BEHAVIOURAL COUNSELLING: A TREATMENT MODALITY FOR BEHAVIOURAL PROBLEMS IN CHILDREN

THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY

IN

PSYCHOLOGY

By

E.D.JOSEPH

DEPARTMENT OF PSYCHOLOGY

UNIVRSITY OF CALICUT

2005

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CALICUT UNIVERSITY-673635

CERTIFICATE

This is to certify that this thesis, Behavioural Counselling: A Treatment Modality for Behavioural Problems in Children is a record of bonafide study and research carried out by E.D.Joseph under my supervision and guidance. This thesis is submitted in partial fulfillment of the requirements for the degree of Ph.D. This report has not been submitted by him for any award of degree, diploma or title in this or any other university.

Supervisor

Dr.C.B.Asha 12-2005

Professor

Dept. of Psychology

University of Calicut.

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DECLARATION

I, E.D.Joseph, do hereby declare that Behavioural Counselling: A Treatment Modality for Behavioural Problems in Children, is an authentic record of research carried out by me in the Department of Psychology, University of Calicut, under the supervision of **Prof. Dr. C.B. Asha**, and that it has not been submitted part or full by me for any award of degree, diploma or title in this or any other university.

E.D.Joseph

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ACKNOWLEDGEMENT

With deep sense of gratitude I acknowledge and thank the Almighty God who has allowed me to complete this work successfully.

I gratefully acknowledge my guide Dr. C.B. Asha, Professor, Department of Psychology, University of Calicut for her valuable guidance, earnest encouragement and essential help she has rendered to me through out this work.

I am thankful to Dr. John Baby, Reader and Head of the Department of Psychology, University of Calicut for providing me all the departmental facilities and support for the completion of the study.

When mind is full words are few. I have no adequate words to express my heart full thanks to Dr. John Johnson, NIMHANS, Bangalore who has extended his boundless help to make this research work a reality.

I am much grateful to Dr.John Johnson's family including his wife Mrs. Dr. Shobhana, his sons Joel and Abel who have received me in their house and accommodated all the inconveniences for me and was a ceaseless encouragement to complete this work.

I am grateful to my wife and children who have been an endless source of support and help to complete this study.

I thank all my friends and well-wishers who have extended their timely help in different stages of this study and encouraged me to complete this work.

I express my special thanks to my clients – parents and children – who have participated in this study, without their cooperation this research study would not have been a reality.

15 December, 2005.

E.D.Joseph

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Discipline your son, and he will give you rest;
he will give delight to your heart.

THE BIBLE (Proverbs, 1, 8-9)

Hear, my son, your
father's instruction,
And reject not your mother's teaching;
For they are a fair garland for your head,
And pendant for your neck.

THE BIBLE (Proverbs, 29, 17)

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Chapter – I

INTRODUCTION

Like flowers and butterflies to a garden, children add flavor and bliss to family life. Giving birth and raising children, two universal functions of any family, are major responsibilities associated with parenting. Bringing up children provides happiness, meaning, direction and fulfillment of parental life. Though at times naughty and mischievous, childish behavior is often enjoyed by everyone. Frequently this enjoyment by others adversely reinforces the focal children to continue to behave in the same way or behave in more and more of similar ways. Thus, in order to get attention, they may continue such behavioral styles. When such behavioral styles get entrenched at the cost of appropriate and desired developmental tasks, problems in the behavior of children become a matter of grave concern to parents and significant others. Many a times the reasons for development of such unwarranted, inappropriate or undesirable behaviors range from the reinforcements that they receive, through the attention these behaviors get from the supposedly corrective measures adopted by the parents, to absence of appropriate models and consequences. According to Bandura (1962), behavioral problems among children are learned. Hence, unlearning the old ways and relearning desirable behavior is the focus of behaviorism. Parents, teachers and other significant adults besides peer group have a vital

role in the development as well as extinction of undesirable behaviors.

The problems created by children's troublesome behavior constitute one of the most serious sources of difficulty in our society. Children's problems may lead to dissatisfaction, to distress, or even to violence among family members. Behavioral problems are behaviors of children, which are perceived and judged by parents, teachers and others as problem behavior and are not 'normal'. Antisocial behavior, conduct disorders, attention deficit behavior and noncompliant behavior are commonly known as problem behavior. Children with such problem behavior are also likely to show academic deficiencies as reflected in achievement levels, grades, being left behind in school, early termination from school, and deficiencies in specific skill areas such as reading (Kazdin, 1997).

The definition of "behavior problem child" is complicated by numerous factors. There appears to be four primary complicating factors in defining this:

1. What is a behavior problem in one situation may not be so in a different situation. The definition of behavior problem must involve the setting in which the behavior occurs.

2. The personal opinion of the observer or judge such as the classroom teacher will influence the definition.

3. The theoretical orientation of the professional observer or judge will influence the definition.

4. There is little doubt that any definition of behavior problem child put forward by anyone is relative.

In general, the definition of behavior problem in the school context emphasizes the judgments of teachers. The following definition can be put forth:

"The behavior problem child is one who cannot or will not adjust to the socially acceptable norms for behavior consequently disrupts his own academic progress, the learning efforts of his classmates and interpersonal relations" (Kazdin, 1977).

Behavior generally described as 'out-of-control' of the parents include: aggressiveness toward others (hitting, kicking, fighting); physical destructiveness; disobedience to adult authorities; temper tantrums; high rate annoying behaviors (yelling, whining, high activity level, and threatening others); and to a lesser extent community rule violations such as stealing or fire setting (Peed, Forehand, & Roberts, 1977).

The emotional maladjustments of children frequently are characterized by anxiety reactions. They may include habit disorders such as nail biting, thumb sucking, bed wetting and temper tantrums. Conduct disorders such as extreme aggressiveness, lying, stealing, destructiveness, fighting, fire setting, cruelty, and running away from home are also characteristic of childhood emotional maladjustment. Behavior problems are exhibited through non compliancy, excessive crying, inability to eat, insomnia, fighting with others, stubborn behavior etc.

Unhealthy parent-child relationship may contribute to the disturbed behavior in children. Disruptive parental actions like alcoholism, hostility, cruelty, neglect, overprotection of the child, excessive

ambitions and expectations of the child are common factors that cause behavior disorder in children. The existence of neurotic, psychotic, or psychopathic conditions in the parents often contribute to a faulty parent-child relationship. The death or loss of a parent may also have a lasting effect on his emotional growth and behavioral characteristics. Faulty child-rearing practices of parents are also a contributing factor for behavior problems in children.

Behavior Modification Techniques with children have been applied to a diverse set of behaviors in the home, at school, and in the community, as well as traditional settings where treatment is provided such as outpatient clinics and institutions. The range of behaviors included in such programs has varied widely in the severity of problems they encompass. Many behaviors treated are those that emerge as part of normal development such as toileting and self care skills. More frequently, behavioral techniques have been applied to address problem behaviors at home and at school that involve noncompliance, aggressive behavior, and poor academic performance. In addition, techniques have been applied to many serious problems where the child may be institutionalized because of behavioral problems.

Historical beginning of behavior modification of child behavioral problems in the home.

The application of principles of operant and respondent conditioning to modify child behavior problems in the home goes back to the early years of the century. Kazdin (1978) has traced the development of the field from that time, citing early work in the conditioning of emotions by Jones, 1924, and other operant and respondent conditioning research with children. One important illustration is Mowrer's work in 1938 on a conditioning treatment for enuresis: a pad with a buzzer that awakens the child at the onset of urination.

Way back in 1959, Williams introduced the topic of parent's use of operant principles to alter their child's behavior. He trained the parents to ignore and thereby eliminate the child's temper tantrums at bedtime. In another classic work (Wahler, Winkel, Paterson and Morrison, 1965), mothers were trained to decrease the frequency of deviant behavior by not paying attention to them and by reinforcing competing responses.

Prior to 1965, most attempts to treat childhood behavior problems focused exclusively on the child. Approaches included out patient play therapy, and inpatient child therapy. Since the mid-1970s, however, there has been a shift in treatment philosophy for child conduct problems from an exclusive focus on the child to recognition of the primary social context in which the child lives – that is the family. As a result, parent training (PT) has become an integral part of services for many childhood disorders including autism and developmental disabilities (Schreibman, Kaneko, & Koegel, 1991).

In India, the research in the field of child mental health, however, has been slower. It was only around 1960s that interest was shown in pursing research in the area of child psychiatry as a result of funding made available by the Indian Council of Medical Research (ICMR). But somehow the development in the area of child mental health started losing ground after the mid-sixties (Prabhu, 1987). On reviewing the psychiatric research undertaken in India, one finds that child psychiatry has remained a largely neglected field. Most of the studies that have been done in this area confined to analysis of clinical data (Prabhu, 1980). Few studies have been done to obtain the prevalence estimates of problem behavior in the

general population (Sood & Misra, (1995). Studies on intervention strategies for child problem behavior are almost nil.

