</i> Positive improvements in parental depression and stress shown immediately post intervention remained largely maintained at 2 year FU.  <i>Child:</i> Statistically significant improvements in child behaviour were evident and mean scores in all fields reduced to below the clinical cut-off post intervention. Findings were	Modest sample size. Limited information reported presentation of children and parents who took part in the study, hard to ascertain which populations the findings may be able to be generalised to. Lack of CON group as means that it is not possible to establish whether reported outcomes can be attributed to

								maintained at 2 year FU. At FU 1/3 of children showed deterioration in child behaviour from post group to FU, 2/3 of these children had experienced adverse life events or received a secondary diagnosis (e.g. ADHD, ASD) since completing the intervention.	intervention
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**Note:**

*Group Programmes:* CT=Child Training, GD=group discussion, GDVM=group discussion and videotape modelling, IVM=self-administered video-tape modelling, IY=Incredible Years, IY Basic=Incredible Years Basic version, PATHS=Promoting Alternative Thinking Strategies (school based intervention), PCIT=Parent-Child Interaction Therapy, PEP=Prevention Program for Externalising Problem Behaviour, PPI=Parenting Practices Inventory, PT=Parent Training, , Triple P= Positive Parenting Programme, TT=Teacher Training.

*Outcome Measures :* BDI=Beck Depression Inventory, BSI=Brief Symptoms Inventory, CAPRS=Conners Abbreviated Parent Rating Scale, CBQ=Conflict Behaviour Questionnaire, CBCL=child behaviour check-list, CDI=Child Depression Inventory, CII= Coder Impressions Inventory, CSQ= Consumer Satisfaction Questionnaire, C-TRF=Caregiver Teacher Report Form, DPICS=Dyadic Parent-Child Interaction Coding System, ECBI=Eyberg Child Behaviour Inventory, EDS=Elliot Delinquency Scale, GDS= General Delinquency Scale, HDUS=Hard Drug Use Scale, KIDDIE-SADS=Child Version of Schedule for Affective Disorders and Schizophrenia ,MAST=Michigan Alcohol Screening Test, NIMH DISC-IV=NIMH Diagnostic Interview Schedule for Children Version IV, NYS=National Youth Survey, PACS=Parent Account of Child Symptoms, PBQ=Preschool Behaviour Questionnaire, PCQ=Preschool Characteristics Questionnaire, PCSC=Teacher rating Scales of the Perceived Competence Scale for Young Children, , PDP=Parent Defined Problems Questionnaire, PDR=Parent Daily Report, PS=Parenting Scale, PSBC= Problem Setting and Behaviour Checklist, PSI=Parenting Stress Index, PSOC=Parenting Sense of Competence Scale, RCMAS=Revised Children's Manifest Anxiety Scale, RSE= Rosenberg Self Esteem Scale, SBQ= Social Behaviour Questionnaire, SCL-ADHD= Symptom Checklist Attention-Deficit/Hyperactivity Disorder, SCL-DBD= Symptom Checklist Disruptive Behaviour Disorder, SCRS=Self-Control Rating Scale, SEFS= Self-Efficacy Scale, SPP-A=Self-Perception Profile for Adolescents, SUASA=Substance use and Sexual Activity, TASB=Teacher Assessment of Social Behaviour, TRF=Teacher Report Form.

**Assessing methodological quality of included studies.** The quality of the included studies was assessed using the Effective Public Health Practice Project (EPHPP) Quality Assessment Tool for Quantitative Studies (Appendix A). This tool comprises 6 domains on which to assess the quality of a given study: 1) selection bias, 2) study design, 3) control for confounding variables, 4) blinding of investigators and participants, 5) validity and reliability of data collection tools, and 6) the number of withdrawals and drop-outs. For each individual domain, and according to criteria provided in the EPHPP, a rating of “strong”, “moderate” or “weak” is given. In addition, a global rating for each study can be derived, again using a rating of “strong”, “moderate” or “weak”.

The EPHPP has been shown to be a reliable tool in assessing the quality of quantitative research studies. A comparison study by Armijo-Olivo et al. (2012) compared the EPHPP to the Cochrane Collaboration Risk of Bias Tool (CCRB). The results concluded that the EPHPP has “fair” inter-rater reliability for individual domains and “excellent” reliability for the global rating score. In comparison, the CCRBT showed only “slight” inter-rater reliability on the individual domains and “fair” inter-rater reliability for the global rating.

Each of the 19 articles which met criteria for inclusion was assessed using the EPHPP, with a second rater rating the quality of a sample of four papers, with any discrepancies discussed. Using this method individual domains as well as global ratings were obtained for each study (see Table 2).

**Table 2:** *Quality assessment of included studies (presented in chronological order)*

Study	Selection Bias	Study Design	Confounders	Blinding	Data Collection	Withdrawals & drop outs	Overall rating
Webster-Stratton, Hollinsworth & Kolpacoff (1989)	Strong	Strong	Moderate	Strong	Strong	Moderate	Strong
Webster-Stratton (1990)	Strong	Strong	Strong	Strong	Strong	Moderate	Strong
Long et al. (1994)	Strong	Strong	N/A*	Weak	Strong	Moderate	Moderate
Bradley et al. (2003)	Strong	Strong	Moderate	Moderate	Strong	Weak	Moderate
Reid, Webster-Stratton & Hammond (2003)	Strong	Strong	Moderate	Strong	Strong	Strong	Strong
Nixon et al. (2004)	Moderate	Strong	Strong	Moderate	Strong	Strong	Strong
Stewart-Brown et al. (2004)	Moderate	Strong	Strong	Moderate	Strong	Moderate	Strong

Scott (2005)	Moderate	Strong	Strong	Strong	Strong	Strong	Strong
Gardner, Burton & Klimes (2006)	Moderate	Strong	Strong	Strong	Strong	Strong	Strong
Bywater et al. (2009)	Moderate	Strong	Strong	Strong	Strong	Weak	Moderate
Drugli et al. (2010) <sup>1</sup>	Moderate	Strong	Weak	Moderate	Strong	Moderate	Moderate
Hautmann et al. (2009)	Moderate	Moderate	N/A*	Weak	Strong	Moderate	Moderate
Drugli et al. (2010) <sup>2</sup>	Moderate	Strong	Weak	Moderate	Strong	Moderate	Moderate
Hahlweg et al. (2010)	Moderate	Strong	Strong	Moderate	Strong	Strong	Strong
Malti, Ribeaud & Eisner (2011)	Strong	Strong	Strong	Moderate	Strong	Strong	Strong

Reedtz, Handegard & Morch (2011)	Strong	Strong	Strong	Moderate	Strong	Moderate	Strong
Webster-Stratton, Rinaldi & Reid (2011)	Moderate	Moderate	N/A*	Weak	Strong	Strong	Moderate
Posthumus et al. (2012)	Weak	Moderate	Strong	Moderate	Strong	Moderate	Moderate
Roberts (2012)	Moderate	Strong	N/A*	Weak	Strong	Moderate	Moderate

Note: **Red**= Weak, **Amber**=Moderate, **Green**= Strong. Overall rating defined as: Strong=no weak ratings, Moderate=one weak rating, Weak=two or more weak ratings (EPHPP, see Appendix A) \*n/a as no comparison group to warrant the need to control for confounding variables.

## **Results**

### **Overview of studies**

#### **i) Sample size**

The total included sample comprised 3627 children, 3511 individual parents and 187 families (where in some cases both parents attended the group). Attrition rates from pre to follow-up time-points varied from as little as 2% (Halweg et al., 2010) to as much as 72% (Bradley et al., 2003).

#### **ii) Participants**

##### ***Children***

*Age and gender.* Only 9 of the 19 studies provided a breakdown of the children's gender, and of those the majority (69%) were male.

At the time of recruitment most of the included children were those in early childhood (4-7 years of age; N=14 studies). Three studies (Bradley, 2003; Bywater et al., 2009; Nixon, 2004) specifically recruited children in infancy (under 4 years of age). Two studies (Hautmann, 2009; Roberts et al., 2012) included children across infancy, early and middle Childhood (1-12 years of age).

*Presentation.* The presentation of children at the time of recruitment varied across studies depending on their specific inclusion criteria. Some programmes (N=9 studies) appeared to be acting as a "preventative" intervention, targeting those children who may be displaying behavioural difficulties, but did not necessarily meet the threshold to receive a diagnosis of CD/ODD or score above the clinical cut-off on the measures of child behaviour at the time of recruitment (Bradley et al., 2003; Halweg et al., 2010; Hautmann et al., 2009; Long et al., 1994; Malti et al., 2011; Reedtz et al., 2011; Roberts et al., 2012; Webster-Stratton et al., 1989; Webster-Stratton, 1990).

In others (N=7 studies), the presence of a clinically-significant child behaviour problem (assessed by scoring within the clinical range on the measure of child behaviour at the time of recruitment) was a prerequisite for entry to the group (Bywater et al., 2009; Gardner et al., 2006; Nixon, 2004; Posthumus et al., 2012; Scott, 2005; Stewart-Brown et al., 2004; Webster-Stratton et al., 2011). In 3 studies this was also extended to those children who

already met the criteria for a diagnosis of ODD/CD based on DSM-IV-TR (2000) criteria (Drugli et al., 2010<sup>1</sup>; Drugli et al., 2010<sup>2</sup>; Reid et al., 2003).

### ***Parents***

*Age and gender.* Only 4 studies provided information regarding the age of included parents (Halweg et al., 2010; Hautmann et al., 2009; Nixon et al., 2004; Posthumus et al., 2012), and three provided details regarding gender (Hautmann et al., 2009; Webster-Stratton et al., 1989; Webster-Stratton, 1990). Based on information from these studies the mean age of parents was 35.7 years, with the majority (83%) being mothers.

*Demographic information.* Little information was provided in the included studies regarding the population of parents who took part in the parenting programmes (e.g. socio-demographics, ethnicity). However, 1 of the included studies (Halweg et al., 2010) focused on drawing comparisons between outcomes for parents and children from 1 parent homes and those from 2 parent homes. Also of note, Posthumus et al. (2012) found that the average educational level of included parents was significantly higher than that of the general population.

### **iii) Study design and quality**

The quality of included studies was assessed using the EPHPP (see Table 2). Of the 19 included studies 9 were given an overall rating of “moderate” and 10 were rated as “strong”. No papers received an overall rating of “weak”, which increases confidence that the research studies on which the findings are based employed good quality, reasonably robust designs.

All of the included studies, by necessity of the chosen in/exclusion criteria, employed a quantitative design, using standardised questionnaire measures. However, 1 study (Stewart-Brown et al., 2004) also incorporated the use of qualitative semi-structured interviews, exploring how able parents felt to maintain changes they experienced immediately following attendance at a group over the longer-term, which helped to address mechanisms and barriers to change at follow-up.

Of the included studies 14 reported using a randomised control trial design (Bradley et al., 2003; Bywater et al., 2009; Drugli et al., 2010<sup>1</sup>; Drugli et al., 2010<sup>2</sup>; Gardner et al., 2006; Halweg et al., 2010; Malti et al., 2011; Nixon et al., 2004; Reedtz et al., 2011; Reid et al., 2003; Scott, 2005; Stewart-Brown et al., 2004; Webster-Stratton et al., 1989; Webster-



Stratton, 1990) which involved comparing the outcomes of the intervention group(s) with those of a control group who did not receive the treatment (parenting programme) during the intervention phase. One additional study (Posthumus et al., 2012), used a case-control design, comparing the intervention to a wait-list control. These study allowed direct comparisons to be made between the outcomes for families who attended a parenting programme and those who did not, over the same period.

In addition to a wait-list control, 6 of the above 14 studies also employed a “head-to-head” design (Drugli et al., 2010<sup>1</sup>; Drugli et al., 2010<sup>2</sup>; Malti et al., 2011; Nixon et al., 2004; Webster-Stratton et al., 1989; Webster-Stratton, 1990), where different interventions were compared. In some cases the intervention used for comparison was also that of a parenting group-based programme, for example Parent Child Interaction Therapy versus an abbreviated form of the therapy (Nixon et al., 2004). However, in some studies this meant comparing the parenting group intervention with another type of intervention aimed at improving child behaviour, such as comparing school-based interventions for teachers (Malti, Ribeaud & Eisner, 2011; Reid, Webster-Stratton & Hammond, 2003), or interventions undertaken directly with children (Drugli et al., 2010<sup>1</sup>).

For those 14 studies that employed a comparison group, in some, parents were assigned to groups using clearly described “true” randomisation (Bywater, 2009; Gardner et al., 2006), with experimenters blind to which experimental condition participants had been assigned to. Where true randomisation was not possible, participants were assigned to groups based on factors such as time of referral (Scott, 2005), and availability of parents to attend the parenting programme (Stewart-Brown et al., 2004).

It is important to note that due to the nature of the target intervention used in the studies it was often not deemed practical and/or ethical to continue to employ the use of a wait-list control group at follow-up time-points. As a result, in most instances (n=9) those studies that did include a wait-list control group in the intervention phase were not able use this group for comparison at the subsequent follow-up time point(s) as the control group went on to receive the intervention themselves. Four studies were able to retain a non-intervention comparison group at follow-up (Halweg et al., 2010; Malti et al., 2011; Reedtz et al., 2011; Stewart-Brown et al., 2000).

The remaining 4 papers did not employ a control group, using a within-subjects, repeated measured design (Hautmann et al., 2009; Long et al., 1994; Roberts et al., 2012; Webster-Stratton et al., 2011). Two studies attempted to address this lack of comparison group by comparing the outcomes of those who attended a parenting programme with a published normative data or matched comparison group (Long et al., 1994; Webster-Stratton et al. 2011).

#### **iv) Interventions/Programmes**

The primary intervention used across all of the studies was group based parenting programmes. The majority of studies (n=11) employed the use of the Webster Stratton “Incredible Years” Programme (IY) of which there are a number of variations, including the “Basic” programme which is aimed at parents of children aged 3-12 years (focusing on specifically developing parenting skills), and “Advanced” programme, aimed at supporting parents to manage difficult behaviours in children aged 6-12 years, and includes an additional focus on parenting inter-personal issues such as communication and problem solving. Of those 11 IY studies reviewed here, 8 used the “Advanced” programme (Bywater et al., 2009; Drugli et al., 2010<sup>1</sup>; Drugli et al., 2010<sup>2</sup>; Gardner et al., 2006; Posthumus et al., 2012; Reid et al., 2003; Stewart-Brown et al., 2004; Webster-Stratton et al., 2011), and 3 used the ‘Basic’ version of the programme (Reedtz et al., 2011; Roberts et al., 2012; Scott, 2005).

In 1 study (Reedtz et al., 2011), the “Basic” IY programme was compared with a shortened version of the programme to assess whether brief parenting programmes are as effective as their full version counter-parts. Another study which used a brief parenting programme intervention was Bradley et al. (2003) who assessed the long-term effectiveness of the Magic 1-2-3 programme, a three-week group parenting programme to help with simple, practical ways of managing child behaviour difficulties.

Other included parenting programmes were “Helping Non-Compliant Children” (Long et al., 1992), “Prevention Program for Externalising Problem Behaviour” (Hautmann et al., 2009), “Triple-P Positive Parenting Programme” (Standard Version; Halweg et al., 2010; Malti et al., 2011), and “Parent-Child Interaction Therapy” (Nixon et al., 2004).

#### **v) Outcome measures used**

As the primary aim of parenting programmes is to improve child behaviour problems, all 19 included studies were selected on the basis that they included at least one standardised measure of child behaviour. In addition, 13 studies also included measures of parental mood (in order to assess changes in parents' own well-being e.g. anxiety, stress and depression); 13 included measures assessing parenting skills, style and competency; and four included teachers' reports of child behaviour difficulties. The 2 studies which included the longest follow-up periods (Long et al., 1994; Webster-Stratton et al., 2011) of 14 and 8-12 years respectively, also gathered data directly from the children themselves, now that they were young adults, on a number of areas including drug and alcohol misuse, delinquency and self-esteem (Appendix B details the outcome measures used in each study).

#### **vi) Length of follow-up**

Typically, follow-up assessments of the effects of parenting programmes have been less than 6 months (Kazdin, 2002). In order to assess the long-term effects of attending such a programme, the studies included in this review were those with a follow-up time-point of at least 1 year. The length of follow-up for included studies ranged from 1-14 years, although in most cases follow-up time periods were between 1-3 years (N=16).

Six studies (Bywater et al., 2009; Drugli et al., 2010<sup>1</sup>; Drugli et al., 2010<sup>2</sup>; Nixon et al., 2004; Webster-Stratton et al., 1989; Webster-Stratton, 1990) included follow-up data collection at multiple time-points (see Table 1), which allowed assessment of not only the extent, but also the trajectory, of changes over time.

### **Study outcomes**

#### **i) Child outcomes**

***Parent-rated child behaviour.*** Parental reports of child behaviour were used to evaluate the effectiveness of the programmes in helping to improve child behaviour problems in 17 of the studies. The 2 studies which did not include parental reports of child behaviour (Long et al., 1994; Webster-Stratton et al., 2011) instead relied on self-reports from the children themselves, now that they had reached adolescence (15-17 years old).

At follow-up, 5 of the included studies (Bradley et al., 2003; Garden et al. 2006; Hautmann, 2009; Posthumus et al., 2012; Roberts 2012) found that improvements made

immediately following attendance at a parenting programme (that is to say where there was a statistically significant change in scores from pre-post group), were maintained at the follow-up time-point(s) in the areas of hyperactivity, aggressive behaviour, hyperactivity, peer problems and pro-social behaviour. The maintenance effect was demonstrated statistically with no statistically significant change in scores from post to follow-up time-points. This stability of scores was demonstrated to last up for up to 2 years (the longest follow-up time-point included in these studies), suggesting that, for the majority of parents, post-group levels of child behaviour remained the same up to 2 years later.

Five of the 17 studies using parental reports of child behaviour assessed improvements in child behaviour based on clinically significant changes (rather than changes in mean scores; Bywater et al., 2009; Drugli et al., 2010<sup>1</sup>; Drugli et al., 2010<sup>2</sup>; Reid et al., 2003; Scott et al., 2005), and similar stability in changes from post to follow-up were found. Scott (2005) found that at pre-group the mean scores of child behaviour fell above the 97<sup>th</sup> percentile (in the clinical range), but at post-intervention they fell to below the 82<sup>nd</sup> percentile (within the normal range). Similarly, Bywater et al. (2009) found that although at the start of the programme all children scored within the clinical range on the measure of child behaviour, at 1 year follow-up 63% of children had made at least a modest clinically significant change on this measure, and these findings were maintained at a further follow-up 6 months later (18 months post intervention). Of the studies that specifically recruited children who met the criteria for a diagnosis of ODD/CD (Drugli et al., 2010<sup>1</sup>; Drugli et al., 2010<sup>2</sup>, Reid et al., 2003) it was found that at follow-up time-points ranging from one to 5/6 years post-intervention, approximately 2/3 of children in these studies no longer met the threshold for such a diagnosis (based on DSM-IV-TR criteria).