Families of behavior problem children are characterized by a high rate of "coercive" interaction among family members. Children engage in excessive rates of behavior aversive to parents (e.g. Noncompliance, physically aggressive behavior, and temper tantrums), and parents retaliate with equally excessive rates of aversive responses (e.g. Threatening commands and criticisms) designed to "turn off" their children's negative behavior (Patterson, 1976).

Parents might fail to model or reinforce more appropriate pro-social skills and may continue to respond to the child's coercive behavior. Researches have been focused on four major approaches for the treatment of behavior problems in children.

1. Reprogramming the social environment via parent behavioral training.
2. Use of token economies in the home.
3. Behavioral contracting.
4. Conflict resolution skills training.

More attention is given to reprogramming the social environment via parent behavior training. This approach often includes use of token economy or behavioral contracting as part of an overall program. Parent training involves the child's parents or caregivers as behavior change agents or as administrators of the treatment program in the home setting. Parent behavior and child behavior is modified at the same time (Wells & Forehand, 1981).

Excess and Deficit Behavior in Children.

An excess behavior occurs when a person shows a certain class of response too often, too intensely, or in too many stimulus contexts, such as a child's grabbing toys from peers, having tantrums at bed time, scratching his or her skin, lying, or stealing. It is considered excess because it occurs at a rate or an intensity that is maladaptive in that it is "costly" to the child or to others in the long run. The cost can be in terms of either lost reinforces or unnecessary punishers. The behavior may also be viewed as socially maladaptive in that it is atypical and thus may bring about undesirable social consequences (e.g. being teased or ostracized).

A deficit behavior occurs when a person shows a certain class of response at too seldom a rate, at too low an intensity, or in too few stimulus contexts, such as child's failing to learn to read, infrequent interacting with other children, failing to do home work, talking too quietly, or rarely expressing his or her wishes (i.e., being nonassertive). These are considered deficits only if they are maladaptive in the sense stated above (Morris & Hawkins, 1999).

Behavioral Counseling of Parents.

Counseling was geared toward teaching parents to modify their responses to the child in order to affect the child's subsequent behavior (Patterson, 1971). The stress was on the importance of learning theory in understanding parent-child behavior. Patterson (1971) had isolated two initial steps in the process.

1. Training parents to carefully observe and record the child's behavior; and
2. Training them to reinforce the child's behavior appropriately.

The common denominator, therefore, was teaching the principles of conditioning and their application in specific circumstances. Among the procedures explained to the parents were the operant procedures such as extinction of undesirable behavior by withdrawing attention, reinforcing competing behaviors, reprogramming the social environment, reinforcement contingencies, time-out and spending quality time with the child to increase warmth and affection in the family. Home observations of behavior were also stressed. They were taught behavioral contracting and conflict resolution skills training (Wells & Forehand, 1985).

Parental Skill Training.

Parental skill training program by Dishion & Andrews (1995) focuses on helping parents develop consistent, non-harsh methods of setting limits on children's behavior while increasing their positive reinforcement of appropriate social behavior. The specific parenting skills include (a) making neutral requests, (b) using rewards, (c) monitoring, (d) making rules, (e) providing reasonable consequences for rule violations, (f) problem solving, and (g)

active listening. As a result of the program, Dishion and Andrews found that parents and child negative behavior in problem solving interactions was significantly reduced and teacher ratings of the focal child improved on the Externalizing Scale of the Child behavior Check List by Achenbach (Dishion & Andrews, (1995).

Inadequate parental monitoring and discipline marked by high levels of coercive interaction predict the development of antisocial behavior both in childhood and adolescence (Irvine et al, 1999). Ary et al (1999) found that parent-child conflict, inadequate monitoring and poor family relationships contributed to the development of general problem behavior. Parental skills training programs for parents have been shown to bring about improvements in these parenting practices and to lead to reduction in childhood problem behaviors (Taylor & Biglan, 1998).

What particular behavioral skills are taught to families with problem children is a matter of concern. For increasing behavioral repertoires, basic behavioral procedures are taught. Providing clear verbal prompts, hierarchies of prompting, contingent reinforcement, and shaping continue to be common elements across parent training programs (Harrold, Lutzker, Campbell, &

Touchette, 1992. Moran & Whitman, 1991, Robbins & Dunlap, 1992, Sanders & Dadds, 1993). Basic procedures for reducing problem behaviors commonly include time out (Harrold et al., 1992; Sanders & Dadds, 1993), physical guidance (Robbins & Dunlap, 1992), extinction, physical restraint, and differential reinforcement (Moran & Whitman, 1991).

Which Family Members are taught? The majority of studies of behavioral training in intact families with problem children have focused on mothers as primary careers (Singer & Irvin, 1990). Some reports do not differentiate between parents (Kashima et al. 1988). Fathers have been taught successfully in generalized behavioral skills, and there is some evidence that fathers may learn skills incidentally through a modeling effect from a trained mother (Horton, 1984).

Characteristics of Families Who have Benefited most from Behavioral Training.

Reviews of parent behavioral training research have indicated that desired behavioral change in both parents and children is more likely when families have particular advantages (Frankel &

Simmons, 1992; Graziano & Diament, 1992; Friest & Forehand, 1982; Webster-Stratton & Hammond, 1990). Higher socioeconomic status, a wide range of social contact and support, absence of psychopathology (particularly depression and psychosis), membership of the ethnic majority, absence of negative life crises and environmental stress, and an intact family low on marital distress have been found to be predictors of success. Families without some of these advantages may drop out of training (Frankel & Simmons, 1992), or they may not access training that may be available, or they may complete training but may not benefit.

Theoretical and Ethical Rationale.

In a review Berkowitz et al (1972) discussed the theoretical, empirical and ethical rationales for the training of parents as behavior therapists for their own children. Thirty-four studies, ranging from single case studies to reports of large-scale, multi-family training programs were reviewed. They concluded that there is little doubt that behavioral techniques could be effectively applied to children's problem behaviors through the training of their parents.

There are several theoretical and practical arguments in support of the development and use of behavioral parent training. The application of the principles and procedures of behavioral parent training to children suggests that many of their behaviors are shaped and maintained by events in the natural environment i.e., at home, and therefore can best be changed by the modification of these events at home itself. Thus parents are trained in the effective use of such techniques as reinforcement and punishment to increase or decrease specific child responses (Sisson & Taylor, 1989). The basic principles are relatively simple and can be learned and applied by comparatively unsophisticated and uneducated persons (Feldman, Case, Rincover, Towns and betel, 1989).

The evolution and development of parent training had two major influences:

1. The theory of operant conditioning (Skinner, 1938): It serves as a foundation of the techniques used in parent training. Every such program utilizes basic behavioral techniques viz. reinforcement, punishment, time out, extinction, modeling etc.

2. Studies on parental disciplinary practices: Research over the past 30 years has demonstrated that inept disciplinary practices develop and exacerbate undesirable behaviors in the child.

It has been said that much of their phenomenology of behavioral disorders and personality deviations can be linked directly with motivations resulting from parents' attitudes towards their children. For example, parents of antisocial children have been found to be both power assertive and lax in their discipline (Dumas et al., 1995). They lack consistency in dealing with children and this inconsistency coupled with vague equivocal instructions tends to maintain and exacerbate antisocial behavior. Dumas (1989) further elaborates the behavioral perspective associated with understanding and managing childhood problems. He proposed that:

i. Human behavior is a function of the contingencies of reinforcements and punishments to which an individual is exposed in course of daily exchanges with the environment.

ii. Undesirable behaviors are learned and sustained through the reinforcements children receive from social agents, particularly parents.

iii. Therapy seeks to establish a shift in social contingencies.

iv. Maintenance and generalization of treatment relies on a process of positive reinforcement.

Empirical evidence regarding the above assumptions has come from studies of interact ional patterns in families of antisocial children. These studies have been based on both analog procedures and direct observations of family interactions (Wahler et al., 1990) and provide a strong rationale for the application of behavioral parent training in childhood behavioral problems.

Outcome Studies of Behavioral Counseling of Parents with Problem Children.

Parents were assigned a relatively minor role in treatment until the 1950's and 1960's when they were co-opted as active "therapists"

for their children and given varying degrees of responsibility for planning and carrying out treatments (Berkowitz & Graziano, 1972). More recently, parents are seen as predominantly in need of education in parenting skills to help them cope with their problem children, and they are also perceived as having a more equal role in parent-professional joint ventures to help children (Mittler & Nittler, 1983). Current approaches to parent group interventions are based on a range of theoretical models and thus vary in both method and context of training (O'Dell, 1974; Tavormina, 1974). Nevertheless, all deal with child rearing and child management issues and shares the broad aim of teaching parents singly or in groups, to ameliorate present problems of their children in the hope that this will prevent future difficulties too.

O'Dell (1974) believed that effective parent training required three steps:

1. The parents must acquire the modification skills and change in their own behavior,
2. Changes must be implemented with the child, and
3. Changes must generalize and persist.

Of these three phases, he contended that only the implementation phase had received sufficient attention. The tendency to focus on the child had resulted in a neglect of obtaining data on changes in parent behavior.

Childhood behavior problems may be due to faulty learning patterns and faulty child rearing practices of parents. However, the goals and objectives of a prevention-oriented approach to child behavior problems can be formulated on the theoretical assumption that behavior problems are learned ones and may be prevented if appropriate learning opportunities are available. These goals include:

1. The development of positive child-rearing habits through successful and non-aversive parent / child interactions at an early stage,

2. Improvement in the parents ability to cope with stress; and,

3. The development of the child's adaptive behaviors that will contribute to their overall adjustment. (Wolfe, 1985).

Prevention and intervention studies suggested that parents who had previously used extra punitive and harmful child management approaches could learn appropriate skills with relative ease. Moreover, parents reported fewer child behavior problems during post treatment and follow-up, presumably due to their improved child rearing ability. In general, these parents sere initially quite resistant to efforts directed at their own behavior. The focus upon child behavior problems allowed for structure, direction, and readiness for the initiation of treatment. In this manner, the parents viewed modifying several aspects of parental behavior toward their child as a means to an end and they readily accepted. Rather than complaining, parents would respond to the new skills favorably once they realized the methods were not all that difficult or strange (Wolfe, 1987).

Parent Variables or Type of Parents.

Several parents and family characteristics are associated with conduct disorders (Kazdin, 1995b; Robins, 1991; Rutter &Giller, 1983). Conduct disorder is associated with a variety of untoward living conditions. Many of the untoward conditions in which families live place stress on the parents or diminish their threshold

for coping with every day stressors. The net effect can be evident in parent-child interaction in which parents inadvertently engage in patterns of behavior that sustain or accelerate antisocial and aggressive interactions (Dumas & Wahler, 1983; Patterson, Capaldi & Bank, 1991). Therefore several investigators have attempted to evaluate the type of parents with whom training in behavioral principles would be useful. Salzinger, Feldman and Poertnoy (1970) reported parent success relating to educational level, intelligence and particularly reading ability. Training was based primarily on verbal learning of behavioral principles. Patterson, Cobb and Ray (1972) found training some uneducated, lower socio-economic status parents to be difficult because of their lack of even the most rudimentary child management skills and low availability of reinforces. Working with parents without spouses or working in homes with parental conflicts required considerably more time and effort to achieve success.

In an effort to account for variability in success rates of parent training, researchers have identified parent variables, which differentially influence treatment outcome. For example, parents of a higher socio economic status in comparison to relatively lower socioeconomic status parents, exhibit greater proficiency in

behavioral management skills following parent training (Kazdin & Frame, 1983; Philips & Ray, 1990; Reisinger, Ora & Frangia, 1976). In addition, low socio economic status parents are more likely to terminate treatment prematurely than are their higher income counterparts (Clark & Baker, 1983; Dumas & Wahler, 1983; Firestone & Witt, 1982).

What may account for the negative relationship between low income and successful parent training outcome? Several authors have suggested that differences between low and middle-income parents' reading ability, marital conflict, and pretreatment child management skills may influence parent-training outcome (O'Dell, 1974; Ollendick & Cerny, 1981). In addition, Dumas and Wahler (1983) suggested coercive interchanges between disadvantaged mothers and adults outside the home might lead to negative parent-child interactions. They also proposed that the disadvantaged, insular mother might lack the social or problem-solving skills necessary to benefit from parent training and to generalize her use of the techniques to new situations.

One unexplored hypothesis for the high failure rate of parent training with low income parents may be that different income

groups vary in their perceptions of the social validity of treatment procedures. If, for example, lower income parents judge an intervention to be an unacceptable solution to their problems, they may be more likely to drop out of parent training or fail to use the techniques appropriately. Thus, behavioral interventions taught to parents may be less socially valid when taught to low, rather than middle, income mothers.

Effective Behavior Management.

Parents and other adults who work with children are consistently faced with the challenge of managing children's behavior. "My child never listens to me!" "She won't pick up her toys!" "He won't clean his room!" Such frustrated exclamations are all too familiar to many caregivers. One area that is continually of concern for parents and other adults who work with children is behavior management.

When considering behavior management, adults often tend to focus on how children control (or do not control) themselves. However, by observing effective managers in a business setting, for example, it is realized that effective management is

implemented by the individuals in charge, not by the people being managed. Effective behavior management is not so much about what children do. Instead, it involves adults' behavior, and research shows that adults vary in both discipline and care giving styles.

Discipline Styles.

One common misconception about discipline is that discipline is synonymous with punishment. The Latin root of the word discipline, however, means "instruction" or "knowledge." Thus, discipline is really a process by which adults teach children and convey knowledge about appropriate behavior for various situations. However, some methods of discipline are better at achieving this than others.

Research (Kochanska, 1991) suggests that there are at least three discipline styles. The first, power-assertive discipline, involves such adult behavior as spanking, withdrawal of privileges, and threats of punishment or physical harm. Children respond to adults' requests out of fear, rather than respect. Consequently, children's motivations for appropriate behavior are external, and they conform to expectations to avoid punishment. However, when

children find themselves in situations where they will not be "caught," they are likely to engage in inappropriate behavior.

The second discipline style, love withdrawal, involves such adult behavior as refusals to speak or listen to children, threats to leave children, or expressions of dislike and disappointment. Adults who practice this discipline style often give children the proverbial "cold shoulder" when inappropriate behavior occurs. As a consequence, children conform to expectations because they fear abandonment or the loss of adults' love and affection. Like power-assertive discipline, love withdrawal produces external motivation for appropriate behavior (Hoffman, 1975).

The third discipline style, induction, incorporates the true nature of discipline teaching. (Krevans, J; & Gibbs, J. C. 1996). Adults who practice induction provide children explanations for appropriate behavior as well as reasonable consequences for inappropriate behavior. Because children understand WHY certain actions are expected of them and others are prohibited, they internalize reasons for these behaviors. As a result, children's motivation to behave appropriately comes from within, and they are more likely to engage in expected behaviors even when they are in situations

where they are not being watched and thus will not be "caught." An additional benefit of induction is that children will be more likely to understand the effects of their behaviors on others and exhibit empathy.

Care Giving Styles

Research (Baumrind & Black, 1967) on care giving styles also tells us something about the most effective ways of interacting with children. This research suggests that care giving behavior can be organized along two dimensions: demandingness and responsiveness.

Caregivers vary in the demands that they place on children. Some adults establish high standards for responsible behavior, and they expect children to live up to those standards. Other adults, however, place few demands on children and seldom try to control children's behavior.

Responsiveness involves warmth, affection, and the degree to which adults consider children's ideas, feelings, and perspectives. Some adults are affectionate and receptive to children's ideas.

Additionally, these responsive adults allow for some give-and-take between adult and child in establishing standards and consequences for behavior. Other adults, though, are more aloof but are less likely to consider children's perspectives. The contrast here is similar to the contrast between a democracy and a dictatorship. Although both involve some sort of government or management, they differ in the extent to which they consider the voice of the governed (Baumrind, 1968).

Studies demonstrate that the most effective care giving style includes both high expectations and a high degree of responsiveness. Effective caregivers clearly communicate high standards to children, but they are also flexible and reasonable in their expectations, modifying them to accommodate the needs or perspectives of the children. Children of this type of caregiver are more responsible, better adjusted, and have higher self-esteem than children of less responsive or demanding caregivers (Zahn-Waxler et al, 1979)

In sum, research on discipline and care giving styles indicates that cooperative communication is crucial in adults' interactions with children. Effective caregivers clearly convey high expectations to

children and provide reasons for expected behaviors, while remaining receptive to the perspectives, suggestions, and needs of children. Additionally, effective caregivers are nurturing and responsive to children, even when mistakes occur, because they view discipline as a teaching and learning process.

Communication and Effective Behavior Management.

Communication with children promotes more effective behavior management.

Effective communication is Clear communication.