Six studies included multiple data follow-up points over the period following attendance at a parenting programme. Of these studies, Bywater et al. (2009) found that improvements in child behaviour (both internalising and externalising behaviours) reported immediately following attendance at a parenting programme remained stable across a follow-up time points at 12 and 18 months. Drugli et al. (2010<sup>1</sup>, 2010<sup>2</sup>) included follow-up time-points at 1 year and at 5/6 years post intervention and were able to assess stability of clinically significant changes that were observed immediately post intervention over this time. Prior to starting the group all children fulfilled the criteria for a diagnosis of ODD/CD, and at 1 year

follow-up only 34% still received this diagnosis. These children were then followed up 5/6 years post intervention and at this time point 24% of children who had not met the criteria for a diagnosis at 1 year now received such a diagnosis, whereas conversely, 28% of children who fulfilled the criteria at 1 year follow-up no longer received such a diagnosis. Thus for a quarter of children improvements were made between 1 year and 5/6 year follow-up, and for a further quarter there was a deterioration in symptoms between the follow-up time-points. The findings from this study are significant in the fact that rather than reporting mean changes in scores over time they were able to evaluate the changes for the individual children. The finding that for some children outcomes were improved over the longer period, whereas for others there was a clinically significant increase in their symptoms, may suggest that some parents were better able than others to maintain positive changes found immediately post-intervention over time. Reid et al. (2003) also found that the trajectory of change for individual children varied over time, and although there was an overall 20% reduction in clinically significant child behaviour problems following attendance at a parenting programme, for some children this change occurred immediately post intervention and for others after a delay (i.e., at the 2 year follow-up time-point).

Webster-Stratton et al. (1989, 1990) also used multiple follow-up time-points and found that at a 1 year follow-up positive mean score changes were maintained in the areas of pro-social behaviour, externalising behaviours, aggression, hyperactivity and peer problems. However when these families were followed up 2 years later there had been a statistically significant escalation in children's externalising behaviours, and 1/3 of parents reported to have on-going concerns about their child's behaviour. These findings suggest that initial short-term changes (up to 1 year) were maintained, but that the maintenance of these improvements over the longer-term (2 years) was not possible for some families.

The study by Halweg et al., 2010 compared the long-term reported outcomes of child behaviour for both single and 2 parent families. This study found that although immediately post-intervention all parents reported statistically significant improvements in their child's behaviour (both internalising and externalising behaviours), at a 2 year follow-up time-point these improvements had been maintained for parents from 2 parent families, but single parent families did not report such positive outcomes. Rather, for single parent families there was a reported decline in child behaviour (i.e., worsening) from post-group to follow-up. This study

poses interesting questions about the specific groups of parents for whom the effects of attending a parenting programme are effective over time and who might need additional parenting support.

A control group was used for comparison in 14 of the studies during the intervention phase, but for ethical reasons (namely the control group then going on to receive the treatment themselves) this group was lost at follow-up. However, there were 4 studies that were able to retain a control group for comparison at follow-up (Halweg et al., 2011; Malti et al., 2011; Reedtz et al., 2011; Stewart-Brown et al., 2004), which produced some interesting findings. Of these studies, Malti et al. (2011) found that for the intervention groups in their study, positive improvements in child externalising behaviour were evident both post group and at follow-up (2 years), but not for the control group. However, no reported changes in children's pro-social behaviour were found in either the control or intervention groups throughout the intervention and at follow-up, which the authors noted was in contrast to previous studies that had shown that parenting programmes were able to have a positive impact on both child externalising and pro-social behaviour.

Reedtz et al. (2011) found that although at baseline (pre-group) there were no statistically significant differences between the control and intervention group on measures of parental reports of child behaviour, post-group a statistically significant difference between the 2 groups did emerge, with the intervention group showing significant improvements post-group in regards to both externalising (e.g. aggression, hyperactivity) and internalising (e.g. somatic complaints) behaviours. However, at a 1 year follow-up it was found that the difference between these 2 groups had "faded out", with results suggesting that the intervention group was unable to maintain the initial positive improvements in child behaviour over time.

Stewart-Brown et al. (2004) also included a control group for comparison at the 1 year follow-up time-point, and found that although positive changes in child behaviour (e.g. hyperactivity, conduct problems) were maintained at a 1 year follow-up for the intervention group, these changes were also observed in the control group who also showed significant improvements in child behaviour at the follow-up time-point, which the authors suggest may be due to 'Hawthorne Effect' (McCarney et al., 2007), whereby subjects improve or modify

their behaviour in response to the fact that they are being observed (in this case, parents taking a greater interest in their child's behaviour than they had done previously).

Overall, all 17 studies reported significant (clinical and/or statistical) improvements in parent reports of child behaviour from pre- to post- group. At follow-up, stability of these improvements were found in all of the studies that included just 1 follow-up time-point of up to 2 years post intervention (Bradley et al., 2003; Gardner et al., 2006; Hautmann et al., 2009; Posthumus et al., 2012; Reid et al., 2003; Roberts et al., 2012; Scott, 2005), and in 3 of the studies that included multiple follow-up time-points (Bywater et al., 2009; Drugli et al., 2010<sup>1</sup>; Drugli et al., 2010<sup>2</sup>) up to 5/6 years post intervention. In studies that included multiple follow-up time-points, some found differences in the trajectory of reported changes in child behaviour across the follow-up period for some children (Drugli et al., 2010<sup>1</sup>; Drugli et al., 2010<sup>2</sup>; Reid et al., 2003) and groups of parents (Halweg et al., 2010). Two methodologically strong studies which included control groups for comparison at follow found that either differences between groups found immediately post intervention “faded out”, with parents in the intervention unable to maintain positive changes at follow-up, (Reedtz et al., 2011), or that positive improvements in reported child behaviour were also found in the control group (Stewart-Brown et al., 2004).

***Teacher-rated child behaviour.*** Four studies (Drugli et al., 2010<sup>1</sup>; Drugli et al., 2010<sup>2</sup>; Halweg et al., 2010; Malti et al., 2011) also included the use of teacher-rated child behaviour measures, aimed at validating any changes in child behaviour reported by parents. Of the studies that did employ the use of these additional measures of child behaviour, a number of different findings were evident. In some cases there was a consistency between parent and teacher reports of improvements of child behaviour at follow-up (Drugli et al., 2010<sup>1</sup>; Drugli et al., 2010<sup>2</sup>), and in others there was a conflict between parent and teacher reports.

Halweg et al. (2010) found that, in contrast to the improvements in child behaviour reported by parents, no significant changes in child behaviour were found either post-intervention or at a 2 year follow-up. Malti et al. (2011) also found a lack of consistency between parent reported child behaviour and teacher reported child behaviour, but in the opposite direction (with teachers reporting more significant changes at follow-up than parents).

These inconsistencies between parent and teacher reports (despite the reliability of measures used to assess child behaviour) may be indicative of actual differences in child behaviour across settings (school and home), or may be related to differences in perceived changes in child behaviour between parents and teachers. It is also important to note that in some studies (Malti et al., 2011), some teachers also received their own intervention, which may have impacted on the changes they reported and/or observed in the child's behaviour.

***Child reported behaviour.*** Only 2 papers used views from children/adolescents themselves on their behaviour and functioning. Given the long-term follow-up employed in Webster-Stratton et al. (2011), the target population had reached adolescence by the time of follow-up, which meant that self-report outcomes were administered to the young people themselves. A total of 66 young people (aged 15-17 years), whose parents had attended a parenting group 8-12 years earlier, were followed-up as teenagers. A variety of assessment measures were used to capture information about a range of externalising behaviours (e.g. drug and alcohol use, delinquency, sexual activity) and internalising behaviour (depression, anxiety, self-worth). Outcomes showed that 10% of the young people were in the clinical range for internalising behaviours, 46% had engaged in substance use, 23% had engaged in delinquent acts, which were in line with published national normative data on reports of adolescent behaviour. Despite the reported positive outcomes for these young people as they reached adolescence, the lack of an untreated comparison group and the fact that no data were collected on interventions and significant life events which occurred in the follow-up time-periods means it is not possible to say whether these positive outcomes can be attributed to the parenting intervention some 8-12 years earlier.

Another long-term 14 year follow-up study undertaken by Long et al. (1994) also included self-report from 26 young people (aged 17 years) whose parents had taken part in the parenting group when they were children, using measures assessing multiple areas of functioning including drug and alcohol use and delinquency. This population was compared with a community comparison group and, in line with the findings of Webster-Stratton et al. (2011) the intervention group appeared to be functioning well (in comparison to their peers) across a range of areas including delinquency, emotional adjustment, academic performance and relationship with parents when compared to a matched comparison group. Again, due to the methodological limitations of the included study (small sample size, lack of untreated



control group at follow-up, no data collected on interventions received during follow-up period), the findings of this study do little to tell us whether parenting interventions themselves have significant long-term effects once the sample of included children reach adolescence.

## **ii) Parent outcomes**

***Observed parenting skills and style.*** Of the included studies 4 employed the use of observational methods to assess changes in parenting skills and style before and after attendance at a parenting programme, and a variety of outcomes emerged from the studies which used this method of assessment. Three of the included studies (Bywater et al., 2009; Gardner et al., 2006; Hautmann et al. 2009) found that observed positive changes in parenting (e.g. increased positive statements and decreased negative statements towards the child) were present post-intervention and remained stable at follow-ups of up to 18 months.

However, Posthumus et al. (2012) observed a decrease in “critical statements” and an increase in “labelled praise” between pre to post intervention (indicating improvements in parenting), but this effect disappeared at the 2 year follow-up time-point, suggesting that parents were unable to maintain the initial positive effects in this area over time.

***Parent reported parenting skills and style.*** Eleven of the 19 included studies also incorporated the use of self-report measures of changes in parenting skills and style. Gardner et al. (2006) and Posthumus et al. (2012) both found large, significant improvements in parents’ reports of parenting skills (in particular positive changes in the areas of “harsh” and “coercive” parenting styles) at post intervention which remained stable at 18-month and 2 year follow-ups (respectively). Interestingly, Posthumus et al’s (2012) findings were in contrast with those of observed parenting which suggested parents were unable to maintain positive improvements in parenting over time.

Reedtz et al. (2011) was one of the few studies that was able to retain the control group at follow-up so that direct comparisons could be made between changes observed in the intervention and control group. On parent self-reports of parenting, immediately post intervention there was found to be a significant difference in scores between the control and intervention group, in particular in the area of “harsh” discipline, where there was no

significant change for the control group from pre to post group but a moderate to large statistically significant decrease in this type of parenting for the intervention group. At a 1 year follow-up this statistically significant difference between the 2 groups remained.

In 1 study (Roberts et al., 2012) qualitative methods were used to assess whether parents continued to use strategies learnt during the parenting programme at a 2 year follow-up. A total of 57 parents were included in the follow-up study and were given prompt cards of strategies and asked to state which strategies they continued to use on a regular basis. It was apparent that parents continued to use a range of strategies they had acquired from attending the group, most significantly the use of “rewards” (N=27) and “praise” (N=26), which suggests that parents were able to continue to make use of some of the strategies in regards to their parenting skills which they had learnt from attending the group.

***Parental sense of competency.*** Parents’ own sense of competency in managing their child’s behaviour was also assessed in 5 of the included studies, which yielded some conflicting findings.

Two of the studies which included a parental-self report measure of parenting competency found that significant changes in pre-post scores on this measure (which suggested an improvement in parents’ feelings of competency after attending a parenting programme) were maintained at 18 month to 1 year follow-ups (Bradley et al., 2003; Gardner et al., 2006). Reedtz et al. (2011) compared the outcomes of parents who had attended a parenting programme with those in a control group, and at the follow-up time-point found that there was a small but significant positive difference in the intervention group when compared to the control group, in parents own sense of competency.

Hautmann et al. (2009) found there was an increase in parent reports of competency post group but that there was also a significant positive growth in these changes from the post-group to follow-up time-point (1 year), which would suggest that parents continued to improve in their feelings of competency in managing their child’s behaviour after finishing the parenting programme, perhaps due to having the opportunity to practice parenting techniques acquired from the programme over time.

In contrast to the above findings, Bywater et al. (2009) found a small but statistically significant decrease in parents’ sense of competency in implementing parenting skills 18

months following attendance at a parenting programme (which is in contrast to the findings immediately post intervention). Interestingly, this was not consistent with observed changes in parenting. It is important to note, however, that the findings from this study were based on a significantly reduced sample than those included in the intervention phase (attrition rate=48%), which may be reflective of the small effect size supporting these findings.

***Parental wellbeing.*** Nine of the studies also sought to assess whether attendance at a parenting programme had a positive impact on parents' own feelings of anxiety, stress, depression and self-esteem.

Of these studies, 8 (Bywater et al., 2009; Drugli et al., 2010<sup>1</sup>; Drugli et al., 2010<sup>2</sup>; Halweg et al., 2010; Reid et al., 2003; Roberts et al., 2012; Stewart-Brown et al., 2004; Webster-Stratton et al., 2011) found that reductions in symptoms of stress and depression made immediately following attendance at a parenting programme were maintained up to 6 years following intervention. Of the studies which also included a control group for comparison (Drugli et al., 2010<sup>1</sup>; Drugli et al., 2010<sup>2</sup>; Halweg., 2010; Stewart-Brown et al., 2004), similar findings were shown, which were in contrast to those of the control group who did not report such positive changes at follow-up.

In contrast, Gardner et al. (2006) found that, despite the fact that a significant number of parents scored within the clinical range on a measure of depression at the start of the intervention there were no significant intervention effects on parental depression following attendance at a parenting programme. These findings remained constant throughout intervention and at 18 month follow-up suggesting that for parents who attended parenting programmes in this study the benefits of the group did not include an improvement in their own mood and feelings of well-being, both in the short and longer term. However, there were reported improvements in child behaviour in this study, suggesting that low mood did not impact on parents' abilities to make changes that may have impacted on their child's behaviour.

Interestingly, although levels of parental well-being were reported to improve following attendance at a group (both in the short and longer term), Drugli et al. (2010<sup>1</sup>, 2010<sup>2</sup>) and Reid et al. (2003), noted that for children who did not report an improvement in child behaviour following intervention was linked to higher levels of maternal stress and depression, both

during the intervention phase and at follow-up. Although questions can be raised in regards to the direction of this reported link.

## Discussion

**Overall findings.** The aim of this review was to establish the long-term outcomes for parents who attended a group parenting programme and their children. Overall, the findings showed that there are long-term benefits of attending such programmes.

The primary aim of parenting programmes is to improve child behaviour problems, and to this end all 17 studies which used parental reports to assess changes in child behaviour found that this aim was achieved immediately following attendance at a parenting programme. However, if parenting programmes are to be truly preventative, any benefits gained immediately following attendance a parenting programme must be able to be maintained over the longer-term.

In order to establish the long-term benefits of parenting programmes, the included studies employed the use of follow-up time-points, which in the majority of studies (n=14) was between 1-3 years following completion of the group. One study included a follow-up of 5/6 years following intervention (Drugli et al., 2010<sup>2</sup>), and two studies were able to follow-up children who were now adolescents whose parents had previously attended a parenting group (Long et al., 1994; Webster-Stratton et al., 2011). The overall findings showed that positive improvements in child behaviour shown immediately following attendance at a parenting programme were consistently found up to 2 years later. However, outcomes after 2 years varied, with one study finding that improvements could be maintained up to 5/6 years after intervention (Drugli et al., 2010<sup>2</sup>), and others (Webster-Stratton et al., 1990) demonstrating that initial improvements in child behaviour immediately post-intervention and at a 1 year follow-up began to show a decline at a 3 year follow-up time point. In contrast 1 study (Reid et al., 2003) found a sleeper effect, where for some children positive improvements in behaviour were not evident immediately following the parenting programme but were demonstrated at a 2 year follow-up time point.

A significant limitation of many of the included studies was the lack of a control group for comparison at follow-up time-points. Those studies which were able to include a control group at follow-up (Reedtz et al., 2011; Stewart-Brown et al., 2004) found that, although significant positive changes were able to be maintained at follow-up, the difference between changes for control and intervention groups was not statistically significant. In 1 case (Reedtz

et al., 2011) this was related to parents in the intervention group being unable to maintain positive changes in regards to their child's behaviour at follow-up, and in another (Stewart-Brown et al., 2004) children in the control group also showing significant improvements in child behaviour at the follow-up time-point (which the authors suggest may be due to Hawthorne effect). However, it is difficult to draw any firm conclusions from these findings as it is not reported whether any confounding variables during the interim period may have impacted on the reported outcomes for both groups at follow-up, both positively for the control group (e.g. having received support from other services, effects of medication) and negatively for the intervention group (e.g. significant negative life events).

In light of the above, the normal trajectory of child behaviour problems is important to consider. On the one hand, there have been suggestions that natural maturation of child behaviour may occur over time, including suggestions that with increased age children become more compliant (Smetana, Kochanska, & Chuang, 2000). On the other hand, longitudinal evidence suggests that untreated child behaviour problems have significant adverse effects in later life (Fergusson et al., 2005), which would suggest that spontaneous improvements in difficult childhood behaviour are unlikely to occur. Indeed 1 of the studies included in this review that used multiple follow-up time-points to assess changes over time (Webster-Stratton, 1990) found that for children with behaviour problems, even with the support of a parenting programme, initial improvements in behaviour following attendance at a group declined over time.

As well as changes in child behaviour, many of the studies also looked at the long-term benefits for parents who attended a parenting programme. Of the included studies 11 incorporated the use of parental reports of parenting skills and style, and significant improvements in positive parenting styles were reported up to 2 years following intervention (Gardner et al., 2006; Posthumus et al., 2012). This was in contrast to the lack of change in self-reports of parenting in parents in control groups who had not received this intervention (Reedtz et al., 2011). Observational methods were used in 4 studies to assess changes in parenting skills and style as a result of attending a parenting group (Bywater et al., 2009; Gardner et al., 2006; Hautmann et al., 2009; Posthumus et al., 2012) and in the majority (n=3), significant positive improvements observed immediately following the parenting programme remained stable over time. However, in 1 study (Posthumus et al., 2012) although

observed improvements in parenting were found immediately post group, parents appeared unable to maintain these changes over time (2 years post intervention).