A key to effective behavior management is planning beforehand to prevent behavior problems. Adults need to clearly define their expectations for children at the outset. Establishing routines or specific procedures for certain behaviors, such as doing homework or getting ready for bed, will help children remember expected actions. In addition, making a set of rules about desired or forbidden behaviors will aid in informing children of adults' expectations. Keep children's developmental level in mind. Do not

expect more than children are capable of performing or overwhelm them with long lists of rules. Research (Baumrind, 1967) with elementary school students suggests the following four general rules:

1. be polite and helpful,
2. respect other people's property,
3. listen quietly while others are speaking, and
4. Do not hit, shove, or hurt others.

Effective Communication is Cooperative

The American Heritage Dictionary defines communication as an interchange. Effective communication, whether with children or adults, is exactly that. It is cooperative. Rather than just dictating wishes to children or demanding things from them, effective caregivers talk with children. One specific way to ensure that communication is a two-way street is to allow children to participate in decisions about behavior management. For example, when assigning household chores or making rules, ask children for

their suggestions. Children will be more motivated to complete tasks or obey rules if they have participated in choosing them.

Effective Communication Conforms to Children's Cognitive Level.

In order for children to comply with parents expectations, children must understand what parents want them to do. A major factor that affects children's understanding is their level of cognitive development (Piaget, 1969).

Concrete Communication

Until they reach adolescence, children are very concrete in the way that they think. They have difficulty in understanding abstract concepts. Thus, adults should use concrete examples to make expectations more clear. For example, if an adult says "be nice to others," children may not understand how to apply this expectation to everyday situations. Adults could aid children's understanding by saying, for example, that being nice means keeping your hands

to yourself, not taking things from others, or saying please and thank you when playing with other children's toys.

Capacity

Children are also limited in the amount of information that they can consider at one time. They can be overwhelmed easily if parents request or expect too much at once. What seems very simple to an adult may be quite complex for a child. When a parent tells a child to "go clean your room," it may be found that the child doesn't even know where to begin. However, if the job is broken down into concrete, manageable steps -- "first pick up your blocks, then pick up your dirty clothes and put them into the hamper" -- the child will have an easier time tackling the task. Because they are concrete thinkers, children may even need to see a behavior or procedure before they understand it well enough to perform it on their own. Demonstrating a routine for "room cleaning" (with the child's help, of course) will help the child learn desired behaviors in a positive, cooperative environment.

Cues

Because of their limited memory capacities, children may also need visible cues to remind them of appropriate behavior. A sign or chart posted on the bathroom mirror, for example, may serve as a cue for brushing teeth or picking up dirty clothes. For young children especially, pictures may be more potent reminders than printed signs. In addition, a signal such as a "dinner bell" can remind children to wash their hands prior to mealtime. Like adults, children need reminders to establish healthy habits, and they get a positive sense of accomplishment when completing an assigned task on their own.

Effective Communication is Complete Communication

Finally, effective behavior management involves communicating reasons for expected behaviors. Rather than just telling children what is expected, tell them WHY the expected behavior is important. For example, when asking children to pick up their toys, explain that someone may trip over the toys and get hurt or that the toys may be stepped on and broken. When children are given reasonable explanations for expected behaviors, children are more

likely to internalize the reasons and behave appropriately in the future (Hoffman, 1975).

Consequences.

Another area essential to effective behavior management involves consequences for children's behavior. Behaviors are strengthened or diminished by consequences. For example, when a child cries for a toy or candy at the market and an adult purchases the desired product, the child experiences a pleasant consequence, a reward. As a result, he or she is MORE likely to cry for toys or candy when visiting the market in the future. Children learn associations between behaviors and consequences, and the types of consequences experienced by children affect their behavior directly. When attempting to manage children's behavior, careful attention must be paid to specific behaviors in children as well as to the consequences that follow the behaviors (Madsen et.al, 1968).

Graded Consequences

Often, using graded consequences that increase in severity is effective in reducing unwanted behaviors. For example, a child

may lose video game privileges for one day the first time an unwanted behavior occurs. The second time the behavior occurs, the child might be "grounded" for one day, and so on. Adults can plan a series of increasingly negative consequences to control troublesome behaviors in children.

The Two C's -- Clarity and Consistency

Using consequences to manage children's behavior requires advance planning. Adults must clearly define consequences before children's behaviors occur, and caregivers should discuss these so that they respond similarly to children. Consistency is crucial in this process. If children are only rewarded for desired behaviors on a part-time basis, those behaviors are not likely to increase. Similarly, if children are punished for inappropriate behaviors sporadically, these behaviors are likely to continue. Remember, rewards are more effective than punishments, and adult attention is very rewarding to children. Thus, adults should spend more time and attention on desired behaviors than undesired behaviors (Holden & West, 1989).

Attention

What many adults may not expect is that children thrive on adult attention. In fact, even when an adult "reprimands" a child for inappropriate behavior, the attention the child receives may actually serve as a reinforcer! Unfortunately, adults may overlook desired behaviors because they are not troublesome, and respond more vocally and more often to undesired behaviors. Children will continue to act out because their inappropriate actions are rewarded with adult attention. Knowing this, we can adjust our own behavior so that we provide children MORE attention for appropriate behavior than for inappropriate behavior (Holden & West, 1989).

Rewarding Behavior with Behavior

As would be expected, children enjoy some activities more than others. Adults can use activities that are enjoyable to children to reward children for completing less enjoyable activities. This is known as the Premack Principle (Premack, 1965). For example, most children enjoy helping their teacher in school. Thus, helping erase the chalkboard or distribute papers (more enjoyable) can be

rewarding for children who complete all of their assignments (less enjoyable). Similarly, helping to wash the car or playing with friends might be rewarding for children who complete their regular chores or homework.

There are generally two types of consequences: reinforcement and punishment (Skinner, 1989).Generally, when adults think of consequences for children's behavior, unpleasant things like spanking or restricting privileges are being thought of. Research demonstrates (Mills & Grusec, 1989) that reinforcement, or pleasant consequences, may actually be a more powerful motivator for children. The following sections suggest some ways or techniques to utilize consequences in managing children's behavior.

Behavior Modification Techniques.

Reinforcement Techniques:

There are two types of reinforcement techniques.

1. Positive Reinforcement.
2. Negative Reinforcement.

The most distinctive feature of behavioral counseling is its use of reinforcement techniques. The value of reinforcement has long been recognized. Mark twain said, "I can live for two months on a good compliment". Shakespeare said, "Our praises are our wages".

The key to the successful use of reinforcement is proper timing. The reinforcer must be presented immediately following the desired behavior, and it must not be presented immediately following undesired behavior.

Very frequently teachers and parents ignore the productive task-oriented behavior that they are hoping to encourage and, instead, pay attention to a child only when he is causing difficulty. Attention from a powerful adult figure may frequently serve as a rein forcer to a child even when that attention may seem somewhat aversive to the adult (Krumboltz, 1969).

Positive Reinforcement:

Positive reinforcement is an operant conditioning procedure in which a response is strengthened by the onset of an event (positive rein forcer), incentive, which follows the response in time. The

response-strengthening effects of positive reinforcement typically involve an increase in the future rate or probability of occurrence of the response, although other changes in behavior (e.g., a decrease in response latency or an increase in response magnitude) may also be indicative of positive reinforcement (Poling, 1985). Positive reinforcement is providing rewards or incentives for a desired behavior.

Children can also be rewarded by eliminating unpleasant activities or events. For example, many high schools reward superior academic performance by exempting "A" students from final exams. Similarly, parents can reward children by eliminating (or offering to complete) children's household tasks for a period of time. Clearly, there are many methods to reward appropriate behavior in children. Remember, rewards appear to be more effective than punishments in motivating children, and adult attention is very reinforcing for children. Thus, in order to manage children's behavior effectively, adults must be sure that the bulk of the attention paid to children is for desired behaviors rather than undesired behaviors

Negative Reinforcement: Punishment.

Although reinforcement is generally more effective and should be used most often, punishment may also be used in an effective program of behavior management (Skinner, 1989). The defining feature of punishment is that it should create an unpleasant situation for the child either because adults take away something the child likes, or because adults provide something the child does not like. The classic example of punishment is spanking. Because some research (Strassberg et al, 1994) suggests that frequent spanking may produce negative effects in children, many parents opt to use this technique sparingly. Punishment is a negative reinforcement.

Restricting Privileges

Restricting privileges is an effective means of punishment. This technique will vary according to the age and preferences of the child. For example, taking telephone or car privileges from a teen-ager might be very effective. Similarly, restricting access to the television, video games, a bicycle or other favorite toy might be more effective for an elementary-school-aged child (Baumrind & Black, 1967).

Time-out:

Time-out is a procedure whereby positive reinforcement is not available to an individual for a period of time. Implementation of the procedure is contingent upon the emission of a response (typically an undesirable one by an individual), and it is designed to decrease such behavior. Time-out primarily is utilized with children but can be utilized with adults also. Time-out has been used in homes, daycare centers, pre-schools, schools, institutions, and public facilities. The procedure has been found to be effective in reducing a wide range of maladaptive behaviors, including but not limited to, non compliance, aggression, stealing, disruptive verbalization, property destruction, and tantrums (Forehand, 1985). Time out continues to be taught routinely as one component in training programs for parents to enable them to reduce common problem behaviors (Lutzker, 1992; Sanders &Plant, 1989).

Procedures of Time out:

1. Obtain child's attention,
2. Briefly explain what child was doing wrong,
3. Prompt appropriate behavior,

4. Praise correct behavior if it occurs,
5. If disruptive behavior continues, place child in time out chair or area.
6. After two minutes of quiet in timeout, remove child from time out,
7. Return to activity and,
8. Praise correct behavior when it occurs. (Sanders & Plant, 1989).

Time out technique can effectively be used with preschool-aged children as a method of punishment. This method involves restricting a child's activities and contacts for a short period of time. In order to use Time Out effectively, adults must realize that it creates an unpleasant situation for children because it provides time AWAY from anything reinforcing such as toys, other children, or adults. If adults are talking to a child while she or he is in Time Out, the adult's attention is actually rewarding the child! Similarly, sending a child to his or her room for Time Out is rewarding because they have access to all of their toys. To maximize the effectiveness of this procedure, select a location for the Time Out that is removed from family activity and other interesting items. A chair facing a blank wall works well. In

addition, remember that attention is reinforcing, so adults (and others who are present) must not interact with the child during the Time Out period (Betz, 1994).

Response Cost:

Response cost is a punishment procedure in which an individual or a group loses a positive reinforcement contingent upon a specified behavior. The positive reinforcement is often conditioned reinforcement within the context of a token economy. Thus, response cost might involve the removal of a token from a client's possession when the token was exchangeable for an hour of off-grounds privileges. A traffic citation involving the payment of a fine is a common example of response cost. Response cost is distinguishable from extinction in that extinction consists of the failure to deliver reinforcements, whereas response cost involves the removal of reinforcements in one's possession. Response cost is distinguishable from time out, in that time out specifies a time period in a less reinforcing environment, whereas response cost need involve no temporal component. Response cost derives from the notion that the probability of the occurrence of behavior is related to its physical or monetary cost. That is, the grater the cost

of performing behavior, the less likely it is that the behavior will be performed. Response cost often is a remarkably effective behavior reduction procedure, both in terms of the degree of suppression and the onset of the effect. The procedure can be applied to numerous behavior problems (Axelrod, 1985).

Contingency Contracting:

It is a behavioral change procedure in which an agreement is made between the persons who desire to change behavior (i.e., parents, teachers, counselors, etc.) and those whose behavior needs to be changed (i.e., child, student, client, etc.) or in which a bilateral contract is made between two or more people each of whom desires mutual changes in the other. Contingency contracts, usually in the form of written agreements, specify the relationships between behaviors and consequences. The contract clarifies the positive and negative consequences that can be expected to follow specific behaviors. Contracts often imply an "if-then" relation between behaviors and consequences (Dowd & Olson, 1985).

Behavioral Contracting:

Behavioral contracting involves the entering of a formal agreement with the child about what behaviors are required of him and what reinforces will be consequently available. Contracts are usually written, and need to be constructed with a careful eye to specificity. From a theoretical perspective, behavioral contracts are a particular example of establishing rule-governed behavior in the child (Martin & Pear, 1996).

Token Economy:

The token economy is an intervention based on the delivery of positive reinforcement for specific target behaviors. The reinforcement that is delivered consists of tokens (e.g., tickets, coins, stars, points) that can be exchanged for a variety of other rewards that vary with the particular clientele. Essentially, three ingredients define a token economy: (1) the tokens or medium of exchange (2) the rewards or back-up reinforcement s that can be purchased with the tokens, and (3) the set of rules that define the inter-relationships among the specific behaviors that earn tokens and the back-up reinforcements for which tokens are exchanged.

The notion of an economy reflects the fact that tokens operate in a similar fashion to money in an ordinary economy. In fact, many concepts from economics such as earnings, expenditures, and savings, all have important counterparts in a token economy in a treatment environment.

Any event can serve as a token as long as it is feasible to administer. The tokens must only be obtainable by performance of desired behaviors. Once earned, the tokens can be spent for privileges and other rewards such as consumable items (e.g., food), special activities (e.g., free time, watching television), money, clothes, and others. A wide range of back-up reinforcements is provided from which clients may select. The range of back-up reinforcements imbues the tokens with their generalized reinforcing properties.

The use of tokens offers several advantages. First, tokens are potent reinforcements and can often maintain behavior at a higher level than other reinforcements such as praise, approval, or feedback. Second, tokens help bridge the delay between client performance of a desired behavior and delivery of a reward (back-up reinforcement). Third, tokens are less subject to satiation than

many other reinforcements because they can be used to purchase a variety of back-up events. Fourth, tokens permit conducting large-scale incentive programs using a simple system of reinforcement. All clients can receive a common reinforcement (the tokens) and exert their individual reward preferences in exchange for tokens for back-up events. It is indicated by many studies that the token economy can be extremely effective in producing change in specific target behaviors while the program is in effect (Kazdin, 1985).

According to Skinner (1989), young children respond well to concrete rewards such as colorful stickers. These can be used individually to reward simple behaviors like washing hands or sharing toys. Stickers (or other small tokens) can also be collected by children and traded for bigger rewards. This kind of system is especially helpful with more complex behaviors. Rewards will help young children to better understand and remember the desired behaviors and potential rewards

Behavior Problem Prevention in Classroom.

Three classroom-based instructional strategies can be utilized to prevent behavior problems in school.

1. *Proactive classroom management*: This is aimed at establishing an environment that is conducive to learning that promotes appropriate student behavior, and minimizing disruption of classroom activities. Such an environment increases opportunities for skill development for all students and should therefore increase student commitment to learning. Teachers are taught to give clear and explicit instructions for student behavior and to recognize and reward attempts to cooperate. Classroom routines are to be established by the teacher at the beginning of the school year. These set up a consistent pattern of expectations between the teacher and the students. Clear directions and consistent expectations should result in effective use of classroom time for skill development and should prevent discipline problems (Emmer & Evertson, 1980).

Teachers are also taught methods for preventing minor classroom disruptions from interrupting instructions and decreasing opportunities to teach (Cummings, 1983). The teacher learns to take immediate and brief action to restore the learning environment while simultaneously downplaying the incident. Also integral to effective management of the classroom is the frequent, appropriate use of encouragement and praise. Praise should specify exactly

what student behavior is being rewarded so that desired behaviors are reinforced (Martin, 1977). The contingent use of praise should increase social bonding of student to teacher and classroom.

2. *Interactive Teaching*: This is a method based on the premise that virtually all students can and will develop the skills necessary to succeed in the classroom, under appropriate instructional conditions (Bloom, 1976). This approach has resulted in improved learning in a wide variety of classroom situations (Block, 1971; 1974; Stallings, 1980). The components of interactive teaching are mental set, objectives, input, modeling, checking for understanding, remediation, and assessment. Interactive teachings require that students master clearly specified learning objectives before proceeding to more advanced work. Grades are determined by demonstration of mastery and improvement over past performance rather than in comparison with other students. Interactive teaching expands opportunities for students to attain success while reducing the risk of failure. This should enhance students' perceptions of their own competence as well as their commitment to educational pursuits. The use of clear and explicit objective standards in grading should promote students' belief in the fairness of the educational system (Hawkins & Lam, 1987).

3. *Cooperative Learning*: Cooperative learning involves small, heterogeneous groups of students as learning partners. Students of different abilities and backgrounds work together in teams to master curriculum material, and receive recognition as a team for their group's academic performance. Cooperative learning makes students depend on one another for positive rewards (Slavin, 1980). Team scores are based on the individual student's academic improvement over past performance, allowing student to contribute to the team's overall achievement. Cooperative learning creates a classroom norm favoring learning and academic performance (Slavin, 1979). Mastery of learning tasks, motivation, positive student attitudes towards teachers and schools, and self-concept are greater in cooperative classrooms than in competitive or individualistic ones (Johnson & Johnson, 1980; Slavin, 1979). Research has shown that cooperative learning methods are more effective than traditional methods in increasing student achievement and in developing mutual concern among students across racial groups. In combination with training in basic cooperative skills, this approach reinforces students in helping each other to succeed in classroom endeavors. Positive student interaction should reduce alienation in the classroom and promote attachment among students based on the pursuit of accepted

academic goals. This should, in turn, reduce the likelihood that students will form alternative attachments with delinquent peers that lead to delinquent behavior (Hawkins.1981).