Parents' own sense of competency in their parenting skills was also assessed by parent self-reports in 5 of the included studies, and it was consistently found that significant improvements in parents' own feelings of competency around managing their child's behaviour were maintained over the longer-term. In 1 study (Hautmann et al., 2009) it was even found that there continued to be significant improvements in parents' sense of competency following completion of the parenting group. These results are significant when holding in mind the evidence around the link between parenting and the presence of behaviour problems in children (Farrington, 2009; Morrell & Murray, 2003; Connor & Scott, 2007).

Self-reports of improvements in parents' own well-being were also shown to significantly improve in the areas of anxiety, stress and depression immediately post intervention and at follow-up, in 8 of the 9 studies which included measures assessing this, whereas non-intervention control groups did not show such improvements (Stewart-Brown et al. 2004). In contrast, however, a study by Gardner et al. (2006) found no reported improvements in parents' own feelings of depression during and following the intervention. These findings are important in light of the finding that parents who experienced increased levels of depression also reporting fewer improvements in their child's behaviour both immediately following intervention and at follow-up time-points (Drugli et al., 2010<sup>1</sup>; Drugli et al., 2010<sup>2</sup>; Reid et al., 2003). However, it is important to note that the direction of these outcomes was not established in these studies, in other words, whether increased child behaviour difficulties led to increased levels of depression and stress or whether parents experiencing symptoms of depression and stress were unable to make changes that would contribute to improvements in their child's behaviour. Interestingly Gardner et al. (2006) found that despite the reported lack of intervention effects on parental depression reported in their study, this did not correlate with the reported improvements in child behaviour.

Typically, follow-up time-points in the studies were less than 3 years, which still does not go far enough in being able to postulate whether the findings above are consistent with the outcomes for children as they reach adolescence. The 2 studies which employed the longest follow-up time-points (Long et al., 1994; Webster-Stratton et al., 2011), who included follow-

ups between 8-14 years post intervention, were able to follow-up children whose parents had participated in a parenting programme when they were children, now that they had reached adolescence. Overall, findings from these 2 studies indicated that the children whose parents had participated in a parenting group performed consistently with their peers on a number of domains (e.g. substance misuse, delinquency), despite having experienced behaviour problems as children. However, there are a number of limitations to the above studies, such as limited information on events that had occurred during the follow-up time-point which may have impacted on these findings, small statistical power behind these findings due to large attrition rates at follow-up, as well as suggestions that children and adolescents self-reports are not good indicators of their actual behaviour (Smith et al., 2000).

Overall the included studies found that attendance at a parenting programme does yield positive longer-term outcomes with regards to child behaviour, parental well-being and parenting competency and skills, but important questions arise as to why some families may be able to maintain positive outcomes following attendance at a parenting programme and why others may not. One hypothesis may be the population of children the intervention is targeting. On reviewing the studies in this area it was apparent that interventions could generally be grouped into those which acted as a *preventative* intervention, recruiting children who were beginning to show the signs of developing behaviour problems, and *treatment* interventions, recruiting children who were already experiencing clinically significant child behaviour problems or who had received a diagnosis of CD/ODD. There have been suggestions (Axford et al., 2012) that the effects of parenting interventions are diluted for children whose behaviour problems are less severe at the start of the programme, which may account for why some children benefit more from the intervention than others over the longer-term and this may have been the case in some of the included studies. Indeed, it was acknowledged by Scott (2005) that the lack of clinically significant changes in a third of their sample may be due to floor effects related to the children not experiencing clinically significant problems at the time of recruitment.

One study (Stewart-Brown et al., 2004) also included the use of qualitative questions to help gain information about why some families may experience long-term benefits of attending a parenting group and others may not. Findings from this study suggested that some parents found that when “left to their own devices”, without the weekly support from the



parenting programme, it was hard to maintain changes experienced immediately following attendance at a group. This may be an important point for future research in the area of parenting programmes to address, in order to maximise the initial benefits parents experience from attending a parenting group over time.

Finally, it is important to address the question as to what is viewed as a long-term positive effect of attending a parenting group. Although the primary aim of parenting groups is to improve child behaviour some of the studies included in this review found that the most significant long-term changes were not only in the area of child behaviour but in parents' own well-being and sense of competency in managing their child's behaviour (which may in turn also impact on changes in their child's behaviour). Reedt et al. (2011), who were able to utilise the benefit of a control-group at follow-up, found that although there were differences between the intervention and control group on measures of child behaviour at follow-up (with the intervention group making significant improvements), at a 1 year follow-up these effects had disappeared, with the intervention group appearing unable to maintain positive improvements shown immediately post- intervention. In contrast, they found that effects of parenting and parents own sense of satisfaction did remain significant at follow-up for the intervention group, and concluded that lasting changes as a result of attendance at a parenting programme may therefore be related to experiences of being a parent (e.g. satisfaction, self-efficacy), rather than changes in child's behaviour difficulties. Interestingly, Bywater et al. (2009) also found that attendance at a parenting programme was associated with a modest but steady decline in the frequency of contact with primary care services, which the authors suggest would be indicative of a decrease in associated costs of accessing services, which may also be one of the long-term benefits for families, and services, of parenting programmes.

**Limitations and suggestions for future research.** Overall, all 19 included studies were rated overall as being moderate to strong studies, suggesting that we can be relatively confident in the findings they report. However, despite this there are a number of limitations of the studies which should be held in mind.

Firstly, and possibly most significantly, the lack of a non-intervention control group at follow-up in most of the studies means that any suggested long-term benefits for parents attending a parenting group cannot be compared to those for families who did not receive such an intervention. Without the use of a control group it is not possible to conclude that

long-term effects shown after attending a parenting group are due to the intervention itself or because of other extraneous variables. This is particularly important to hold in mind in light of the findings from the studies which did include the a control group at the follow-up time-point (Reedtz et al., 2011; Stewart-Brown et al., 2004) which reported that on measures of child behaviour there were no statistically significant differences between the intervention and control group at post and follow-up time-points, or those that were present post-group dissipated over time.

A variety of methods were used to capture the lasting effects of attending a parenting group, including self-report measures, teacher report measures and observations, and in doing so some conflicting outcomes at follow-up arose, particularly in the areas of child behaviour improvements and parenting skills and style. Nixon et al. (2004) noted limitations in relying solely on parental reported changes in child behaviour and acknowledge that using multi-source assessments including those from independent sources (e.g. teacher reports) could have acted as way of validating the outcomes reported by parents at follow-up. Similarly, Halweg et al. (2010) noted that teacher reports of child behaviour do not commonly report significant changes in child behaviour post intervention, which is in contrast to parents own reports which. However, rather than being a limitation, conflicting reports in changes in child behaviour when using multiple sources may instead reflect the fact that changes in child behaviour may be more significant in some settings than others (e.g. at school but not at home), or may reflect the different perceptions in child behaviour from teacher and parent perspectives.

Finally, high drop-out rates in parenting interventions are common in the literature, with reported drop-out rates ranging from 40-60% (Axford et al., 2012), and in a number of studies included in this review high attrition rates were observed at both post-group and follow-up time points (as much as 72%), which may impact on the statistical power of the reported findings. Despite this, some studies were able to recruit as many as 1,675 participants (Malti et al., 2011) and a number of studies were able to retain a large portion of the initial parents recruited to the study at subsequent time-points, with drop-out rates as low as 2% (Halweg et al., 2010). This is important, as at follow-up an unbiased analysis could be undertaken as a large number of the original participants were able to be contacted at this time-point.

**Clinical implications.** The overall findings suggest that parenting programmes can be beneficial over the longer-term for both parents and children in the areas of: child behaviour; parenting skills and style; parents' competency in managing their child's behaviour; and parental well-being. Therefore future parenting groups should strive to include components that cover all of these areas, in order to maximise the benefits of such programmes. In addition, a variety of outcome measures and methods (e.g. parent reports, teacher reports, observations) should be used in order to adequately capture such change, although it is important to hold in mind that, as parenting programmes are undertaken in real-world clinical settings, a balance should be sought between the number of methods used to assess change, and the additional burden this may place on both parents and clinicians in order to gather this information. In light of the findings from this review, a minimum data set including is suggested for use in future evaluations of parenting programmes to include: a measure of parental behaviour and style (ideally using both observational and self-report measures e.g. PS); parents own sense of competence in using the skills they have acquired during the group (e.g. PSOC); child behaviour (both internalising and externalising e.g. ECBI, CBCL, SDQ); and parents' own feelings of wellbeing (depression, stress, anxiety and self-esteem e.g. PSI, BDI, RSE).

A number of included studies, and indeed parenting groups in general, suffered from large attrition rates at follow-up (up to 72%). This has implications on our ability to be able to establish the overall long-term benefits for all families who attended a parenting programme, rather than a reduced (possibly biased) sample that we are able to follow-up. A recent study by Axford et al. (2012) sought to address some of the factors that contribute to the engagement and retention of parents in parenting programmes. Themes that arose from this study included the importance of making parenting programmes as accessible as possible (e.g. location of group, transport to facilitate parents getting to and from the group, child care provisions), the importance of facilitators building relationships with parents, and the use of incentives for parents attending such programmes. These themes are important for both parenting group facilitators and researchers in the area of parenting programme to hold in mind, not only during the recruitment and intervention phase of the programme, but also at follow-up in order to maximise the amount of families we are able to gather information from at this time-point.

A significant limitation of the included studies was that although an RCT design was used at the intervention phase, it was often not possible to retain the control group at follow-up for comparison. As such, for most of the reported findings at follow-up it was not possible to establish whether these findings could be attributed to the fact that parents had previously attended a parenting programme, or due to other extraneous variables. This limitation is reflective of the fact that parenting programmes were undertaken in real-world clinical settings and as such, more robust research methodology were often not possible. In order to address this, clinicians and researchers in the area of parenting programmes should use next best methods, such as including measures at follow-up capturing any significant events or additional support families may have received since the intervention, in order to help establish whether there may be other factors influencing the findings at follow-up time-points. Similarly, the use of pre-baselines time-points (where questionnaires are also completed a number of months prior to parents starting a parenting programme) could be employed in order to compare the magnitude and direction of changes prior to attending the group with the changes observed during the intervention phase, as well as between post-group and follow-up time-points.

The studies included in this review showed a variation in recruitment criteria with regards to the presentation of children at the pre-group time-point. In some cases, children who were experiencing behaviour difficulties not yet in the clinical range were recruited to the groups in order to prevent their problems from becoming clinically significant difficulties (therefore with the aim of being a preventative intervention). In others, children already experiencing clinically significant/diagnosed child behaviour difficulties were specifically recruited to the programme with the aim of trying to improve these already present problems from having further reaching implications in the longer-term. The results from this review found that both short and long-term positive outcomes can be found for both these populations of children, although in the case of those children who did not experience significant behaviour programmes at the start of the group, these changes were not clinically significant changes. The findings suggest therefore, that parenting programmes can have long-term positive impacts for the range of children who experience behaviour problems and as a result facilitators should seek to recruit this range of children to their parenting programmes, as well as to hold in mind what may be an expected positive outcome dependent on the extent of child

behaviour difficulties displayed (e.g. clinically significant improvements versus stability/improvement of lower level behaviour problems).

Finally, some of the included studies reported that positive outcomes shown immediately post intervention were not able to be maintained over the longer-term for some families (e.g. single parent families as opposed to two parent families). It is therefore important to establish why some groups of parents are able to maintain the positive effects they gained from attending a parenting programme over time and others are not. Stewart-Brown et al. (2004) used qualitative methods to try and establish not only whether positive effects can be maintained over the long-term, but potential barriers parents face in being able to do so. These findings suggested that for some parents, without regular parenting group sessions it was not possible to maintain positive changes over the longer-term. Consequently it is important for parenting programme facilitators to help parents to be able to maximise the benefits of attending a parenting programme, using methods such as “top-up sessions” following completion of a parenting programme, to support parents to be able to continue to employ the strategies learnt in the group programme.

## **Conclusion**

The aim of this review was to add to the research body on the effectiveness of parent training programmes, specifically, whether the previously reported short-term benefits of attendance at such a programme can be maintained over the longer-term.

Overall, the findings from this review showed that attendance at a group parenting programme can result in benefits for both children and their parents (including improvements in child behaviour, parenting style and skills, and parental well-being) up to 2 years following completion of a parenting programme. However, the findings of effects more than 2 years following a parenting programme yielded mixed results. In some cases stability of positive effects found immediately following attendance at a group were shown to be able to be maintained up to 5/6 years later. In others however, sleeper or dissolving effects were found over the longer-period, with some families showing an improvement in outcomes that were not present immediately following completion of the programme, and others demonstrating deterioration over this longer period.

Despite the consensus in the literature that long-term follow-up studies are important, the majority of studies included follow-up time-points less than 3 years following completion of the programme. Of note, 2 studies that did include significantly longer-term follow-ups (12-14 years post- intervention) observed positive outcomes for children who had previously experienced behaviour problems and whose parents had attended a parenting programme, once they reached adolescence. However, a number of methodological limitations (in particular the lack of a non-intervention group for direct comparison and small sample size) meant that it was not possible to establish whether these long-term positive outcomes could be attributed to the programme itself. Indeed, although all of the studies included in this review were of moderate to strong quality, the lack of a wait-list control group at follow-up (although often unavoidable for practical and ethical reasons) was a significant limitation in being able to establish the true effect of the intervention over time.

There is still some way to go in being able to assess whether parenting programmes are effective over the much longer-term, which groups of parents and children are able to maintain the initial positive gains over time, and whether positive findings at follow-up time-points can truly be attributed to the effects of the programmes themselves.

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## **Chapter Two**

**An uncontrolled, pre, post and follow-up evaluation of the Understanding Your Child's Behaviour (UYCB) group: A parenting group intervention based on the Solihull Approach.**

## Abstract

**Background.** Untreated conduct problems in children have been linked to the development of a number of adverse outcomes in later life and parenting programmes have been suggested as the treatment of choice in managing conduct problems in children with the aim of preventing them from resulting in further difficulties in later child and adulthood (NICE, 2013).

Understanding Your Child's Behaviour (UYCB) is a 10 week parenting programme based on the Solihull Approach. The Solihull Approach was developed by Douglas (2007) and is based on key principles of containment, reciprocity and behaviour management. A previous pilot study of UYCB yielded positive outcomes in the areas of child behaviour and parental wellbeing. The current study sought to build on the pilot study by not only measuring changes in child behaviour and parental well-being, but also included a measure of parent-child relationship. A follow-up time-point at three months post intervention was also incorporated.

**Method.** Participants were recruited from two research sites, with all parents attending an UYCB group during the period in which the research took place invited to take part in the research. A within-subjects repeated measures design was used and consenting parents asked to complete questionnaires assessing child behaviour (SDQ), parental well-being (DASS-21) and parent-child relationship (CPRS), at pre-group, post-group and follow-up (3 months after the group had finished) time-points. Fidelity of programme delivery was assessed by group facilitators completing a fidelity checklist at the end of each weekly group session.

**Findings.** A total of 160 parents completed questionnaires at the pre-group time-point, 119 at post-group and 35 parents at the follow-up time-point. Short-term (pre to post group) outcomes showed statistically significant improvements in the areas of child behaviour, parental well-being and the parent-child relationship. The analysis of data for those parents who completed questionnaires at the follow-up time-point showed a trend in the data towards the stability of gains shown immediately following the intervention to be maintained over time.

**Conclusions.** Findings showed that attendance at UYCB has a positive impact in the areas of child behaviour, parental well-being and the parent-child behaviour, both in the short and longer-term. However, limitations of the study including the lack of a control group for comparison and reduced sample-size at the follow-up time-point are acknowledged and suggested as points for future research in this area to address.

## **Introduction**

The prevalence of behaviour problems in children in the UK has been estimated at between 10-20% (Green et al., 2004), with untreated childhood onset behaviour problems linked to the development of antisocial behaviour in adolescents and further difficulties during adulthood (Fergusson et al., 2005). It is not difficult, therefore, to see the importance of early intervention in childhood to help prevent the development of further difficulties in later life. The Allen Report (2011) (a government report on early intervention) emphasised the necessity of giving children the right kind of support in early years to help support their social and emotional development and prevent problems in later life. It also highlighted the economic benefits of helping to prevent criminal behaviour, substance misuse and teenage pregnancy, all of which have been linked to untreated behavioural problems in childhood.

Parenting has been shown to be fundamental to child development (Pugh et al., 1994) and parenting interventions can reduce problems in childhood and the chances of difficulties later in life (Gibbs et al., 2003). The Home Front Study (2011) sought to understand how parents learn about parenting and found that a large number of parents use secondary sources (e.g., friends, broadcasting information, professional advice) as a resource to help guide their own parenting. Parents said that parenting advice made them feel more confident about their abilities to parent and key recommendations of the study were to help parents build on their existing skills with targeted early intervention, to include parenting programmes.

NICE guidelines (2013) on the management of conduct disorders in children under 12 years of age recommend parenting programmes as the treatment of choice and, since their introduction in the 1960s, there have been a growing number of manualised parenting programmes available to parents (e.g., Positive Parenting Programme (Triple P), The Incredible Years, Families and Schools Together (FAST), Strengthening Families). The aim of all of these programmes is to help parents to make changes in their parenting behaviour and thinking, in order facilitate changes in their child's behaviour.

Systematic reviews evaluating the evidence of the impact of parenting programmes have consistently found that they can be effective, both in terms of outcomes for parents and their children from across the age span. In a review by Barlow (1999), 18 randomised control trials were included that indicated that statistically significant changes in behaviour in

children aged 0-3 years were consistently observed for those children whose parents attended a parenting programme, both in parental reports and observations of child behaviour immediately following attendance at a parenting programme. As well as young children, reviews have shown that positive child behaviour outcomes, as a result of parenting programmes, can be observed in children in middle childhood (3-12 years) (Gibb et al., 2003), through to teenage years (12-18 years) (Barlow et al., 2010). A review by Thomas et al. (1999) also found that parenting programmes can have a positive impact across a range of child behaviour problems, including: improvements in the areas of non-compliance; oppositional and externalising behaviour; and social skills in children.

A Cochrane Review by Barlow and Coren (2004) looked specifically at the impact parenting programmes have on maternal mental health in the areas of: depression, anxiety/stress, self-esteem, social support, and relationship with spouse/marital adjustment. A total of 26 studies were included in their review and results showed that there was a small to medium significant positive effect with regards to parental well-being (depression, stress and anxiety), relationship with spouse/marital adjustment and self-esteem, with no significant improvements found in the area of social support. These findings suggest that, as well as improvements in child behaviour, attendance at a parenting programme can also lead to improvements in parents' own well-being.