Parent Management Training

Behavioral parent training began in the 1960s (Serketiech, 1996) for children who presented with problems of emotion or conduct. Hanf (1969) developed one of the first such programs using didactic instruction, modeling and role-playing to teach parents to modify their own behavior to increase the child's compliance.

The term 'Parent training' depicts the educational aspects of parenting and is in opposition to the popular view that being a parent comes about instinctively and naturally. Parent training has become quite popular in recent years and this may be not only due to the documented effectiveness but also because it can be administered by paramedical personnel, is relatively inexpensive and much shorter than other traditional forms of child psychotherapy. The term parent training (Kazdin, 1997; Danforth, 1998) has been used both in a general and specific sense.

Generally speaking, it refers to the use of educative interventions with parents that aim to help them cope better with a range of problems they experience with their children (Callias, 1994). It has also been used more specifically to refer to the use of behavioral principles in developing programs aiming to help parents manage behavioral problems inherent in many psychiatric problems encountered in children. In parent training, parents are taught behavioral strategies in order to modify their child's behavior and re-establish positive relationships within the family (Danforth, 1998; Sonuga-Barke et al, 2001).

Parent Management Training (PMT) refers to procedures in which parents are trained to alter their child's behavior in the home. The parents meet with a therapist who teaches them to use specific procedures to alter interactions with their child, to promote pro-social behavior and to decrease deviant behavior. Training is based on the general view that conduct problem behavior is inadvertently developed and sustained in the home by maladaptive parent-child interactions. The general purpose of PMT is to alter the pattern of interchanges between parent and child so that pro-social, rather than coercive behavior is directly reinforced and supported within the family. This requires developing several

different parenting behaviors such as establishing the rules for the child to follow, providing positive reinforcement for appropriate behavior, delivering mild forms of punishment to suppress behavior, negotiating compromises and other procedures. These parenting behaviors are systematically and progressively developed within the sessions in which the therapist shapes parenting skills. The program that parents eventually implement in the home also serves as the basis for the focus of the sessions in which the procedures are modified and refined.

Parent management training involves procedures geared toward teaching parents to manage their child's behavior in the home. A therapist meets with the parents to teach them techniques to increase pro-social and decrease delinquent behaviors. There is also emphasis on helping parents to recognize when they may be inadvertently reinforcing negative behaviors in their child. The overall purpose of parent management training is to change the cyclical pattern of interaction between the child and parent.

Although many variations of PMT exist, several common characteristics can be identified. First, treatment is conducted primarily with the parent, who implements several procedures in

the home. The parents meet with a therapist who teaches them to use specific procedures to alter interactions with their child, to promote pro-social behavior and to decrease deviant behavior. There is usually little direct intervention of the therapist with the child. Second, parents are trained to identify, define and observe problem behaviors in new ways. Careful specifications of the problem are essential for the delivery of reinforcing or punishing consequences and for evaluating if the program is achieving the desired goals. Third, the treatment sessions cover social learning principles and the procedures that follow from them including: positive reinforcement (e.g., the use of social praise and tokens or points for pro-social behavior), mild punishment (e.g., use of time out from reinforcement, loss of privileges), negotiation and contingency contracting. Forth, the sessions provide opportunities for parents to see how the techniques are implemented, to practice using the techniques, and to review the behavior change programs in the home. The immediate goal of the program is to develop specific skills in the parents. As the parents become more proficient, the program can address the child's most severely problematic behaviors and encompass other problem areas, e.g., school behavior. Finally, child functioning at school is usually incorporated into the program and teachers are also involved.

Teachers can play an important role in monitoring or providing consequences for behavior at school.

PMT is one of the most well researched therapy techniques for the treatment of conduct-disordered children. Treatment effects have been evident in marked improvements in child behavior on a wide range of measures including parent and teacher reports of deviant behavior, direct observation of behavior at school and home and institutional records. The effects of treatment have also been shown to bring problematic behaviors of treated children within normative levels of their peers who are functioning adequately in the community.

The impact of PMT is relatively broad. The effects of treatment are evident in siblings also. Siblings of conduct-disordered children also improve in their behavior. This is an important effect because siblings of conduct-disordered children are at risk for severe antisocial behavior. Maternal psychopathology, particularly depression has shown to decrease systematically following PMT (Kazdin, 1985). These changes suggest that PMT alters multiple aspects of dysfunctional families.

Parent management strategies typically entail training parents to interact most effectively with their children and to use various behavioral principles (e.g., reinforcement, extinction, and punishment) to increase pro-social behavior. PMT has been applied to parents of diverse clinical populations including aggressive, acting-out, autistic, and mentally retarded children. Numerous studies have applied PMT to children with marked antisocial and oppositional behavior (Kazdin, 1984; Kazdin & Frame, 1983; Patterson, 1982; Wahler, 1976). The most programmatic work has been completed by Patterson and his colleagues, who have developed a model relating how antisocial behavior develops. The model emphasizes the role of coercive interactions between and among family members that serve to exacerbate aggressive behavior (Patterson, 1982). PMT focuses on directly altering these negative interaction patterns, reducing coercive interchanges between parent and child, and enhancing pro-social behavior through systematic reinforcement (Kazdin, 1984). A number of outcome investigations have been reported over the past fifteen years that clearly demonstrate the efficacy of Patterson's program with systematic replication with the program itself and extensions by other clinical researchers (Fleischmann & Szykula, 1981; Patterson & Fleischmann, 1979).

Although PMT is a promising treatment technique, it is not without limitations. First, PMT is not, of course, invariably effective. The efficacy of PMT appears to depend upon the types of families that participate, the intensity of the treatment (e.g., duration, supervision in the home) and several parent and family factors (e.g., parental discord and psychopathology) (Kazdin, 1984). In dysfunctional families, the treatment may produce little or no change or gains may not be maintained once they are achieved (Wahler, Berland, & Coe, 1979).

A related concern with PMT is the breadth of its applicability. For clinically severe children it is not always a viable strategy. Limitations may not exclusively rest with the families and associated familial conditions in which they are embedded. For example, in a study to investigate inpatient treatments for children with serious conduct disorder, approximately 75% of the families of the children were not suitable for PMT. Parent psychiatric dysfunction, apathy, or disinterest in contributing further attention to their children were limiting conditions for the effective use of PMT. For this reason, the clinical services intensive treatment

efforts have been focused on the child rather than the child and parent combined.

At the end of the spectrum, PMT might appear to be applicable for large-scale preventive efforts. Based on existing evidence, there may be some benefit to large-scale dissemination of PMT. However, such an extensive application of PMT currently exceeds the present status of the evidence. PMT can be highly effective when administered intensively to an individual family or small groups of families. With regard to large-scale preventive efforts, the administration of this form treatment raises multiple problems including feasibility. Wide-scale application of PMT may sacrifice the intensity of treatment and the integrity of its execution (Michelson, 1987).

PMT places numerous demands on parents, including mastering educational materials, conducting home observations, successfully implementing treatment techniques, and attending weekly treatment sessions over a period of several months. These demands may affect the attrition rate that is reported between 17% and 32% (Eyeberg & Johnson, 1974; McMahon, Forehand, Griest & Wells, 1981; Patterson & Fleishmann, 1979). Moreover, other

factors may mediate drop out including low socio-economic status, depression, social insularity, and parental psychopathology (Kazdin, 1984; McMahon, 1981). While many parents undertake and successfully complete parent management training, others may refuse even to participate or only become minimally involved in implementing the comprehensive therapeutic regimen.

Overall, the PMT literature reveals treatment gains in adaptive child behavior both at home and at school. Follow-up studies ranging from 1 to 4 years (Fleishman & Szykula, 1981; Baum & Forehand, 1981) support the efficacy of PMT with regard to decreasing aggressive, noncompliant, and antisocial behavior in children from age 3 through 12 years (Patterson, 1982). Eyeberg and Johnson (1974), Patterson (1974), and Wells et al. (1980), have also reported that PMT is effective in reducing antisocial and deviant behavior in children to within normative levels of functioning as compared to adjusted peer cohorts.

Alternative Strategies.

While PMT is regarded as one of the more effective and currently practiced behaviorally based treatment strategies for antisocial

youth, it cannot be professed as the primary or sole therapy of choice. Alternative therapies like Interpersonal Cognitive Problem Solving (ICPS) and Behavioral Social Skills Training (BSST) have been evolved as an intervention strategy in cognitive therapy.

Interpersonal cognitive problem solving skills training emphasizes the importance of cognitive processes in understanding, mediating, and resolving interpersonal conflicts. Cognitive treatments focus on modifying dysfunctional thinking processes that are presumed to result in antisocial behavior. The specific cognitive processes that are targeted for change differ according to the varying characteristics of the child or adolescent.