Despite the positive outcomes attendance at a parenting programme can yield for both children and their parents, there continues to be limited data on the long-term impacts of such interventions, and if follow-up time-points are included, these are typically less than 6 months (Kazdin, 2002). In reviews by Barlow and Parsons (2004) and Thomas et al. (1999) it was found that improvements in maternal well-being and child behaviour problems can be shown to be maintained up to one year following attendance at a group, however there is a general consensus in the literature that there is a need for more studies including follow-up time-points in order to be able to assess the impact parenting programmes have over the longer-term (Bunting, 2004).

Understanding Your Child's Behaviour (UYCB) (formerly known as the 'Solihull Approach Parenting Group') is a parenting programme based on the Solihull Approach (Batson et al., 2008). The Solihull Approach itself was developed in 1996 and is an integrative approach drawing together psychoanalytical thinking, child neurodevelopment and

learning theory. The cornerstones of the model are the principles of containment, reciprocity and behaviour management. The Solihull Approach is a relationship-based parenting programme and proposes that if a parent feels contained this will impact on their own feelings of anxiety (containment) and, in turn, “free them up” to think about their child’s behaviour and what their child is trying to communicate to them (reciprocity). Consequently, through the processes of containment and reciprocity, parents should be more able to effectively and sensitively manage their child’s behaviour (behaviour management). Douglas (2007) proposed that it is the integration of the psychoanalytic, neurodevelopmental, and behavioural approaches that lead to improved emotional well-being in both the child and the parent, resulting in an overall improvement in the parent-child relationship.

There have been a small number of research studies supporting the effectiveness of the general Solihull Approach for a variety of audiences: improving consistency in clinical practice for health visitors trained in the model (Douglas & Ginty, 2001); as an effective brief individual intervention for parents (Douglas & Brennan, 2004); in helping to improve job satisfaction in health visitors (Whitehead & Douglas, 2005); and in improving mothers’ perceptions of community health support (Maunder, Giles and Douglas, 2007). The Solihull Approach was extended into the UYCB parenting programme in 2004 with the aim of developing a group-based parenting intervention that was effective, cost efficient and accessible to all parents of children aged 0-18 years with a range of issues.

The NICE guidelines on the management of conduct disorders in children include the UYCB programme as an implementation example (NICE, 2006), and previous evidence on the effectiveness of the UYCB programme has been positive, although limited in methodology. A pilot study of the UYCB (Bateson et al., 2008) sought to support the hypothesis that attendance at the group would result in positive outcomes in terms of parental well-being and child behaviour. A within-subjects repeated measures design was used, with parents completing questionnaires regarding their own well-being and their child’s behaviour at the start and end of the 10-week group programme. A total of 72 mothers consented to take part in the research, and measures of parental well-being (Beck Depression Inventory, Beck & Steer, 1993) and child behaviour (Child Behaviour Check-List, Achenbach, 1993, and The Strengths and Difficulties Questionnaire, Goodman, 2005) were taken. The findings showed that, following attendance at the group, parents reported a statistically significant decrease in



child externalising behaviours and conduct problems. Although there was a decrease in reported child internalising difficulties and emotional, hyperactivity and peer problems, these reductions were not statistically significant. Moreover, there was a reduction in parental depression, although this was not statistically significant. The authors acknowledged that although these initial findings were positive in suggesting that the UYCB did have a positive impact on child behaviour and parental well-being, the limited statistically significant findings (which may have been influenced by the reduced sample size) and lack of a wait-list control group for comparison, means it is difficult to ascertain whether the reported improvements were due to the intervention itself or to other factors. The lack of a follow-up time-point (which was due to practical reasons associated with the research being undertaken in a busy clinical setting), meant that it was also not possible to establish whether any positive impacts of attending the group were maintained over time.

More recently, a mixed-methods evaluation, using weekly parent-completed evaluation forms to gather the views of 236 parents attending UYCB courses, was undertaken (Johnson & Wilson, 2012). The study involved parents completing weekly evaluation forms at the end of each group session across the ten week UYCB programme. A simple 3-point Likert scale ('Great', 'Ok' and 'Poor') was used, where parents were asked to indicate: 1) how relaxed they felt in being able to share experiences in the session; 2) how much they felt the session had helped them to better understand their child; and 3) how much they felt the session helped them to identify any changes that they wanted to make. Analysis of these weekly evaluation forms found that throughout the sessions the 'poor' response was consistently low, with at most only 2% of parents using this rating. Conversely, 98% of responses throughout the course were 'ok' or 'great', which the authors felt indicated that in general parents were highly satisfied with the intervention. Open questions were also used in session 10 to gather parents' views on the course as a whole. Content Analysis was used to identify themes that arose from parents' responses to these questions and five broad themes were identified: 'Making Changes'; 'Feelings'; 'Improved Interactions'; 'Increased Knowledge'; and 'Improved Understanding'. The authors argued that, in particular the themes of 'Making Changes', 'Improved Interactions', 'Feelings' and 'Understanding' were indicative of parents feeling more able to implement the cornerstones of the Solihull Approach of containment, reciprocity and behaviour management. Despite the positive outcomes of this study there were a number of limitations to the study which were

acknowledged, including the fact that the weekly session evaluation outcomes do not provide objective evidence of actual changes parents were able to make as a result of attending the programme, and the fact that demographic information was not collected meant that it was not possible to establish which parents and children the UYCB group was most helpful for. It is also important to recognise the potential risk of bias associated with the authors of the study also being clinicians who worked in the service and were involved in both the development and delivery of the groups.

The purpose of this current study is to build on the previous pilot study by Bateson et al. (2008) to further explore the effectiveness of UYCB in relation to changes in domains of parental well-being and child behaviour. As the UYCB is based on the Solihull Approach, which has a specific focus on the relationship between parent and child, it was also deemed important to include a measure to be able to capture changes in this domain as a result of attending the UYCB programme. Given the lack of follow-up evaluation used in the pilot study, and the importance of gathering these data (as identified in the literature), this current study also included the addition of a follow-up time point to explore sustainability effects. The hypotheses were: that attendance at an UYCB parenting group programme would lead to an improvement in the areas of: child behaviour; parental well-being; and the relationship between child and parent (indicated by improvements in scores on the outcome measures used to assess these concepts after attending the programme); and that any positive effects demonstrated immediately after completing the programme would be sustained at the three month follow-up point.

## Method

**Intervention.** Understanding Your Child's Behaviour (UYCB) is a ten-week programme run by a range of community practitioners (e.g., psychologists, health visitors, school nurses, psychotherapists) who have attended a 2 day Solihull Approach foundation training course and a 1 day parenting facilitators training. Each UYCB group is co-facilitated by 2 practitioners; each facilitator is provided with a manual outlining the content and method (e.g., presentation, role play, group discussion, video) of each session to aid facilitation and fidelity to the programme (Table 3).

**Table 3:** Programme sessions

Session	Title
1	Introduction
2	How are you and your child feeling?
3	Tuning into your child's development
4	Responding to your child's feelings
5	Different styles of parenting
6	Parenting child partnership- having fun together
7	The rhythm of interaction and sleep
8	Self-regulation and anger
9	Communication and attunement- how to recover when things go wrong
10	Celebration

**Fidelity of programme delivery.** Treatment fidelity is an important component of the delivery of the UYCB group programme, and as such in order to maintain treatment group facilitators are required to attend both comprehensive training prior to delivering a group. In addition, regular supervision with a qualified Clinical Psychologist throughout the 10 week course is provided in order to address any queries or difficulties related to both the delivery of the group programme and process issues that may arise.

In order to assess the quality of the intervention delivered by the UYCB group facilitators, fidelity checklists were developed for this study and provided to facilitators for completion after each of the ten UYCB group sessions (Appendix C). The checklist was

comprised of a simple 6-point Likert scale (ranging from 0-5; where 0 = ‘not easy at all’ and 5 = ‘very easy’). Facilitators were asked to indicate to what degree they felt able to adequately cover all the goals set out for each group session in the manual.

**Sampling.** To enhance the ecological validity and real-world evaluation of the UYCB group the usual clinical practice and pathways used by the UYCB team were used to recruit parents to the UYCB groups. This involved group facilitators approaching parents they felt may be suitable for the course at a range of venues, including schools, children’s centres, and clinics where they work. Once a parent decided to take part in the UYCB programme and at approximately 2-4 weeks prior to the beginning of each course, they were provided with an information sheet outlining the research of this study (Appendix D). Those consenting to participate in the UYCB group and contribute their data for the purpose of the study completed a consent form (Appendix E). As a small compensation for the time contribution of those parents participating in the research and completing questionnaire packs at all 3 time points (pre, post and follow-up) names were entered into a prize draw with the opportunity of winning one of three high street shopping vouchers, ranging in value from £10 to £50.

In agreement with the UYCB team, a list of inclusion and exclusion criteria were generated to identify those parents who would be suitable for participating in the study (Table 4). The criteria were developed based on the standard requirements and expectations of the UYCB groups (and hence standard clinical practice).

**Table 4:** Participant Inclusion and Exclusion Criteria

<b>Inclusion Criteria</b>	<b>Exclusion Criteria</b>
Parents/carers of children aged 0-18 years	Parents whose child’s behaviour difficulties are such that they require more immediate and intensive input from a CAMHS or other specialist team
Parents with a sufficient understanding of spoken and written English to participate in the group and complete questionnaires	Parents whose language or literacy skills are limited such that they will not be able to complete the questionnaire booklet
Parents with children who have some degree of behaviour difficulty and would therefore	Parents of children with a diagnosed learning disability

benefit from a better understanding of their  
child's behaviour

Parents attending at least 8 out of the 10  
group sessions, with sessions missed not  
occurring on consecutive weeks

Young parents (under the age of 18)

An apriori power calculation using G\*Power 3 computer programme (Faul et al., 2007) (significance set at  $p < 0.05$ , power 0.80), indicated a sample size of 138 would be needed to detect a small effect size.

**Procedure.** At the start of session one of the UYCB course all parents were asked to complete a pre-course questionnaire booklet (Appendix F) At the end of the course (in session 10), parents were again asked to complete a post-course questionnaire booklet (Appendix G), which contained the same questionnaires as the pre-course booklet.

Three months after completing the course, parents consenting to the research were sent a follow-up questionnaire booklet (Appendix H) which contained the same questionnaires assessing parental well-being, child behaviour, and the parent-child relationship. Questionnaires were to be completed and returned in a provided pre-paid envelope.

**Ethics.** An NHS Research Ethics Committee approved the study (Appendix I), as did the Research and Development Departments of the organisations hosting the research (Appendix J).

**Design and questionnaires.** The study used a within-subjects repeated measures design in which each participants completed the same questionnaires (measuring child behaviour, child-parent relationship, parental well-being) at each time interval (pre, post and 3 month follow-up). The three questionnaire booklets contained the same questionnaires, presented in the same order.

The questionnaires used were:

- 1) Strengths and Difficulties Questionnaire (SDQ; Goodman, 2005)

The SDQ is a widely used brief screening measure of child behaviour and emotional difficulties. The 25-item scale measures parents' reports of their child's problematic

behaviours and positive social behaviours. It includes 4 problem subscales (conduct problems, hyperactivity, emotional symptoms, peer relationship difficulties), and a fifth pro-social behaviour scale, which should show an increased score if the child displays improved social behaviour. An impact supplement is also included to establish whether the parent feels the child has a problem and, if so, enquires further about the onset of the problem and perceived associated distress, social impairment and burden to others. The mean published Cronbach's alphas for the 5 scales is 0.73. Cronbach's alphas for the current study were: conduct problems  $\alpha=0.77$ , hyperactivity  $\alpha=0.78$ , emotional symptoms  $\alpha=0.70$ , peer relationship difficulties  $\alpha=0.60$ , and pro-social behaviour  $\alpha=0.75$ .

2) Depression Anxiety Stress Scale, Short Version (DASS-21) (Lovibond and Lovibond, 1995)

The DASS-21 was selected as a measure of parental well-being and is a shortened version of the original 42-item DASS self-report inventory that is used to assess symptoms of depression, anxiety and stress. For all items, respondents are asked to rate how much they felt that a given statement applied to them over the past week. Responses are scored on a four-point scale ranging in severity from 0 = 'did not apply to me at all', to 3 = 'applied to me very much/most of the time'. Each of the three DASS scales (Depression, Anxiety and Stress) contains 7 items and scores for each scale can be calculated by summing the scores for the relevant items. A total score can also be derived by adding together the total score of each sub-scale. Higher scores are indicative of more problematic wellbeing across the three scales, and total score. Published Cronbach's alphas are in the range of 0.82-0.91, and the internal reliabilities for the current study were: depression  $\alpha=0.92$ , anxiety  $\alpha=0.89$ , and stress  $\alpha=0.92$ .

3) Child-Parent Relationship Scale, Short Version (CPRS) (Pianta, 1992)

Reliable and valid methods of assessing child-parent interactions (indicative of the quality of the parent-child relationship) often use observational methods, which is not practical in large cohort research (Pasalich et al., 2011). Therefore a robust quantitative measure to assess parent-child relationship was sought for inclusion in the study. In doing so it was established that few such measures had been developed, and

of those identified the CPRS was selected due to its good face validity as well as being a short, quick to complete measure that is free to use (important inclusion criteria when selecting questionnaires for inclusion in the questionnaire packs). However, it is acknowledged by the author that this is a less robust measure than those used to capture child behaviour and parental well-being included in this study.

The CPRS is a 15-item scale comprising of a five-point rating scale. The CPRS breaks down into two subscales of conflict and closeness. Conflict measures the degree to which a parent feels his/her relationship with their child is characterised by negativity. Closeness assessed the extent to which parents feel the relationship with their child is characterised by warmth, affection and open communication. An elevated conflict score indicates increased conflict between the parent and child, similarly a high closeness score indicates increased closeness within the parent-child relationship. A total relationship score can also be derived by calculating the average item score (i.e. a score between 0-5, where 0 = a poor parent-child relationship and 5 = a close parent-child relationship).

The original scale was normed on a population of 563 children in the US, aged 4.5-5.5 years. Given the limited age range of children used to develop the measure, to date there are no published clinical cut-offs or norms in order to be able to establish whether the reported total scores could be classed in regards to being in the 'normal range'. Despite this limitation, the CPRS has been demonstrated to have good internal reliability with published Cronbach's alphas: Closeness  $\alpha=0.69-0.74$  and Conflict  $\alpha=0.78-0.84$ . For the current study Cronbach's alphas were: Closeness  $\alpha=0.87$  and Conflict  $\alpha=0.90$ .

Given the methodological limitations of the CPRS, on including the scale in this study it was deemed important to establish its stability over time and concurrent validity with another scale assessing attachment/parent-child relationship. To establish concurrent validity, and for the purposes of this research, the CPRS was assessed for its association with 7 items from the 'attachment' scale of the widely used Parent Stress Index (PSI) (Appendix K). To do this, a pilot study was used prior to the main study evaluation of the UYCB group. Using an opportunity sample of 29 parents of children aged 0-18 years, who were not currently receiving any parenting support,

parents were asked to complete the CPRS as well as the 7 items from the PSI at a baseline time-point. Without any form of intervention from the research time, the same group of parents were again asked to complete the same questionnaires 1 month later, to assess the test-retest stability of the CPRS measure.

An Intra-Class Correlation (ICC) analysis was undertaken to assess the stability of scores on the CPRS over time (i.e., across a 4-week interval). The ICC analysis (Table 5) indicated ‘satisfactory’ to ‘excellent’ levels on both items (Closeness and Conflict), as well as the ‘Total Relationship’ score (according to guidelines by Anastasia (1998) of .60 being the minimum acceptable score).

**Table 5:** Intra-Class Correlation (ICC) for the Child-Parent Relationship Scale

	<b>Closeness</b>	<b>Conflict</b>	<b>Total Relationship</b>
<b>Pre &amp; Post (4-weeks)</b>	.64	.79	.71

On assessing the concurrent validity of the CPRS to an established measure of attachment/parent-child relationship (PSI), inter-correlations between the ‘Total Relationship’ subscale of the CPRS with the PSI ‘Attachment’ subscale showed a statistically significant positive correlation ( $r=.73$ ,  $p<.001$ ). Table 6 (below) also shows positive correlations between the ‘Closeness’ subscale of the CPRS and PSI, a negative relationship between ‘Closeness’ and ‘Conflict’ subscales, and a negative relationship between ‘Conflict’ and PSI score.

This indicates a strong relationship between the CPRS total score and the 7 items of the PSI, such that a stronger parent-child relationship on the CPRS was associated with a stronger attachment score on the PSI. This strengthened the reasoning for including the CPRS as a measure of the parent-child relationship in the current study.



**Table 6:** Inter-correlations between CPRS subscales and PSI Attachment Scale.

Subscales	Correlations
Closeness vs Conflict	-.75
Closeness vs Total Relationship	.92
Closeness vs PSI	.68
Conflict vs Total Relationship	-.95
Conflict vs PSI	-.69
PSI vs Total Relationship	.73

In addition to the above standardised questionnaires, each parent also completed a brief demographics form (Appendix L), indicating their gender, ethnicity, age range, employment status, as well as details about their child and any support they may currently be receiving from other agencies (psychologists, social workers, etc).

**Data collection.** Data were collected from 2 research sites within the West Midlands over approximately 14 months, during which time 46 UYCB group programmes took place. Completed pre- and post-course questionnaire booklets were collated by the group facilitators who returned them to the research team for analysis. Approximately 3 months after parents completed the course they were sent a follow-up questionnaire booklet in the post to complete and return to the research team.

**Statistical analysis.** Double entry of data and screening was conducted to check for error, and SPSS (version 20; Armonk, NY: IBM Corp) was used for analysis. Data were checked for normality and homogeneity of variance prior to the use of parametric and non-parametric analysis. Descriptive data are presented before inferential data analysis.

A p-value of <0.05 was chosen and used throughout (although exact p-values are reported). This is based on suggestions by Feise (2002) that decisions about which p-value to employ in research studies should be informed by the robustness of the study design, expected effect size and included sample size. Given the less robust within-subjects design used in this study, small expected effect size, and the fact that many of the analyses were underpowered

due to reduced sample size, a less conservative  $<0.05$  was selected. However, the author acknowledges that by using this p-value and in controlling for Type II error (incorrectly accepting the null-hypothesis- in this case that the treatment has no effect) this may result in an increase in the likelihood of Type I error (the false rejection of the null hypothesis),

Two analyses were undertaken to assess changes on the 3 outcome measures across the 3 time-points (pre, post and follow-up): 1) a pre-post group analysis for those parents who completed questionnaire packs at both pre- and post-group time-points ( $n=119$ ); and 2) a pre-post-follow-up analysis for parents who completed questionnaire points at all 3 time-points ( $n=35$ ). For some of the analyses sample size was reduced due to parents not completing all 3 questionnaires in the questionnaire pack; for these analyses, and in order to maximise statistical power, the biggest possible sample was included.