A number of cognitive operations are commonly focused upon in treatment, including remediation of negative perceptions, attributions, self-statements, and expectations, and enhancing effective problem solving strategies. 'The assumption of cognitive therapy is that children with deviant behavior suffer a deficiency in particular processes or an inability to use their applied cognitive skills', says Kazdin (1984).

Another strategy that holds much promise for the prevention and/or treatment of antisocial disorders in children and adolescents is Behavioral Social Skills Training (BSST). This modality is directed at developing specific and complex interpersonal behaviors that encompass a wide variety of social situations to promote pro-social interactions. BSST is based on the view that children with antisocial, aggressive, noncompliant, and acting-out behavior have not sufficiently developed the requisite skills to function optimally, both inter and interpersonally. BSST focuses on developing complex and adaptive behavioral repertoires to enhance personal competencies.

There has been a sea-change in the notions and ideas about parenthood and parenting practices. On one hand, there has been a demonstrable link between some of the 'mal-adaptive' parenting practices and deviant behaviors in children. On the other hand, it is being recognized increasingly that it is possible to teach these parenting skills to the concerned parents. Efficacy studies do suggest that although limited, one might expect a certain degree of improvement. There has been increasing interest both in the clinical and research aspects of parent training and it seems to be promising field both for the client and the therapist. Recent trends

suggest that incorporation of cognitive and social learning skills along with the behavioral ones might further augment the effectiveness of the same.

Certain moderating factors, which may limit the effectiveness of behavioral parent training programs have been identified and are as follows:

1. Socio-economically disadvantaged families (Wahler, 1980; Dumas, 1984).

2. Single parent is mother (Patterson, 1974; Webster-Stratton, 1990).

3. Depression in mother (Griest et al., 1981).

4. Marital discord (Reisinger et al., 1976).

Basic Assumptions of Behavioral Management

Behavioral assessment is based on several assumptions about behavior. The first assumption is that behavior is lawfully

determined by the confluence of interrelationships between setting events and individual responses (Hawkins, 1986; Haynes, 1978). The second assumption is that the lawful interrelationships between settings and responses can be identified most effectively through the use of minimally inferential empirical methodologies (Barlow & Herson, 1984; Cone, 1988; Hay, 1982). The third assumption is that setting and response interrelationships can be systematically modified to foster improved functioning in patients with a wide range of behavior disorders (Eysenk, 1988; Kazdin, 1984).

Behavior disorders are thus presumed to be the manifestation of complex setting X response interactions that may have transitory and/or lasting effects. Further, each factor in the setting X response interaction may subsume distinct components, levels, and parameters (Cone, 1988; Hyness, 1991; Schwartz, 1986).

Consumer Satisfaction

The assessment of consumer satisfaction with mental health services was unusual a few years ago. Consumer evaluation is

found to be useful method of assessing services. Measures of consumer satisfaction assess the extent to which treatment gratifies the wants, wishes, and desires of clients for service (Lebow, 1982).

Due to an increasing emphasis on treatment effectiveness in outcome research, consumer satisfaction is becoming recognized as an essential component in the outcome assessment of psychological treatments, including parent training (Plante, Couchman, & Diaz, 1995; Seligman, 1995). Consumer satisfaction in the context of psychosocial treatments refers to the extent to which patients or clients liked the process and the outcome of the treatment they received, including the treatment format, the techniques used, and the effects of treatment. As such measures of consumer satisfaction are considered the most subjective measures of treatment effectiveness (Eyberg, 1993). Many outcome studies that have included assessment of consumer satisfaction have suggested that greater satisfaction is related to greater efficacy of treatment (Bradley & Clark, 1993).

Researchers who have attempted to socially validate parent-training interventions typically have evaluated parents' perceptions of the techniques following participation in a parent-training

program (McMahon & Forehand, 1093). Parents generally have reported being satisfied with the treatment they received. Satisfaction ratings typically have been obtained, however, only from those individuals who complete treatment. Given that low-income parents are more likely to terminate treatment prematurely, the generality of consumer satisfaction ratings to low income families is not known. As additional limitation of studies assessing consumer satisfaction is that client reactivity to therapist or to treatment outcome may bias respondents' evaluations of treatment (Kazdin, 1980a; Kiesler, 1983; Lebow, 1982).

Significance of the Present Study

From the above narrative it can be seen that all over the world there are various approaches to deal with problems among children. This includes theoretically specific approaches as well as generic eclectic approaches. Almost all of these works and related studies were conducted in the west. From the available reports it can be seen that a good number of them utilized a generic or eclectic approach. Relatively only few studies have pursued a specific or definite theoretical model. Coming to Indian context, there are not many studies on the effectiveness of training parents

in the management of problem children particularly focusing on assessing the effectiveness of a parental training exclusively from a behavioral perspective. In this context the present study assumes vital importance. In India there are very few trained Clinical Psychologists who work with problem children. Further the rate of incidence and prevalence of behavioral problem among children are comparatively very high. In such a situation equipping other auxiliary personnel with basic skills in behavioral management will go a long way in tackling problems among behaviorally disordered children in our Indian context. Such personnel from the community include lay counselors, parents, teachers, local volunteers and such other groups. Training these groups will help in reaching out to more needy children as early as possible especially when there are not enough trained clinical professionals. The present study is designed to achieve this goal. Further the present study also envisages to empirically assessing the effectiveness of behavioral management of problem children by non professional personnel. Current mental health scenario witnesses a paradigm shift from a conventional therapist oriented practice to a radical collaborative practice. Training and skill empowerment of teachers and parents in fostering positive behavior in children represent this radical shift. The present

research work is planned in this direction. Further this study also intent to appraise the method and outcome of intervention from the attitude of parents as a part of consumer satisfaction. For the convenience of the study the present work was specifically restricted to training up the parents in the behavioral management of their children. This is also determined by consideration of the various requirements of a scientific research such as available time, cost, energy and such other resources. The findings from this study are expected to contribute to enrich existing theoretical knowledge, practice skill, development of policies and plans, and training of appropriate man power even at local levels.

Aims and Objectives of the Study

The present study reads as "Behavioral Counseling: A Treatment Modality for Behavioral Problems in Children". This is an intervention study using parents to modify the problem behaviors of children. Instead of the therapist actively involving in intervention as such directly with children, behavior modification is made directly through parents.

Aims.

The main aim of the present study is to find out the efficacy of behavioral management skills training for parents in modification of problem behavior observed among school children.

This above mentioned aim is further specified categorically into the following objectives:

1. To find out the efficacy of imparting behavioral management skills training for parents in modifying the behavioral problems of their own children.

In other words, this objective targets the success in the transfer of behavioral management skills imparted to parents as assessed through their level of satisfaction (Consumer Satisfaction).

2. To find out the efficacy of behavioral management by parents in modifying the behavioral problems of their own children.

In brief, this objective has its goal of measuring the behavioral change among children as a result of behavioral management by parents.

Operationally, the term "behavior counseling" is often used as a broad label to denote a multitude of behavioral techniques which also includes training of significant persons in behavioral management of problem clients. For the purpose of this study, the behavioral counseling approach used was the behavioral training for parents in management of problem children or problem behaviors among their own children.

BEHAVIOURAL COUNSELLING: A TREATMENT MODALITY FOR BEHAVIOURAL PROBLEMS IN CHILDREN

THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY

IN

PSYCHOLOGY

By

E.D.JOSEPH

DEPARTMENT OF PSYCHOLOGY

UNIVRSITY OF CALICUT

2005

Chapter – II

REVIEW OF LITERATURE

Children must learn to act appropriately, in ways that differ from society to society and from context to context. The question of how best to socialize children so that they can function successfully is a large and crucial question that has fascinated educators and psychologists for centuries. In a world in which children exhibit levels of violence that are strikingly un-childlike, the question of how to bring children up takes as immediacy for parents and psychologists. Does physical punishment prevent further outbreaks of violent behavior? Are there ways of influencing children so that punishment will not be necessary? These are the questions raised by Howlin (1998) in thinking about childhood behavioral problems.

Literature survey reveals that four major approaches have been investigated in the research dealing with behavior problem in children and adolescents. Most of the literature deals with procedures aimed at reprogramming the social environment of the child via parent behavior training. Other approaches include the use of token economies in the home, behavioral contracting, and conflict resolution skills training. The first two approaches have been used most often with younger children. Behavioral approaches with children emphasize that deviant behavior is shaped and maintained through maladaptive patterns of family

communication and behavioral interchange that reinforce (positively or negatively) coercive behavior. Most of the behavioral treatment strategies involve teaching the parents to change their behavior toward the problem child (Wells & Forehand, 1981).