## Results

**Participants.** During the period in which the research study took place a total of 242 parents attended an UYCB parenting programme and were invited to take part in the research. Of these, 160 parents (66%) consented to take part in the research and completed a pre-group questionnaire pack. At the end of the group programme, 119 (74%) parents completed post-group questionnaire pack. All parents who completed the post-group questionnaires were contacted by post three months after the group finished and asked to complete and return a follow-up questionnaire pack, of which 35 were returned (29%). Thus, the pre- to post-group completion analysis is based on a total sample of 119 parents, and the three-month follow-up evaluation is based on a smaller sample of 35 parents.

The majority of the parents included in the study were female (92%), with most parents falling within the age category of 30-39 years (56%), most of whom (94%) were the identified child's biological parent. Seventy-one percent of parents were not in paid employment and a quarter (25%) classed themselves as a "lone parent".

The children, identified by parents to be kept in mind for the completion of the questionnaires, ranged in age from 0-14 years (mean=5.07 years, SD=3.6) and there was an almost even gender split (female = 52%). Seventeen percent of children were reported by parents to have an "additional need" (e.g. physical health problems) and a quarter (25%) were receiving additional professional support (e.g., from social workers, family support workers) at the time of intervention.

**Treatment fidelity.** Thirteen out of a total of 21 group facilitators who were approached to complete fidelity checklist, completed weekly checklists for each group session throughout the programme. Facilitators indicated how able they were to adhere to the goals set out for each group session on a scale of 0-5 (where 0='not easy at all' and 5='very easy'). Analysis of completed checklists showed an average total session score of 4.40 (SD=0.56, range=4.19-4.64), indicating that, on the whole, facilitators felt that they were adequately able to adhere to the content and delivery of the UYCB group programme as detailed in the programme manual.

**Descriptive data.** A total of 160 parents completed questionnaire packs and consented to take part in the research at the start of the group programme. Mean scores on the measure

of child behaviour (SDQ) at the start of the group all fell within the ‘normal’ to ‘borderline’ range, and the mean ‘Total Difficulties’ score was in the ‘normal’ range ( $M = 14.95$ ;  $SD = 7.83$ ). These data show that at the start of the UYCB programme the majority of children were not experiencing clinically significant behaviour problems. Similarly, on the measure of parental well-being (DASS-21), all 3 subscales (Depression, Anxiety and Stress) fell within the ‘normal’ range, indicating that most parents were not experiencing significant difficulties prior to starting the group. There are no published norms for the CPRS (parent-child relationship), so it was not possible to determine whether there were clinically significant difficulties in the relationship between parent and child at the start of the group programme, however the mean ‘Total Relationship’ score was 3.61 ( $SD = 0.74$ ) (where 0 = poor parent-child relationship and 5 = close parent-child relationship).

**Analysis one (pre-post group changes).** A per protocol completer analysis was undertaken for the 119 participants who completed both pre- and post-group questionnaire packs to assess whether there was a statistically significant difference in scores on each of the three outcome measures (SDQ, DASS-21, CPRS). Analyses for normality of distributions on the outcome variables and their subscales were undertaken, with those measures meeting the assumptions of parametric testing being analysed using a paired-samples t-test; Wilcoxon rank sums t-test were used as the non-parametric equivalent (Table 7).

i) Child Behaviour (SDQ)

There was a statistically significant improvement in scores at time two (post-group) compared to time one (pre-group) on all the subscales that make up the measure of Child Behaviour (SDQ), with the exception of ‘peer relationship difficulties’. Although the ‘peer relationship scale’ showed a decrease in scores from pre- ( $M = 2.84$ ,  $SD = 2.09$ ) to post-group ( $M = 2.77$ ,  $SD = 2.07$ ) this change was not statistically significant ( $p = 0.71$ ). The SDQ ‘total difficulties’ score showed a statistically significant ( $p < 0.001$ ) decrease from 14.70 ( $SD = 7.48$ ) at pre-group to 12.40 ( $SD = 6.51$ ) at post-group. Overall, all but one SDQ scale showed statistically significant improvements in children’s behaviour, emotional functioning and perceived impact of difficulties between pre- and post-group time points.

ii) Parental Well-being (DASS-21)

On the measure of parental well-being (DASS-21), statistically significant decreases between time one and time two scores were shown for the subscales of 'depression' ( $p < 0.001$ ), 'Anxiety' ( $p = 0.01$ ) and 'stress' ( $p < 0.001$ ). For the 'total' score, there was a statistically significant ( $p < 0.001$ ) decrease from time one ( $M = 29.53$ ,  $SD = 28.97$ ) to time two ( $M = 20.83$ ,  $SD = 25.19$ ). Overall, across the three subscales and total score, parents reported statistically significant improvements in their mental health and wellbeing from pre- to post-group.

iii) Child-Parent Relationship (CPRS)

The CPRS, which measures the relationship between child and parent, yielded significant pre- to post-group changes. There was a statistically significant increase in the 'closeness' subscale score between time one ( $M = 29.33$ ,  $SD = 4.63$ ) and time two ( $M = 30.48$ ,  $SD = 4.26$ ), and a significant decrease in the 'conflict' score from time one ( $M = 22.69$ ,  $SD = 8.34$ ) to time two ( $M = 20.22$ ,  $SD = 8.14$ ). The 'closeness' and 'conflict' pre- to post-group score changes were reflected in the statistically significant change between the pre- ( $M = 3.62$ ,  $SD = .75$ ) to post-group ( $M = 3.89$ ,  $SD = 0.75$ ) 'total relationship' scores in the direction of improvement in the parent-child relationship. Overall, statistically significant improvements in closeness and total parent-child relationship scores, as well as statistically significant reductions in conflict, between pre- and post-group time points were found.

**Table 7:** Pre-post group changes

Variable	N	Pre		Post		T	Z	df	P
		M	SD	M	SD				
Child behaviour (SDQ)									
Conduct problems	112	3.75	2.60	2.57	2.08	-	-5.19	108	<0.001*
Hyperactivity	110	5.72	2.65	4.94	2.59	3.50	-	109	0.01*
Emotional symptoms	112	3.12	2.30	2.23	2.12	-	-4.59	109	<0.001*
Peer relationship difficulties	112	2.84	2.09	2.77	2.07	-	-0.37	109	0.71
Pro-social behaviour	112	6.57	1.98	7.24	2.22	-	-4.25	109	<0.001*
Total difficulties	110	14.70	7.48	12.40	6.51	3.10	-	109	<0.001*
Impact	112	1.83	2.60	0.91	1.41	-	-4.17	109	<0.001*
Parental well-being (DASS-21)									
Depression	118	9.79	11.14	6.08	9.23	-	-4.27	117	<0.001*
Anxiety	118	6.40	8.72	4.77	7.83	-	-2.45	117	0.01*
Stress	118	13.42	10.94	10.30	9.71	-	-3.23	117	0.001*
Total score	118	29.53	28.97	20.83	25.19	-	3.91	116	<0.001*
Child-parent relationship (CPRS)									
Closeness	112	29.33	4.63	30.48	4.26	-	-3.72	111	<0.001*
Conflict	112	22.96	8.34	20.22	8.14	4.34	-	111	<0.001*
Total relationship	112	3.62	0.75	3.89	0.75	4.62	-	111	<0.001*

M=Mean mdn=Median, , SD=Standard deviation, IQR=Inter-quartile range, t=paired-sample t-test, z=Wilcoxon rank sums t-test, p=significance level, \*=statistically significant at  $p < 0.05$ , df=degrees of freedom

**Analysis two (pre, post, and follow-up changes at 3-months).** Given the power of parametric statistical tests to be robust to violations of their assumptions, a one-way repeated measures analysis of variance (ANOVA) was conducted to analyse the data for the 35 parents who completed questionnaires at all three time points (pre, post and follow-up). Where statistically significant changes were identified post-hoc analyses were performed using Bonferroni adjustment to account for inflated error when several post-hoc tests are conducted (Table 8).

i) Child Behaviour (SDQ)

On the subscales of ‘emotional problems’ and ‘peer problems’ the analysis showed a decrease in scores from time one (pre), to time two (post), and time three (follow-up) ( $T1 > T2 > T3$ ), although these changes were not statistically significant at

any of the three time points. The subscale scores for ‘hyperactivity’, showed a decrease in scores from time one to time two, but a slight increase in scores from time two to time three ( $T1 > T2 < T3$ ), although again these changes were not statistically significant at any of the three time points.

Statistically significant changes were observed across the three time-points on the subscale of ‘conduct problems’ ( $p = 0.02$ ). There was a significant decrease in scores between time one and subsequent time points, with a slight increase in scores between time two and time three ( $T1 > T2 < T3$ ). However, using guidelines suggested by Cohen (1988) the magnitude of these changes was small ( $\eta^2 = 0.12$ ).

Statistically significant changes in scores were also shown for ‘pro-social behaviour’ ( $p = 0.01$ ), from time one to subsequent time points (two and three), with an improvement in the score from time one to time two, and again at time three ( $T1 < T2 < T3$ ). However, again the size of these changes was small ( $\eta^2 = 0.15$ ).

The overall ‘total difficulties’ score showed a statistically significant ( $p = 0.05$ ) decrease from time one ( $M = 13.44$ ,  $SD = 6.19$ ) to time two ( $M = 11.29$ ,  $SD = 5.08$ ), although there was a slight increase again in scores between time two and time three ( $M = 11.65$ ,  $SD = 7.50$ ) ( $T1 > T2 < T3$ ). The effect size of these changes was again small ( $\eta^2 = 0.09$ ).

ii) Parental Well-being (DASS-21)

No statistically significant changes in the mean scores of the subscales of the DASS-21 (Depression, Anxiety and Stress) were found. On the ‘depression’ subscale there was a decrease in scores from time one to time two, with a slight increase in scores between time two and time three ( $T1 > T2 < T3$ ), which was also the case for the mean scores for ‘anxiety’. The mean subscale score for ‘stress’ showed a decrease in scores across the three time-points ( $T1 > T2 > T3$ ), and although these changes were not statistically significant the data showed a trend towards significant reductions in stress across the three time points ( $p = 0.08$ ).

The ‘total’ score also showed a decrease in mean score at time one ( $M = 22.44$ ,  $SD = 23.58$ ) to time two ( $M = 15.29$ ,  $SD = 17.54$ ), increasing slightly at time three ( $M = 16.12$ ,  $SD = 21.22$ ) ( $T1 > T2 < T3$ ), and again there was a trend towards statistically

significant reductions in total difficulties between time one and subsequent time-points ( $p=0.06$ ).

iii) Child-Parent Relationship (CPRS)

On the measure of relationship between child and parent, both 'closeness' and 'conflict' mean scores showed an improvement from time one to subsequent time points. For the 'closeness' subscale there was an increase in mean scores from time one to time two, with only a very small decrease between time two and time three ( $T1 < T2 > T3$ ), suggesting an improvement in the closeness in the relationship between parent and child after attending the group. The changes between scores at time one and subsequent time-points was statistically significant ( $p=0.02$ ), although the effect size of these changes was small ( $\eta^2=0.12$ ).

The 'conflict' subscale showed a decline in mean scores across the three time points ( $T1 > T2 > T3$ ), again indicative of an improvement in the relationship between parent and child from time one and subsequent time-points. Although the changes across the three time-points were not statistically significant ( $p=0.06$ ) there was a trend in the data towards significance reductions in conflict.

The change in mean 'total relationship' scores did show a statistically significant ( $p=0.01$ ) change in scores between time one ( $M=3.79$ ,  $SD=.75$ ), and time two ( $M=4.05$ ,  $SD=.54$ ) as well as time three ( $M=4.07$ ,  $SD=.58$ ), ( $T1 < T2 < T3$ ), however the reported effect size of this change was small ( $\eta^2=.14$ ).



**Table 8:** Pre-post-follow-up changes

Variable	N	Pre		Post		Follow-up			Df	p	ηp²
		M	SD	M	SD	M	SD	F			
7Child behaviour (SDQ)											
Emotional problems	34	2.26	1.58	1.97	1.87	1.88	2.18	0.86	1.91	0.42	0.03
Hyperactivity	34	5.29	2.46	4.71	2.21	4.74	2.92	1.23	1.92	0.27	0.04
Conduct problems	34	3.41	2.39	2.35	1.67	2.79	2.40	4.29	1.73	0.02*	0.12
Peer relationship difficulties	34										
		2.82	2.26	2.29	1.90	2.24	2.28	1.84	1.83	0.17	0.05
Pro-social behaviour	34	6.97	1.77	7.74	1.60	7.88	1.92	5.95	1.85	0.01*	0.15
Total difficulties	34	13.44	6.19	11.29	5.08	11.65	7.50	3.220	1.92	0.05*	0.09
Impact	34	1.38	2.90	0.71	1.36	0.85	1.89	2.07	1.63	0.15	0.59
Parental well-being (DASS-21)											
Depression	34	6.76	8.92	4.06	6.08	4.82	7.03	2.57	1.44	0.10	0.07
Anxiety	34	4.53	6.46	3.06	5.83	3.12	6.01	1.64	1.32	0.21	0.47
Stress	34	11.12	9.36	9.41	8.68	8.18	9.50	2.83	1.70	0.08	0.79
Total score	34	22.44	23.58	15.29	17.54	16.12	21.22	3.34	1.55	0.06	0.09
Child-parent relationship (CPRS)											
Closeness	35	30.06	4.45	31.62	2.40	31.56	2.85	4.35	1.88	0.02*	0.12
Conflict	35	21.09	8.17	18.82	7.15	18.35	6.98	3.06	1.90	0.06	0.09
Total relationship	35	3.79	.75	4.05	.54	4.07	.58	5.24	1.73	0.01*	0.14

M=Mean, SD=Standard deviation, p=significance level, \*=statistically significant at <0.05, df=degrees of freedom,  $\eta^2$ =partial eta squared

Table 9 (below) illustrates the direction of mean score changes across the 3 time-points (pre, post and follow-up) on each subscale of the included measures.

**Table 9:** Direction of mean changes in scores across all 3 time points

Variable	Pre M	M	Post D	M	Follow-up D
<b>Child behaviour (SDQ)</b>					
Emotional problems	2.26	1.97	↓	1.88	↓
Hyperactivity	5.29	4.71	↓	4.74	-
Conduct problems	3.41	2.35	↓	2.79	↑
Peer relationship difficulties	2.82	2.29	↓	2.24	↓
Pro-social behaviour	6.97	7.74	↑	7.88	↑
Total difficulties	13.44	11.29	↓	11.65	↑
Impact	1.38	0.71	↓	0.85	↑
<b>Parental well-being (DASS-21)</b>					
Depression	6.76	4.06	↓	4.82	↑
Anxiety	4.53	3.06	↓	3.12	↑
Stress	11.12	9.41	↓	8.18	↓
Total score	22.44	15.29	↓	16.12	↑
<b>Child-parent relationship (CPRS)</b>					
Closeness	30.06	31.62	↑	31.56	↓
Conflict	21.09	18.82	↓	18.35	↓
Total relationship	3.79	4.05		4.07	-

M=Mean, D= Direction of change, ↑= increase in score from previous time-point, ↓= decrease in score from previous time-point, – =stability of score from previous time-point

**Clinically significant changes.** In addition to the statistical analysis above, it is important to view the above analyses in the context of clinical significance and the extent to which changes in scores across the three time-points reflect ‘real life’ changes in symptoms for the parents and children who participated in the study.

Clinical cut-offs for all subscales of the SDQ (with the exception of ‘impact’) have been proposed by Goodman (2005). By viewing the mean scores of each subscale at each time-point in the context of clinical cut-offs, it can be seen that at the start of the UYCB group (pre-group) all mean subscale scores fell within the ‘normal’ range, with the exception of ‘conduct problems’ and ‘peer relationship difficulties’ which fell within the ‘borderline’ range. At time two (post-group) all subscale scores for the SDQ fell within the ‘normal’ range, and this was maintained at time three (follow-up).

On the measure of parental well-being (DASS-21), although there was a decline in the mean scores across the 3 time points (indicating an improvement in these symptoms) there

was no change in the clinical significance of the scores, with scores falling within the ‘normal’ range at all 3 time-points on all 3 sub-scales (according to classifications proposed by Lovibond & Lovibond, 1995).

The measure of relationship between child and parent (CPRS) does not have any proposed clinical classifications so it was not possible to place the significance of changes of mean scores within this context, except to say that there was an increase in the mean ‘closeness’ score at time two which was maintained at time three, which would indicate an improvement in the closeness of the relationship between parent and child. Similarly, the decrease in conflict score from time one, to time two and three, although cannot be placed in the context of clinical significance, may indicate a decrease in conflict between parent and child following participation in the UYCB group programme.

**Table 10:** Clinically significant changes

Variable	Pre	Post	Follow-up
<b>Child behaviour (SDQ)</b>			
Emotional problems	2.26 (Normal)	1.97 (Normal)	1.88 (Normal)
Hyperactivity	5.29 (Normal)	4.71 (Normal)	4.74 (Normal)
Conduct problems	3.41 (Borderline)	2.35 (Normal)	2.79 (Normal)
Peer relationship difficulties	2.82 (Borderline)	2.29 (Normal)	2.24 (Normal)
Pro-social behaviour	6.97 (Normal)	7.74 (Normal)	7.88 (Normal)
Total difficulties	13.44 (Normal)	11.29 (Normal)	11.65 (Normal)
<b>Parental well-being (DASS-21)</b>			
Depression	6.76 (Normal)	4.06 (Normal)	4.82 (Normal)
Anxiety	4.53 (Normal)	3.06 (Normal)	3.12 (Normal)
Stress	11.12 (Normal)	9.41 (Normal)	8.18 (Normal)
<b>Child-parent relationship (CPRS)*</b>			
Closeness	30.06	31.62	31.56
Conflict	21.09	18.82	18.35
Total relationship	3.79	4.05	4.07

\*There are currently no corresponding classification systems for the CPRS

## Discussion

The aim of this study was to assess whether attendance at an UYCB group programme would have a positive effect on child behaviour, parental well-being and the relationship between parent and child, both immediately following completion of the programme and at a 3 month follow-up time-point.

Short-term outcomes were assessed by comparing pre-group scores with those at post-group, to see whether any significant outcomes were obtained. Of the 160 participants who started an UYCB programme, 119 of these completed the group and therefore were included in the completer, as per protocol, analysis. Findings from this analysis suggested that parents reported an improvement in their child's behaviour following completion of the UYCB programme, with the exception of 'peer problems' for which, although not statistically significant, scores at post-group did show a clinically significant improvement with scores moving from 'borderline' to 'normal' range. Similar findings were found for parental well-being, with statistically significant improvements in the areas on all three subscales of 'depression', 'anxiety' and 'stress' as well as the total DASS-21 score.

The short-term findings of improvements in parental well-being and child behaviour are in-line with those found in the pilot evaluation study of the UYCB programme (Bateson et al., 2008), as well as other research in the area of parenting programmes (e.g. Barlow & Stewart-Brown, 2002; Barlow et al, 1999; Gibbs et al., 2003; Bunting, 2004). The principle of the Solihull Approach, on which the UYCB programme is based, is that improvements in parental well-being may "free up" parents to be able to think clearly when managing their child's behaviour (Douglas, 2007), which may be supported by the findings from both the pilot and current study that attendance at an UYCB group leads to changes in both of these areas (although the direction of cause and effect is unknown). The Solihull Approach also aims to enhance the relationship between parent and child, and in the current study the CRPS was included to help assess whether the UYCB achieved this aim. The pre- to post group analysis showed statistically significant improvements post-group in the areas of 'conflict' and 'closeness', as well as the overall relationship score. It is important to note that due to limitations with the measure used to assess the relationship between parent and child (and indeed all measures aiming to capture this concept) it is not possible to place these outcomes in the context of clinically significant norms.

As well as establishing the short-term outcomes of attending an UYCB programme, the current study also aimed to build on the pilot study conducted by Batson et al. (2008) by establishing any longer-term benefits of attending the programme. Historically, long-term outcomes of parenting programmes have been under reported (Kazdin, 2002), although there is consensus that if parenting programmes are to achieve their aim of preventing problems in later child and adulthood, any effects from attending a programme must be maintained over the longer-term. In order to establish the longer-term outcomes of attending an UYCB programme, follow-up data were collected 3 months following completion of the programme. Consistent with reported drop-out rates for parenting programmes reported above, only 35 of the initial 160 parents completed questionnaires at follow-up. Analysis of these questionnaires showed a general trend in the data of effects immediately following attendance at an UYCB group to remain stable at the three month follow-up. In some instances statistically significant changes across the three time-points were found ('conduct problems', 'pro-social behaviour' and 'total difficulties' on the SDQ; 'closeness' and 'total relationship' scores on the CPRS), although effect sizes of such changes were small in magnitude ( $\eta^2 = 0.09-0.15$ ). There was also a trend towards significance in the improvements on the DASS-21 'total' score ( $p=0.06$ ) and 'conflict' subscale of the CPRS ( $p=0.06$ ). Given the limited statistical significance and effect size it would seem that the small follow-up rate may have contributed to the lack of power in reported findings across the 3 time-points. It should also be noted that the lack of a wait-list control group at follow-up means it was not possible to ascertain whether the outcomes shown at follow-up were due to the effects of the intervention itself, or other extraneous variables. Also of note is the fact that the research took place in a busy, real-world clinical setting, this meant that it was not possible to include a follow-up time-point of more than 3 months, which may mean that the longer sustainably and sleeper effects of attendance at the UYCB programme may not yet be evident. It would, therefore be important for future research in this area to build on these initial findings in order to be able to strengthen the findings of the longer-term impact for parents attending an UYCB programme.

In order to establish the 'real world' outcomes of this study, mean changes in scores on the 3 questionnaires across the time points (pre, post and follow-up) were placed within the context of clinically significant changes. At time-point one (pre-group) all of the subscale scores that make-up the SDQ and DASS-21 fell within the 'normal range', with the exception of 'peer problems' and 'conduct difficulties' which fell within the 'borderline' range

(Goodman, 2005; Lovibond & Lovibond, 1995). Although there was a decrease in mean scores from pre- to post- group, and relative stability of mean scores at follow-up, clinically significant changes may not have been found due to floor effects (that is to say that the mean scores were in the low range at pre-group and therefore any further reductions in scores would be minimal). Axord et al. (2012) suggest that the effects of parenting programmes for children whose behaviour problems are less severe at the start of the programme may be diluted, meaning that the effects of such interventions are smaller for this population. Despite this, rather than being a limitation of this study, the limited clinically significant changes in scores may be reflective of the fact that the UYCB is a preventative programme, aimed at preventing behaviour problems in children from becoming clinically significant difficulties.

Overall, the findings suggest that attendance at an UYCB programme yield positive outcomes in the areas of child behaviour, parental well-being and the parent-child relationship, immediately following attendance at a parenting programme for those parents who complete the 10 week course. Follow-up findings showed a trend in the data for the effects found immediately following attendance at the group to be maintained 3 months later, however the limited sample size, lack of a wait-list control group for comparison, and relatively short follow-up time-point means that only tentative conclusions about the longer-term impacts of attendance at an UYCB group programme can be drawn.

**Limitations.** The current study was successful in its aim of building on the pilot study of the UYCB by assessing the impact attendance at such a group has on the relationship between the parent and child, and also the longer-term outcomes of attending such a group. Despite this, a number of limitations of the study are recognised that will be important for future research in the area to address.

Firstly, although drop-out rates compared favourably with those of other research in the area of parenting programmes, the significant drop-out rate between pre and post-group (26%) may mean that the positive findings reported in the completer analysis may be subject to bias. Similarly, significant drop-out rates were found between post-group and follow-up time points (71%), meaning that any effects reported at follow-up were small in magnitude and caution should be taken was drawing substantial conclusions about the effects found at follow-up.

In order to address the difficulties associated with high drop-out rates of parents participating in a parenting programme, Axford et al. (2012) sought to establish why, although recruitment to parenting programs is often high, retention is historically poor. Their findings suggested a number of barriers for parents attending parenting programmes, which they found could be successfully overcome by employing strategies such as: making programmes easily accessible to parents; investing and building relationships with parents; and including incentives for parents to complete the parenting programme. By using some of these suggested strategies, the effects of drop-out rates may be avoided and an unbiased evaluation of the findings from parents attending such a group can be undertaken for the majority of parents who attend the parenting programme.

A limitation of the pilot evaluation study of the UYCB programme was the lack of a measure seeking to establish improvements in the relationship between parent and child as a result of attending the programme. Central to the Solihull Approach is the idea that by improving parental well-being parents are able to more sensitively manage their child's behaviour, leading to an overall improvement in the relationship between the parent and the child (Douglas, 2007). For this reason it was deemed important to include a measure in the current study to assess changes in this area. Previous studies aiming to assess the quality of the relationship between parent and child have highlighted the methodological challenges in being able to accurately capture the constructs that contribute to a strong relationship between

a parent and their child (Janssens et al., 2005; Vignoli & Mallet, 2004). In light of this, observational methods are often used which involve researchers observing the interaction between parent and child and coding the quality of these interactions (e.g. The Dyadic Parent-Child Interaction Coding System, Eyberg & Robinson, 1983). Although observational methods are viewed as more valid measures of parent-child relationship than self-report measures, it has been acknowledged that employing such methodology in large scale research is often impractical (Pasalic et al., 2011).

Given the above, a dilemma arose when selecting a suitable measure of the parent-child relationship to be included in the present study. The CPRS was selected due to the fact that it appeared to have good face-validity and was also quick and easy for parents to complete. In selecting such a questionnaire, however, acknowledgement is given to the limitations of this measure, including the limited population the questionnaire was normed on (namely children aged 4.5-5.5 years) and lack of clinically significant cut-offs. To address this, a small scale study was conducted as part of this research study to assess the test-retest reliability and concurrent validity of the measure, which yielded positive results. Despite this, it is important to hold in mind the limitations of using self-report measures to capture the relationship between parent and child, and future research in this area should seek to develop robust, reliable and valid measures to help assess this important area.

As well as the CPRS, the measures of parental well-being (DASS-21) and child behaviour (SDQ) were reliant on parents' self-report. Research in the area of parenting programmes has suggested that relying on parental report alone may skew outcomes (Webster-Stratton & Lindsay, 1999). As this research took place in a naturalistic, busy clinical setting consideration had to be given to the methods used to capture the desired information to assess the impact of attending an UYCB programme. As a result, it was not possible to use other methods of data collection to validate those reported by parents (e.g. teacher reports, observations), and therefore it is acknowledged that the findings from this study may be subject to bias.

The inclusion of a follow-up time-point is a strength of this study, especially given that this was not included in the pilot evaluation. Despite this, there are limitations specifically associated with the follow-up time-point. Firstly, the significant attrition rate at follow-up meant that the findings suggested at follow-up are based on a significantly reduced



sample size. Due to the fact that this research took place in a busy clinical setting it was not possible to follow parents up in person or via telephone to complete the questionnaires at this time-point, and as such follow-up questionnaires were sent to parents in the post to complete and return, and it is acknowledged that using this method to collect data at this time-point may have impacted on the low return rate. In addition, it was not possible to include a follow-up time-point of more than three months, which may have also impacted on the findings as further sustainability, sleeper or deterioration of outcomes may have been shown if it had been possible to include a longer follow-up time-point.

Finally, a significant limitation to the current study is a lack of a control group, which means that it is not possible to conclude that effects found at post-group and follow-up are due to the effects of the intervention alone, and it is acknowledged that the reported improvements may have occurred naturally over time, irrespective of the intervention. A more rigorous design, including a wait-list control group for comparison, was considered however due to constraints within the real-world clinical settings where recruitment took place it was not possible to employ such a design. Similarly a pre-baseline time-point was considered, which would involve parents completing the same questionnaires one month prior to commencing an UYCB programme to assess whether changes occurred in the absence of the intervention. Again, due to the method of recruitment to the UYCB groups employed by the services in which the research took place it was not possible to include this additional time-point, however future research in this area would benefit from the inclusion of such assessments in order to strengthen study design if this is possible.

**Clinical Implications.** As the research was conducted in a real-world clinical setting, there are a number of clinical implications that may be relevant for both the delivery and evaluation of future parenting programmes.

Firstly, although the take-up and attrition rates in this study were favourable when compared with attrition rates for parenting programmes in general, it is acknowledged that a larger sample size would have increased the statistical power of the results that were found. In particular, the small sample size at follow-up means that only tentative conclusions can be drawn about the longer-term impacts of attending an UYCB programme. As such, it is important for future researchers in the area of parenting programmes to maximise sample size

by focusing on the engagement and retention of parents in the parenting group and research process, using strategies such as those suggested by Axford et al. (2012), above.

The use of multiple outcome measures employed in this study means that it was possible to assess changes in a number of domains (child behaviour, parental well-being, the relationship between parent and child), however the initial design of this study also sought to incorporate the use of measures assessing parenting skills and competence, which have also been shown to improve for some parents as a result of attending a parenting programme (Bunting, 2004). However, it was acknowledged that by employing a larger number of questionnaires this may add additional burden for parents associated with the time taken to complete multiple questionnaires, as well as impact on their engagement with the programme as a whole. Therefore, a balance should be struck between being able to accurately capture the changes that may occur for parents as a result of attending a parenting programme, with the increased time it may take for parents to complete such questionnaires.

The fact that the research took part in a real-world clinical setting impacted on the ability to be able to employ a rigorous research design. As such, the use of a wait-list control group for comparison across the three time-points was not possible. Similarly, due to the methods used to recruit parents to the parenting programme it was not possible to use a pre-baseline assessment time-point to assess stability of scores prior to attending the UYCB programme. Therefore a less rigorous within- subjects design was used, which meant that it was not possible to compare the outcomes of those parents who attended a parenting programme with parents who did not receive the intervention over the same period, meaning that any outcomes found at post-group and follow-up time-points cannot be attribute solely to the effects of the intervention. Despite these limitations a number of statistically significant improvements were shown for those parents who completed the programme and it is important for real-world research to continue to be undertaken, despite the fact that it is not always possible to employ more rigorous research designs.

Finally, it is important to note that the population of children who were included in this study were not shown to be experiencing clinically significant behaviour problems at the start of the group, which may have resulted in the fact that only small clinically significant changes were shown at the post-group and follow-up time-points (which may be due to floor effects). These findings are reflective of the nature of the UYCB programme as a preventative

intervention for children who may not yet be experiencing clinically significant behaviour problems and it has been suggested that these populations of children may experience diluted effects of parenting programmes (Axord et al., 2012). Despite the lack of clinically significant changes, the statistically significant change in mean scores from pre- to post-group yielded in this study, and the relative stability of scores over the follow-up period, may indicate that the UYCB is meeting its aim as a preventative intervention. As such, it is important for researchers and parenting programme facilitators to hold in mind the population of children (and parents) who are recruited to their parenting programmes and the outcomes they may expect to see for this particular population as a result of attending the parenting programme.

## **Conclusions**

This study aimed to evaluate the impact for parents attending an UYCB programme, and their children, both immediately following completion of the group and at a three-month follow-up time-point. The findings from the study provided empirical evidence that attendance at an UYCB programme has a positive impact in the areas hypothesised (child behaviour, parental well-being and parent-child relationship), both in the short and longer-term. There are a number of limitations to the study, most notably the lack of control group and significant drop-out rates (in particular at follow-up) that may have impacted on the findings and will be important to address in future research in this area. Despite the limitations, this current study helps add to the body of research regarding the effectiveness of the UYCB, in particular the impact it may have on improving the relationship between parent and child which is a specific aim of the Solihull Approach, on which the UYCB programme is based.

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## Chapter Three

### Public Domain Briefing Document

This document provides an overview of the thesis submitted in partial fulfilment of the requirements for the degree of Doctorate of Clinical Psychology (Clin.Psy.D.) at the University of Birmingham. This document summarises both a literature review and an empirical paper.

#### **Literature review: The long-term outcomes, for children and their parents, of attending a group parent training programme: A systematic review of the literature**

**Background.** Behaviour (or conduct) problems in children are common and, if left untreated can have negative impacts on later childhood and adulthood (Fergusson et al., 2005). They can also have costly implications for society as a whole, and it has been suggested that the cost of supporting a child with behaviour problem is ten times that of supporting a child without these problems (Roberts et al., 2012). Poor parenting has been linked to the development of behaviour problems in children (Farrington et al., 2007), and parenting programmes (which help to modify parent behaviour, with the idea that this will in turn modifying child behaviour) have been suggested as the treatment of choice (NICE, 2013). There is significant evidence that parenting programmes can be helpful in the short-term in helping child behaviour problems, parents' own feelings of well-being, and parenting skills, style and competence (Barlow et al., 1999; Bunting, 2004; Gibbs et al., 2003). However, if parenting programmes are to achieve their aim of preventing behaviour problems in later childhood and adulthood, any positive effects found immediately after attending a parenting programme must be able to be maintained over the long-term, but to date few studies in this area have included follow-up time-points of more than six months (Kazdin, 2006).

**Aim.** The aim of this literature review was to find out whether parenting programmes can be helpful for parents and their children over the longer-term (more than one year after finishing the parenting programme).

**Method.** A systematic search was undertaken to identify studies of parenting programmes targeting conduct problems in children which included a follow-up time-point of one year or over. After screening, 19 studies were chosen to be included in the review.

Relevant data about each study (e.g. study design, parenting programme used, length of follow-up time-point) was extracted, and the quality of each study was also assessed.

**Findings.** The findings from this review found that the positive effects of attending a parenting programme can last up to 14 years after the programme has finished in the areas of child behaviour, parents' own feelings of well-being, and parenting skills, style and competence. However, there were a number of limitations to the studies, in particular the lack of a control group (who did not receive the parenting programme intervention) at the follow-up time point to compare the findings with.

**Conclusions.** The findings from this review suggest that there are long-term benefits of attending a parenting programme, for both children and their parents. However, follow-ups (if they are included at all) are usually less than three years after the programme has finished and there needs to be further research in this area to find out whether the positive effects of attending a parenting programme can be maintained over the longer-term, and which groups of parents and children are best able to maintain these changes.

### **Empirical Paper: An uncontrolled, pre, post and follow-up evaluation of the Understanding Your Child's Behaviour (UYCB) group: A parenting group intervention based on the Solihull Approach**

**Background.** Given the link between parenting and child behaviour (Farrington et al., 2007), parenting programmes have been developed which utilize the impact parent behaviour has on child behaviour. Understanding Your Child's Behaviour (UYCB) is a parenting programme based on the Solihull Approach which was developed by Douglas (2007). The Solihull Approach is based on the principle that if a parent feels contained this will positively impact on their own feelings of anxiety and, in turn, "free them up" to think about their child's behaviour and what their child is trying to communicate to them. As a result, parents should be more able to effectively and sensitively manage their child's behaviour. A previous study of UYCB was undertaken by Batson et al. (2008) and this study showed that attending an UYCB group could lead to positive improvements in child behaviour and parents' own feelings of well-being.

**Aim.** The current study aimed to build on the previous study by Batson et al. (2008) to see whether attending an UYCB programme had a positive impact on child behaviour and parents' own feelings of well-being, as well as the relationship between parent and child. The study also aimed to follow-up parents three months after they had finished the group to see whether any positive effects of attending the group were maintained over time.

**Method.** Parents were asked to complete questionnaires about their child's behaviour (Strengths and Difficulties Questionnaire), their own feelings of well-being (Depression, Anxiety and Stress Scale) and their relationship with their child (Child-Parent Relationship Scale). Parents were asked to complete these questionnaires at the start of the group programme and then again immediately after they had completed the programme. They were also sent the same questionnaires to complete and return three months after the programme had finished.

**Findings.** 160 parents completed questionnaires at the start of the group, 119 at the end of the group and 35 three months later. The results showed that immediately after finishing the group parents reported improvements in their child's behaviour, their own feelings of well-being, and their relationship with their child. Similar findings were reported for those parents who completed questionnaires three months after the group had finished, which suggested that they found the group to be helpful for some months after the group had finished.

**Conclusions.** The results showed that parents found attending an UYCB group programme helped improve their child's behaviour, their own feelings of well-being, and their relationship with their child. Three months after the group had finished, parents still reported these improvements which suggests that attending an UYCB group is helpful in both the short and longer-term.

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## Appendix A: Effective Public Health Practice Project (EPHPP) Quality Assessment Tool

### QUALITY ASSESSMENT TOOL FOR QUANTITATIVE STUDIES



#### COMPONENT RATINGS

##### A) SELECTION BIAS

(Q1) Are the individuals selected to participate in the study likely to be representative of the target population?

- 1 Very likely
- 2 Somewhat likely
- 3 Not likely
- 4 Can't tell

(Q2) What percentage of selected individuals agreed to participate?

- 1 80 - 100% agreement
- 2 60 - 79% agreement
- 3 less than 60% agreement
- 4 Not applicable
- 5 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

##### B) STUDY DESIGN

Indicate the study design

- 1 Randomized controlled trial
- 2 Controlled clinical trial
- 3 Cohort analytic (two group pre + post)
- 4 Case-control
- 5 Cohort (one group pre + post (before and after))
- 6 Interrupted time series
- 7 Other specify \_\_\_\_\_
- 8 Can't tell

Was the study described as randomized? If NO, go to Component C.

No Yes

If Yes, was the method of randomization described? (See dictionary)

No Yes

If Yes, was the method appropriate? (See dictionary)

No Yes

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

### C) CONFOUNDERS

(Q1) Were there important differences between groups prior to the intervention?

- 1 Yes
- 2 No
- 3 Can't tell

The following are examples of confounders:

- 1 Race
- 2 Sex
- 3 Marital status/family
- 4 Age
- 5 SES (income or class)
- 6 Education
- 7 Health status
- 8 Pre-intervention score on outcome measure

(Q2) If yes, indicate the percentage of relevant confounders that were controlled (either in the design (e.g. stratification, matching) or analysis)?

- 1 80 – 100% (most)
- 2 60 – 79% (some)
- 3 Less than 60% (few or none)
- 4 Can't Tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

### D) BLINDING

(Q1) Was (were) the outcome assessor(s) aware of the intervention or exposure status of participants?

- 1 Yes
- 2 No
- 3 Can't tell

(Q2) Were the study participants aware of the research question?

- 1 Yes
- 2 No
- 3 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

### E) DATA COLLECTION METHODS

(Q1) Were data collection tools shown to be valid?

- 1 Yes
- 2 No
- 3 Can't tell

(Q2) Were data collection tools shown to be reliable?

- 1 Yes
- 2 No
- 3 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

## F) WITHDRAWALS AND DROP-OUTS

(Q1) Were withdrawals and drop-outs reported in terms of numbers and/or reasons per group?

- 1 Yes
- 2 No
- 3 Can't tell
- 4 Not Applicable (i.e. one time surveys or interviews)

(Q2) Indicate the percentage of participants completing the study. (If the percentage differs by groups, record the lowest).

- 1 80 -100%
- 2 60 - 79%
- 3 less than 60%
- 4 Can't tell
- 5 Not Applicable (i.e. Retrospective case-control)

RATE THIS SECTION	STRONG	MODERATE	WEAK	
See dictionary	1	2	3	Not Applicable

## GLOBAL RATING

### COMPONENT RATINGS

Please transcribe the information from the gray boxes on pages 1-4 onto this page. See dictionary on how to rate this section.

A	SELECTION BIAS	STRONG	MODERATE	WEAK
		1	2	3
B	STUDY DESIGN	STRONG	MODERATE	WEAK
		1	2	3
C	CONFOUNDERS	STRONG	MODERATE	WEAK
		1	2	3
D	BLINDING	STRONG	MODERATE	WEAK
		1	2	3
E	DATA COLLECTION METHOD	STRONG	MODERATE	WEAK
		1	2	3
F	WITHDRAWALS AND DROPOUTS	STRONG	MODERATE	WEAK
		1	2	3
				Not Applicable

### GLOBAL RATING FOR THIS PAPER (circle one):

- |   |          |                            |
|---|----------|----------------------------|
| 1 | STRONG   | (no WEAK ratings)          |
| 2 | MODERATE | (one WEAK rating)          |
| 3 | WEAK     | (two or more WEAK ratings) |

## Appendix B: Outcome measures used in included studies

<i>Child outcomes</i>			
Measure	Concept measured	Type of measures	Studies used in
<b>Child Behaviour Checklist (CBCL)</b> (Achenbach, 1991)	Child behaviour	Parent report	Webster-Stratton, Hollinsworth & Kolpacoff (1989); Webster-Stratton (1990); Nixon et al. (2004); Drugli et al. (2010) <sup>1</sup> ; Huatmann et al, (2009); Drugli et al. (2010) <sup>2</sup> ; Halweg et al. (2010); Webster-Stratton, Rinaldi & Reid (2011); Posthumus et al. (2012)
<b>Eyberg Child Behaviour Inventory (ECBI)</b> (Eyberg, 1983)	Child behaviour	Parent report	Webster-Stratton, Hollinsworth & Kolpacoff (1989); Reid, Webster-Stratton & Hammond (2003); Nixon et al. (2004); Stewart-Brown et al. (2004); Garnder, Burton & Klimes (2006); Bywater et al. (2009); Drugli et al. (2010) <sup>1</sup> ; Drugli et al. (2010) <sup>2</sup> ; Reedtz, Handegard & Morch (2011); Webster-Stratton, Rinaldi & Reid (2011); Posthumus et al. (2012); Roberts et al. (2012)
<b>Preschool Behaviour Questionnaire (PBQ)</b> (Behar, 1974)	Child behaviour	Parent report	Webster-Stratton, Hollinsworth & Kolpacoff (1989); Webster-Stratton (1990); Bradley et al. (2003); Drugli et al. (2010) <sup>1</sup>



<b>Parent Daily Report (PDR)</b> (Patterson, Chamberlain & Reid, 1982)	Child behaviour	Parent report	Webster-Stratton, Hollinsworth & Kolpacoff (1989);
<b>Teacher Report Form (TRF)</b> (Achenbach, 1981)	Child behaviour	Teacher report	Webster-Stratton (1990)
<b>Preschool Characteristics Questionnaire (PCQ)</b> (Finegan, Niccols & Hood, 1989)	Child behaviour	Parent report	Bradley et al. (2003)
<b>Strengths and Difficulties Questionnaire (SDQ)</b> (Goodman, 2005)	Child behaviour	Parent/teacher report	Stewart-Brown et al. (2004); Scott (2005); Bywater et al. (2009)
<b>Parent Defined Problems Questionnaire (PDP)</b> (Scott, Spender et al., 2001)	Child Behaviour	Parent report	Scott (2005)
<b>Parent Account of Child Symptoms (PACS)</b> (Taylor et al., 1996)	Child behaviour	Parent report	Scott (2005)
<b>Teacher Assessment of Social Behaviour (TASB)</b> (Lain, 2004)	Child behaviour	Teacher report	Reid, Webster-Stratton & Hammond (2003)
<b>Caregiver Teacher Report Form (C-TRF)</b> (Achenbach, 2000)	Child behaviour	Teacher report	Halweg et al. (2010)
<b>Social Behaviour Questionnaire (SBQ)</b> (Bildt, 2009)	Child behaviour	Teacher/parent/child report	Malti, Ribeaud & Eisner (2011)
<b>Substance Use and Sexual Activity (SUASA)</b> (Oregon Social Learning Centre, 1984)	Adolescent behaviour	Self report	Webster-Stratton, Rinaldi & Reid (2011)
<b>Self-Control Rating Scale</b>	Child behaviour	Parent report	Bywater et al. (2009)

<b>(SCRS)</b> (Rohrbeck, 1991)			
<b>Conners Abbreviated Parent Rating Scale (CAPRS)</b> (Conners, 1998)	Child behaviour	Parent report	Bywater et al. (2009)
<b>Child Depression Inventory (CDI)</b> (Kovacs, 1981)	Depression in children	Self report	Webster-Stratton, Rinaldi & Reid (2011)
<b>Self-Perception Profile for Adolescents (SPP-A)</b> (Harter, 1988)	Self-esteem	Self report	Webster-Stratton, Rinaldi & Reid (2011)
<b>Elliot Delinquency Scale (EDS)</b> (Elliott, 1983)	Delinquency in adolescents	Self report	Webster-Stratton, Rinaldi & Reid (2011)
<b>Symptom Checklist Attention-Deficit/Hyperactivity Disorder (SCL-ADHD)</b> (Dopfner et al., 2008)	Screening tool for ADHD	Parent report	Hautmann et al. (2009)
<b>Symptom Checklist Disruptive Behaviour Disorder (SCL-DBD)</b> (Dopfner et al., 2008)	Screening tool for ODD/CD	Parent report	Hautmann et al. (2009)
<i>Parent outcomes</i>			
<b>Parenting Practices Inventory (PPI)</b> Webster-Stratton, Reid & Hammond (2001)	Parenting style	Self report	Reid, Webster-Stratton & Hammond (2003); Drugli et al. (2010) <sup>1</sup> ; Drugli et al. (2010) <sup>2</sup> ; Reedtz, Handegard & Mørch (2011); Posthumus et al. (2012)
<b>Beck Depression Inventory (BDI)</b> (Beck, 1988)	Parental depression	Self-report	Webster-Stratton (1990); Reid, Webster-Stratton & Hammond (2003); Nixon et al. (2004); Gardner, Burton & Klimes (2006); Bywater et

			al. (2009); Drugli et al. (2010) <sup>1</sup> ; Drugli et al. (2010) <sup>2</sup>
<b>Parenting Scale (PS)</b> (Arnold et al., 1993)	Parenting style	Self report	Bradley et al. (2003); Nixon et al. (2004); Gardner, Burton & Klimes (2006) Bywater et al. (2009); Halweg et al. (2010)
<b>General Health Questionnaire (GHQ)</b> (Goldberg & Williams, 1988)	Psychological well-being	Self report	Stewart-Brown et al. (2004); Roberts et al. (2012)
<b>Parenting Sense of Competence Scale (PSOC)</b> (Gibaud-Wallston & Wandersman, 1978)	Parenting competency	Self report	Gardner, Burton & Klimes (2006); Reedtz, Handegard & Mørch (2011)
<b>Self-Efficacy Scale (SEFS)</b> (adapted from Johnson & Marsh, 1989)	Parent self-efficacy	Self report	Hautmann et al. (2009)
<b>Problem Setting and Behaviour Checklist (PSBC)</b> (Sanders et al., 2000)	Parenting skills	Self report	Hautmann et al. (2009)
<i>Parent &amp; Child Outcomes</i>			
<b>Parent-Child Interaction Task</b> (McMahon & Estes, 1993)	Parent-child interaction	Observation	Halweg et al. (2010)
<b>Conflict Behaviour Questionnaire (CBQ)</b> (Robin & Foster, 1989)	Parent-child relationship	Child and/or parent report	Long et al. (1994)
<b>Coder Impressions Inventory (CII)</b> (Capaldi & Patterson, 1989)	Parent-child interaction	Observation	Reid, Webster-Stratton & Hammond (2003)

## **Appendix C: Fidelity Checklist**

### **UYCB Group Facilitator Session-by-Session Checklist**

Please take a few moments at the end of each group session to complete the following checklists.

#### **Session one**

On a scale of 0-5 (with 0 being 'not easy at all' and 5 being 'very easy') please circle how easy you found it to cover the below objectives for today's session:

**1. Help parents develop a common agenda**

0      1      2      3      4      5

**2. Explain the role of facilitators**

0      1      2      3      4      5

**3. Orient the group so they know what to expect both in terms of what will happen and how the group will run and begin to develop a group identity**

0      1      2      3      4      5

**4. Begin to create an environment in which the group can gain a sense of feeling contained and start to feel safe to think about what they want to learn/change**

0      1      2      3      4      5

**5. Reflect upon the group process with regard to the ideas of containment, reciprocity and behaviour management**

0      1      2      3      4      5

### **Session two**

On a scale of 0-5 (with 0 being 'not easy at all' and 5 being 'very easy') please circle how easy you found it to cover the below objectives for today's session:

- 1.      Emphasise that feelings are important and to be aware of unhelpful contrary views that may be expressed**

**0          1          2          3          4          5**

- 2.      Establish in parents the idea that it is important to think about what their child might be feeling**

**0          1          2          3          4          5**

- 3.      Highlight the importance of our feelings in shaping our behaviour both as adults and children**

**0          1          2          3          4          5**

- 4.      Emphasise the benefits of experiencing good emotional containment from others**

**0          1          2          3          4          5**

### **Session three**

On a scale of 0-5 (with 0 being 'not easy at all' and 5 being 'very easy') please circle how easy you found it to cover the below objectives for today's session:

- 1.      Emphasise the link between behaviour and development**

**0          1          2          3          4          5**

- 2. Encourage parents to think about their child's behaviour in terms of 'attempts at learning'**

**0      1      2      3      4      5**

- 3. Be aware that the issue of 'learning' may be a sensitive one, particularly for parents who remember bad experiences of education**

**0      1      2      3      4      5**

**Session four**

On a scale of 0-5 (with 0 being 'not easy at all' and 5 being 'very easy') please circle how easy you found it to cover the below objectives for today's session:

- 1. Help parents think about their own experiences as a way of enhancing reciprocity with their child**

**0      1      2      3      4      5**

- 2. Acknowledge parents' feelings in order to provide a model of emotional containment**

**0      1      2      3      4      5**

- 3. Help parents remember to keep a space in their mind for how their child feels and expresses those feelings**

**0      1      2      3      4      5**

- 4. Help parents identify that the way in which they respond to a child's feelings will affect the way they behave**

**0      1      2      3      4      5**

### **Session five**

On a scale of 0-5 (with 0 being 'not easy at all' and 5 being 'very easy') please circle how easy you found it to cover the below objectives for today's session:

- 1. Acknowledge and attempt to put into words the difficult feelings that may arise**

**0      1      2      3      4      5**

- 2. Protect group participants from disclosing too much personal information which might leave them feeling vulnerable, exposed or ashamed**

**0      1      2      3      4      5**

- 3. Help parents to stay focused on parenting as a role without the need to over personalise or demonise their parents, grandparents, other parents or themselves**

**0      1      2      3      4      5**

- 4. Emphasise the passive nature of intergenerational transmission of parenting styles and the role of insight in preventing transmission of less positive experiences to the next generation**

**0      1      2      3      4      5**

- 5. Neither idealise or demonise a particular style**

**0      1      2      3      4      5**

**6. Recognise where parents have already made a big effort to change the way they parent due to their own poor experience**

**0      1      2      3      4      5**

**7. Give hope that things can be changed through understanding and insight**

**0      1      2      3      4      5**

### **Session six**

On a scale of 0-5 (with 0 being 'not easy at all' and 5 being 'very easy') please circle how easy you found it to cover the below objectives for today's session:

**1. Guide parents safely through an experience of playing**

**0      1      2      3      4      5**

**2. Retain a focus on what children of different ages need from play**

**0      1      2      3      4      5**

**3. Provide containment for any strong feelings in parents about the idea of play and spending time with their child**

**0      1      2      3      4      5**

### **Session seven**

On a scale of 0-5 (with 0 being 'not easy at all' and 5 being 'very easy') please circle how easy you found it to cover the below objectives for today's session:

**1. Emphasise the Dance of Reciprocity as the blueprint which babies learn for future interactions**

**0      1      2      3      4      5**



**2. Help parents think about example of the Dance between parents and children and recognise the steps in the Dance in everyday situations**

**0      1      2      3      4      5**

**3. Convey the idea that the Dance is one of several ways in which parents can get to know their unique child and how that child communicates**

**0      1      2      3      4      5**

**4. Get parents to think about how they can help their children calm down for sleep**

**0      1      2      3      4      5**

**5. Contain the feelings of parents to help them stay in touch with their child's perspective**

**0      1      2      3      4      5**

### **Session eight**

On a scale of 0-5 (with 0 being 'not easy at all' and 5 being 'very easy') please circle how easy you found it to cover the below objectives for today's session:

**1. Link the rhythm of interactions with further examples of self-regulation such as anger and tantrums**

**0      1      2      3      4      5**

**2. Acknowledge any cultural issues around anger**

**0      1      2      3      4      5**

**3. Further explore the Dance of Reciprocity and its relevance for self-regulation**

**0      1      2      3      4      5**

**4. Contain the feelings of parents to help them to stay in touch with their child's perspective**

**0      1      2      3      4      5**

### **Session nine**

On a scale of 0-5 (with 0 being 'not easy at all' and 5 being 'very easy') please circle how easy you found it to cover the below objectives for today's session:

**1. Clarify the different ways in which the Dance of Reciprocity can end- the look away/withdrawal step versus falling out of tune**

**0      1      2      3      4      5**

**2. Help parents to recognise a rupture in the Dance and think about how they can repair the situation**

**0      1      2      3      4      5**

**3. Help parents to think about these ideas in relation to situations in their everyday lives**

**0      1      2      3      4      5**

**4. Help parents to understand that by repairing a situation they are laying down the foundation for their children to learn how to do the same**

**0      1      2      3      4      5**

**5. Be aware of, and acknowledge, any feelings parents may be trying to communicate about the impending end of the group**

**0      1      2      3      4      5**

**Session ten**

On a scale of 0-5 (with 0 being 'not easy at all' and 5 being 'very easy') please circle how easy you found it to cover the below objectives for today's session:

**1. Run the session to allow sufficient time for goodbyes**

**0      1      2      3      4      5**

**2. Help parents to acknowledge their feelings about the ending of the group**

**0      1      2      3      4      5**

**3. Acknowledge their own feelings about the ending of the group**

**0      1      2      3      4      5**

**4. Offer parents time to reflect on their learning from the group, and to think about future support and the way forward**

**0      1      2      3      4      5**

**An Evaluation of Understanding Your Child's Behaviour Parenting Groups**



**Information Sheet**

Dear Parent/Guardian

You are being invited to take part in a research study. Before you decide whether you would like to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. This information sheet is for you to keep.

**Who is undertaking the research?**

The research is being undertaken by a research team at the University of Birmingham in collaboration with the CAMHS teams in Solihull and Walsall. The team includes:

Rebecca Smith- Trainee Clinical Psychologist, University of Birmingham (Chief Investigator)

Dr Gary Law-Senior Academic Tutor/Lecturer, University of Birmingham (Research Supervisor)

Dr Rebecca Johnson-Clinical Psychologist/Parenting Lead, Solihull CAMHS (Research Supervisor)

**What is the purpose of the research?**

The aim of the research is to evaluate how helpful the Understanding Your Child's Behaviour Group is for parents. We want to be able to deliver the best quality group to parents so we are trying to find out whether the strategies parents learn in the group are useful.

**Do I have to take part?**

No, you do not have to take part in the research and if you decide not to take part in the research this will not affect your place in the group or any other support you may be receiving from services.

**What will happen if I decide to take part in the research?**

When you started the parenting group course you completed a number of questionnaires. You are also being asked to complete the same questionnaires now that you have finished the group programme to see whether you have found the group helpful. If you decide to take part in the research you will be agreeing to the data from your completed questionnaires to be included in the research. You will also be sent another questionnaire pack by post in three months time to complete and return. By completing the questionnaires at these three different time points it will help us to show the usefulness of the parenting strategies you have learnt in the group over time.

### **What are the possible benefits of taking part?**

By taking part in the research you are helping us to make sure that we are delivering the best possible parenting group to parents and that the strategies learnt in the group are helpful. This will ensure us to continue to be able to deliver the best possible groups to parents.

As a way of saying thank you for helping with the research each parent who completes the questionnaire packs at all time points will be entered into a raffle with the chance of winning one of the following priced vouchers:

1<sup>st</sup> prize-£50 high street shopping voucher

2<sup>nd</sup> prize-£20 high street shopping voucher

3<sup>rd</sup> prize-£10 high street shopping voucher

### **What are the possible disadvantages and risks of taking part?**

Completing questionnaire packs can be time consuming however we have tried hard to balance the amount of questionnaires we are asking parents to complete with making sure that we gather enough information to be able to accurately tell us whether the Understanding Your Child's Behaviour Group is helpful for parents.

It is important to note that if we are worried about any of your answers on the questionnaires and think you may benefit from additional support a member of the team will contact you within two weeks of you completing the questionnaires to discuss this with you.

### **Will my taking part in this study be kept confidential?**

You have the right to withdraw from this research study up until 1<sup>st</sup> April 2013 without giving a reason. Please contact your group leader or the chief investigator (Rebecca Smith) directly if you do wish to withdraw from the study.

We will make sure that parents cannot be identified or recognised from the information we include in the write-up of the research. Any information provided will be stored in a secure place and will be destroyed once the study has been completed.

### **What will happen to the results of the research study?**

The results from the study will be written up and published so that we can share the findings from the study. A summary of the findings from the research will also be given to everyone who took part in the research.

### **Contact for further information**

If you would like any further information on this research please speak to your group facilitator or contact a member of the research team:

**Rebecca Smith**- Trainee Clinical Psychologist, University of Birmingham (Chief Investigator)

Email: [REDACTED]

Tel: [REDACTED]

**Dr Gary Law**-Senior Academic Tutor/Lecturer, University of Birmingham (Research Supervisor)

Email: [REDACTED]

Tel: [REDACTED]

**Dr Rebecca Johnson**-Clinical Psychologist/Parenting Lead, Solihull CAMHS (Research Supervisor)

Email: [REDACTED]

Tel: [REDACTED]

**Appendix E: Consent Form**

UNIVERSITY OF  
BIRMINGHAM

**Consent form**

Title of Project: **An Evaluation of Understanding Your Child's  
Behaviour: A Parenting Group based on the Solihull Approach.**

Chief Investigator: **Rebecca Smith**



**Consent to participate**

**I confirm that I have read and understood the Participant Information Sheet for the  
above study and have had the opportunity to ask questions and have these satisfactorily  
answered.**

☐

**I understand that the questionnaires I complete will be stored securely and no  
identifiable information will be included in the final write-up of the research.**

☐

**I understand that my medical notes and data collected in the study may be looked  
at by regulatory authorities and by individuals from the Trust and from the University  
Research Team where it is relevant to my taking part in this research. I give permission  
for these individuals to have access to this information.**

☐

**I understand that taking part in the study is voluntary and that I can request  
to withdraw from the study up until 1<sup>st</sup> April 2013 without giving reason and that this  
will not affect any support I may be receiving from services.**

☐

**I agree to participate in the above study.**

☐

Please print your name here.....

Please sign your name here.....

Date.....

## Appendix F: Pre-course Questionnaire Booklet

Location	Facilitator/s	Participant Number	Date Received
----------	---------------	--------------------	---------------

The above boxes are for official use only. Please do NOT complete.



### Understanding Your Child's Behaviour Group Pre-course Questionnaire Booklet

Dear Parent/Grandparent/Carer,

To help us evaluate the Understanding Your Child's Behaviour Group we would appreciate it if you could answer the following questionnaires.

Please answer ALL of the questions as best you can, even if you feel that the question is not applicable or the question seems daft!

When answering the questions please hold ONE child in mind.

Once completed please place this booklet back in the envelope, seal it and return to your group facilitator/s.

Thank you very much for your time. We hope you enjoy your group.

Your Name ..... Child's d.o.b.....

Signature ..... Today's date .....





## Strengths and Difficulties Questionnaire

For each question, please mark the box for Not True, Somewhat True or Certainly True.

**Please give your answers on the basis of the child's behaviour over the last six months**

<b>My child is:</b>	<b>Not True</b>	<b>Somewhat True</b>	<b>Certainly True</b>
Considerate of other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless, overactive, cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often complains of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shares readily with other children (treats, toys, pencils etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often has temper tantrums or hot tempers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rather solitary, tends to play alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many worries, often seems worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other children or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, down-hearted or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally liked by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous or clingy in new situations, easily loses confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picked on or bullied by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often volunteers to help others (parents, teachers, other children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can stop and think things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets on better with adults than with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sees tasks through to the end, good attention span	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>PLEASE ONLY COMPLETE THIS NEXT SECTION IF YOUR CHILD IS 3 YEARS OR YOUNGER</b>			
Often argumentative with adults	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can be spiteful to others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>PLEASE ONLY COMPLETE THIS NEXT SECTION IF YOUR CHILD IS 4 YEARS OR OLDER</b>			
Generally obedient, usually does what adults request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often lies or cheats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steals from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No	Yes- minor difficulties	Yes- definite difficulties	Yes- severe difficulties
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered "Yes", please answer the following question about these difficulties:

- How long have these difficulties been present?

Less than a month	1 – 5 months	6 – 12 months	Over a year
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Do the difficulties upset or distress your child?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
Homelife	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friendships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Classroom Learning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leisure Activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

# DASS<sub>21</sub>

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

*The rating scale is as follows:*

- 0 Did not apply to me at all
- 1 Applied to me to some degree, or some of the time
- 2 Applied to me to a considerable degree, or a good part of time
- 3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (eg, in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3

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## Child-Parent Relationship Scale

Please reflect on the degree to which each of the following statements currently applies to your relationship with your child. Using the scale below, circle the appropriate number for each item.

Definitely does not apply 1	Not really 2	Neutral, not sure 3	Applies somewhat 4	Definitely applies 5
-----------------------------------	--------------------	---------------------------	--------------------------	-------------------------

1. I share an affectionate, warm relationship with my child.	1	2	3	4	5
2. My child and I always seem to be struggling with each other.	1	2	3	4	5
3. If upset, my child will seek comfort from me.	1	2	3	4	5
4. My child is uncomfortable with physical affection or touch from me.	1	2	3	4	5
5. My child values his/her relationship with me.	1	2	3	4	5
6. When I praise my child, he/she beams with pride.	1	2	3	4	5
7. My child spontaneously shares information about himself/herself.	1	2	3	4	5
8. My child easily becomes angry at me.	1	2	3	4	5
9. It is easy to be in tune with what my child is feeling.	1	2	3	4	5
10. My child remains angry or is resistant after being disciplined.	1	2	3	4	5
11. Dealing with my child drains my energy.	1	2	3	4	5
12. When my child is in a bad mood, I know we're in for a long and difficult day.	1	2	3	4	5
13. My child's feelings toward me can be unpredictable or can change suddenly.	1	2	3	4	5
14. My child is sneaky or manipulative with me.	1	2	3	4	5
15. My child openly shares his/her feelings and experiences with me.	1	2	3	4	5

## Appendix G: Post-course Questionnaire Booklet

Location	Facilitator/s	Participant Number	Date Received
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The above boxes are for official use only. Please do NOT complete.



### Understanding Your Child's Behaviour Group Post-course Questionnaire Booklet

Dear Parent/Grandparent/Carer,

Thank you for completing the questionnaire booklet at the start of the course. This booklet contains the same questionnaires, as well as a feedback form to tell us whether you found the group helpful.

Please answer ALL of the questions as best you can, even if the question does not seem applicable or the question seems daft!

Please hold the same child in mind as you did when you completed the questionnaires at the start of the course.

Once completed please place this booklet back in the envelope, seal it and return to your group facilitator/s.

Thank you very much for your time. We hope you enjoyed your group.

Your Name ..... Child's d.o.b.....

Signature ..... Today's date .....



## **Strengths and Difficulties Questionnaire**

For each question, please mark the box for Not True, Somewhat True or Certainly True.

**Please give your answers on the basis of the child's behaviour over the last six months**

<b>My child is:</b>	<b>Not True</b>	<b>Somewhat True</b>	<b>Certainly True</b>
Considerate of other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless, overactive, cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often complains of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shares readily with other children (treats, toys, pencils etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often has temper tantrums or hot tempers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rather solitary, tends to play alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many worries, often seems worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other children or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, down-hearted or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally liked by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous or clingy in new situations, easily loses confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picked on or bullied by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often volunteers to help others (parents, teachers, other children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can stop and think things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets on better with adults than with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sees tasks through to the end, good attention span	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>PLEASE ONLY COMPLETE THIS NEXT SECTION IF YOUR CHILD IS 3 YEARS OR YOUNGER</b>			
Often argumentative with adults	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can be spiteful to others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>PLEASE ONLY COMPLETE THIS NEXT SECTION IF YOUR CHILD IS 4 YEARS OR OLDER</b>			
Generally obedient, usually does what adults request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often lies or cheats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steals from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Since coming to the parenting group, are you child's problems:

Much worse	A bit worse	About the same	A bit better	A lot better
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Has coming to the group been helpful in other ways, e.g. providing information or making the problem more bearable?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Over the last month, has your child had difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No	Yes-minor difficulties	Yes-definite difficulties	Yes-severe difficulties
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered "Yes", please answer the following questions about these difficulties:

- Do the difficulties upset or distress your child?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
Homelife	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friendships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Classroom Learning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leisure Activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

# DASS<sub>21</sub>

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

*The rating scale is as follows:*

- 0 Did not apply to me at all
- 1 Applied to me to some degree, or some of the time
- 2 Applied to me to a considerable degree, or a good part of time
- 3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (eg, in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3

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## Child-Parent Relationship Scale

Please reflect on the degree to which each of the following statements currently applies to your relationship with your child. Using the scale below, circle the appropriate number for each item.

Definitely does not apply 1	Not really 2	Neutral, not sure 3	Applies somewhat 4	Definitely applies 5
-----------------------------------	--------------------	---------------------------	--------------------------	-------------------------

1. I share an affectionate, warm relationship with my child.	1	2	3	4	5
2. My child and I always seem to be struggling with each other.	1	2	3	4	5
3. If upset, my child will seek comfort from me.	1	2	3	4	5
4. My child is uncomfortable with physical affection or touch from me.	1	2	3	4	5
5. My child values his/her relationship with me.	1	2	3	4	5
6. When I praise my child, he/she beams with pride.	1	2	3	4	5
7. My child spontaneously shares information about himself/herself.	1	2	3	4	5
8. My child easily becomes angry at me.	1	2	3	4	5
9. It is easy to be in tune with what my child is feeling.	1	2	3	4	5
10. My child remains angry or is resistant after being disciplined.	1	2	3	4	5
11. Dealing with my child drains my energy.	1	2	3	4	5
12. When my child is in a bad mood, I know we're in for a long and difficult day.	1	2	3	4	5
13. My child's feelings toward me can be unpredictable or can change suddenly.	1	2	3	4	5
14. My child is sneaky or manipulative with me.	1	2	3	4	5
15. My child openly shares his/her feelings and experiences with me.	1	2	3	4	5

## Appendix H: Follow-up Questionnaire Booklet

Location	Facilitator/s	Participant	Date Received

The above boxes are for official use only. Please do NOT complete.



### Understanding Your Child's Behaviour Group Follow-up Questionnaire Booklet

Dear Parent/Grandparent/Carer,

Thank you for completing the questionnaire booklet at the start and end of the course. This booklet contains the same questionnaires.

Please answer ALL of questions as best you can, even if the question does not seem applicable or the question seems daft!

Please hold the same child in mind as you did when you completed the questionnaires at the start and end of the course.

Once completed please return the booklet in the stamped addressed envelope provided.

As a way of saying thank you for helping with the research everyone who completes and returns the questionnaire pack will be entered into a raffle with the chance of winning one of the following priced vouchers:

- 1<sup>st</sup> prize- £50 high street shopping voucher
- 2<sup>nd</sup> prize- £20 high street shopping voucher
- 3<sup>rd</sup> prize- £10 high street shopping voucher

We will contact winners by post so please remember to include your name below.

Thank you very much for your time.

Your Name ..... Child's d.o.b.....

Signature ..... Today's date .....



## **Strengths and Difficulties Questionnaire**

For each question, please mark the box for Not True, Somewhat True or Certainly True.

**Please give your answers on the basis of the child's behaviour over the last six months**

<b>My child is:</b>	<b>Not True</b>	<b>Somewhat True</b>	<b>Certainly True</b>
Considerate of other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless, overactive, cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often complains of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shares readily with other children (treats, toys, pencils etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often has temper tantrums or hot tempers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rather solitary, tends to play alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many worries, often seems worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other children or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, down-hearted or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally liked by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous or clingy in new situations, easily loses confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picked on or bullied by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often volunteers to help others (parents, teachers, other children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can stop and think things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets on better with adults than with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sees tasks through to the end, good attention span	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PLEASE ONLY COMPLETE THIS NEXT SECTION IF YOUR CHILD IS 3 YEARS OR YOUNGER**

Often argumentative with adults	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can be spiteful to others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PLEASE ONLY COMPLETE THIS NEXT SECTION IF YOUR CHILD IS 4 YEARS OR OLDER**

Generally obedient, usually does what adults request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often lies or cheats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steals from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Since coming to the parenting group, are you child's problems:

Much worse	A bit worse	About the same	A bit better	A lot better
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Has coming to the group been helpful in other ways, e.g. providing information or making the problem more bearable?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Over the last month, has your child had difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No	Yes-minor difficulties	Yes-definite difficulties	Yes-severe difficulties
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered "Yes", please answer the following questions about these difficulties:

- Do the difficulties upset or distress your child?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
Homelife	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friendships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Classroom Learning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leisure Activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

# DASS<sub>21</sub>

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

*The rating scale is as follows:*

- 0 Did not apply to me at all
- 1 Applied to me to some degree, or some of the time
- 2 Applied to me to a considerable degree, or a good part of time
- 3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (eg, in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3

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## Child-Parent Relationship Scale

Please reflect on the degree to which each of the following statements currently applies to your relationship with your child. Using the scale below, circle the appropriate number for each item.

Definitely does not apply 1	Not really 2	Neutral, not sure 3	Applies somewhat 4	Definitely applies 5
-----------------------------------	--------------------	---------------------------	--------------------------	-------------------------

1. I share an affectionate, warm relationship with my child.	1	2	3	4	5
2. My child and I always seem to be struggling with each other.	1	2	3	4	5
3. If upset, my child will seek comfort from me.	1	2	3	4	5
4. My child is uncomfortable with physical affection or touch from me.	1	2	3	4	5
5. My child values his/her relationship with me.	1	2	3	4	5
6. When I praise my child, he/she beams with pride.	1	2	3	4	5
7. My child spontaneously shares information about himself/herself.	1	2	3	4	5
8. My child easily becomes angry at me.	1	2	3	4	5
9. It is easy to be in tune with what my child is feeling.	1	2	3	4	5
10. My child remains angry or is resistant after being disciplined.	1	2	3	4	5
11. Dealing with my child drains my energy.	1	2	3	4	5
12. When my child is in a bad mood, I know we're in for a long and difficult day.	1	2	3	4	5
13. My child's feelings toward me can be unpredictable or can change suddenly.	1	2	3	4	5
14. My child is sneaky or manipulative with me.	1	2	3	4	5
15. My child openly shares his/her feelings and experiences with me.	1	2	3	4	5

## Appendix L: Participant Demographic Form



### Understanding Your Child's Behaviour Parent record form

<b>NAME OF PARENT:</b>					
<b>ADDRESS:</b>					
<b>TELEPHONE NO:</b>					
<b>EMAIL ADDRESS:</b>					

<b>PARENT INFORMATION - PLEASE CIRCLE THE RELEVANT ANSWER TO EACH QUESTION:</b>						
<b>Are you:</b>	PARENT/STEP-PARENT		ADOPTIVE PARENT		GRANDPARENT	
<b>What is your age range?</b>	Under 20	20-29	30-39	40-49	50+	
<b>Gender:</b>	MALE			FEMALE		
<b>How would you describe your ethnicity: (please circle as appropriate)</b>	WHITE	BRITISH	IRISH	OTHER		
	MIXED	CARIBBEAN	WHITE & BLACK AFRICAN	WHITE & ASIAN	OTHER	
	ASIAN OR ASIAN BRITISH	INDIAN	PAKISTANI	BANGLADESHI	OTHER	
	BLACK OR BLACK BRITISH	CARIBBEAN	AFRICAN	OTHER		
	CHINESE OR OTHER ETHNIC GROUP	CHINESE	OTHER			
<b>Is English your first language?</b>	YES			NO		
➤ If not, please confirm what your first language is:						
<b>Do you have a long term illness, health issue, disability or additional need?</b>	YES			NO		
➤ If yes, please provide details:						
<b>What is your employment status? (please tick the relevant box)</b>	Employed full time (31+ hours per week)				<input type="checkbox"/>	
In training	<input type="checkbox"/>	Employed part or full time (16-30 hrs p/week)				<input type="checkbox"/>
In education	<input type="checkbox"/>	Unemployed				<input type="checkbox"/>

<b>FAMILY INFORMATION - PLEASE CIRCLE THE RELEVANT ANSWER TO EACH QUESTION:</b>								
<b>Do you consider yourself to be a lone parent?</b>					YES		NO	
<b>How many children of each gender do you have of the following ages:</b>								
	0 – 2	3 – 5	6 – 7	8 – 10	11 – 13	14 – 16	17 – 19	19+
MALE								
FEMALE								
<b>Do any of your children have a long term illness, health issue, disability or additional need?</b>							YES	NO
If yes, please provide details:								
<b>Please provide details of any other agencies involved with your family – psychologist, social worker, etc:</b>								
<b>If you would like to join the Parents' Network and receive regular information about local activities and events, and agree for the above personal details to be passed to the Family Information Service please tick this box to give your permission:</b>								
<b>Solihull Council or Heart of England NHS Foundation Trust may wish to contact you in the future for research purposes – please tick here if you do not wish to be contacted:</b>								
<b>FOR OFFICE USE ONLY:</b>	GROUP VENUE ATTENDED:							
	GROUP DATE & TERM:							