Behavioral intervention procedures have been utilized with a wide variety of childhood behavior problems that occur in the home setting. The majority of these problems fit into the category of conduct disorders.

In an attempt to teach parents to alter coercive behavior, Williams (1959) instructed parents in a simple ignoring (extinction) procedure to modify bedtime tantrums of a 21-month old boy. The parents put the child to bed and did not reenter the room regardless of the child's tantrum. Tantrums were completely eliminated by the eighth night.

Wahler, Winkel, Peterson, and Morrison (1965) treated three boys who engaged in coercive behavior, such as excessive shouting, crying, noncompliance and demanding, by training parents in differential attending and ignoring procedures. Training occurred in the clinic and was facilitated by signal lights that cued the

parents when to ignore and attend to their children's behavior. Results indicated improvement in mother behavior as well as child behavior as a function of training.

O'Leary, O'Leary, and Becker (1967) reported a treatment program for two male siblings, aged six and three, one of whom had been under psychiatric treatment for two years with little improvement in his destructiveness, temper tantrums, aggressiveness, and noncompliance. During the first treatment phase, the therapist administered candy and social reinforces to the children contingent on cooperative play in the home. Later a home token reinforcement was added. During the second phase, the mother was trained to take over the treatment program by attending to the children's positive behavior, ignoring minor deviant behavior, and using a time out procedure for aggressive and destructive behavior. She also learned to administer the token program. The therapist prompted the mother to employ each of these procedures in the home during problematic behavior using a prearranged cueing system. Data from the home observations collected during baseline and treatment phases showed improvement in cooperative play behavior and decrease in deviant behavior as a function of these procedures.

Studies employing more sophisticated experimental methodology were conducted to assess the effectiveness of parent training in a more rigorous fashion. In such a study, Patterson, Cobb and Ray (1973) treated 13 consecutive referrals of conduct disordered boys and their families. Behavioral observations were conducted in the homes before and during treatment using professional observers trained in a complex coding system. Results indicated that 9 out of the 13 families showed improvements equal to or greater than 30% reduction from baseline in scored deviant behavior following treatment.

Parents receive training that involves positive reinforcement, ignoring, commands, and appropriate punishment in accordance with their needs and developmental level of the child. In addition, therapists train parents to engage in daily activities with their child that serve to strengthen the child's area of deficiency and to promote adaptive functioning. These activities include modeling and rehearsal of developmentally appropriate language abilities and social interaction abilities.

Sanders et al. (1982) reviews research on use of self-management procedures to enhance generalization and maintenance effects in behavioral parent training. It is argued that while many training

programs for parents implicitly expect parents to engage in self-controlling behavior, specific training in these skills is rarely provided. Research evidence relating to teaching parents goal selection, self-monitoring, self-determination of rewards and punishments, self specification of performance standards, self administration of rewards and punishments, techniques to rearrange the physical environment, and problem solving skills are discussed. Of these techniques only self-monitoring procedures have adequate empirical support.

The effects of a brief parent training package as parental application of behavioral procedures during child instruction and on child learning of 2 intellectual skills was examined by Bergen et al. (1983). 49 parents and their 21 / 2.5 year old children participated. Discriminate analysis revealed that the training package produced variations in parental use of modeling, physical prompting, verbal instructional prompting, and aversive control. However the pattern of variations differed across instructional tasks. Regression analysis showed that parent training produced differences in child learning.

Hughes & Peter (1988) in a study gave behavioral parent training to parents of 42 conduct-disordered children for the treatment of

their children's behavioral problems. At the end of treatment, in comparison with controls, significant treatment effects were found on the Behavior Problem Checklist.

Vincent et al (1987) conducted a study on parent training to increase compliance in a young child. They implemented a training program to modify a mother's behavior management skills to improve compliance behavior in her 4 year old child. Results indicate that behavioral intervention was effective in training the mother to make behavior management skills. Chi8ld compliance behavior was also increased.

Another research study evaluated the effects of parent management training in the treatment of antisocial behavior of children aged 7 to 12 years. Results indicated that children showed significantly less aggression and externalizing behavior at home and at school and greater pro-social behavior and overall adjustment after the treatment sessions (Kazdin et al., 1987).

In their research Logan et al. (1993) indicate that parent training produces consistently positive outcome changes in both attitudes and behavior and that it is cost effective compared with other forms of psychotherapeutic intervention.

Children with home behavior problems frequently are treated via training their parents to become behavior therapist for their own children. Mothers report that specific home management behaviors were improved. Individually trained mothers expressed significantly more satisfaction with the program (Eyeberg & Matarazzo, 1980).

Henry (1981) affirmatively establishes that parent training is an effective mode of therapeutic intervention with children. The outcome evidence of these studies makes PMT one of the most promising treatments for behavioral problems in children.

The effectiveness of parental training on learning disabled children and their parents was studied by Giannotti et al. (1982). They found parents reporting more confidence in them as parents, greater awareness of the effects of their behavior on children, and more acceptances, understanding, and trust of their children. Similar results were obtained on the children's Report of Parental Behavior Inventory. The Piers-Harris Children Self-concept Scale also showed a significant difference in favor of the children whose parents received training. Teacher ratings on the Devereux Elementary School Behavior Rating Scale indicated that these

children showed less achievement anxiety and external reliance and more actively sought out positive relationships with their classroom teachers.

Forehand et al. (1984) reviews the effects of maternal distress on several aspects of parent child interactions that were identified in the course of a parent-training program for child non-compliance. Distress was measured by a number of self-report questionnaires examining depression, anxiety, marital relations, and extra familial relationships. Assessment and treatment procedures included observations, parental perceptions of child adjustment, and parental distress measures. Distress appears to be related primarily to measures of parent perceptions of child maladjustment. Several relationships between distress and treatment outcome are noted.

In a research on the father's participation in the outcome of parent training Horton (1984) suggested that the father's unsuccessful skill requisition is linked with possible inconsistent parenting, increased marital conflict and lack of generalization of improved child behavior. Data suggest that fathers are able to learn parenting skills, but their skill acquisition may be indirectly from the mother. Research results have failed to demonstrate a clear benefit from including fathers in training possibly due to mother's assumption

of the bulk of childcare responsibilities. However, the father's support of his wife's skill acquisition may be crucial to the effectiveness of parent training.

Rios and Gutierrez (1985) in a review of literature on behavioral parent training (BPT) noted that although BPT has been shown to be effective with a variety of child behavior problems, the adaptation and generalization of this treatment across family populations has not met with consistent success. To promote effective and generalized treatment success across this population, family characteristics like interpersonal and interfamilial factors have to be considered.

The general shortcomings in parent training programs for families of handicapped children are identified by Helm and Kozloff (1986) and they report that parent-training programs typically help families with respect to only a limited number of their short-term needs.

The literature on parent training was surveyed by Lutzker et al. (1983) and suggests that behavior therapists do not have much to offer parents in many areas of parent-child relationships. It is proposed that research should concentrate on planned activities

that separate deviant from non-deviant families and types of physical support and affection offered to children in non-deviant homes.

Budd et al. (1982) reviews studies from 5 behavior journals from 1970 to 1981 to determine the extent of father involvement in parent training research. Out of 72 parents training studies only 28 reported that some fathers were involved in training. Studies also indicate that father participation does not substantially increase the effectiveness of parent training. However, therapists judged that the inclusion of fathers was beneficial since it led to more consistent treatment of the child and support for the mother.

Parents of 46 learning-disabled 4^{th} - 6^{th} graders participated in an 8-wk Parent Effectiveness Training Program or served as delayed treatment controls. Post intervention scores on the Parent Attitude Survey showed a significant improvement on all 5 scales, with parents in the experimental group reporting more confidence in themselves as parents; greater awareness of the effects of their behavior on children; and more acceptance, understanding, and trust of their children. Similar results were obtained on the Children's Report of parental Behavior inventory. The Piers Harris Children self-concept scale also showed a significant

difference in favour of the children whose parents received training: teacher ratings on the Devereux Elementary School Behavior Rating Scale indicated that these children showed less achievement anxiety and external reliance and more actively sought out positive relationships with their classroom teachers. However scores remained low compared to those obtained with non-handicapped children. It is argued that parent training should include a follow-up and be accompanied by direct child interventions and teacher training (Giannotti & Doyle, 1982).

In a study, Gerler and Merrell (1985) investigated the effects of parent training on the perception of mothers and fathers in the perceived behavioral problems of their children. Ss were given instruction in observing and defining behavior recording behaviors, and applying consequences to shape these behaviors. Ss were administered a bipolar adjective checklist before and after the intervention. Results indicate limited change in Ss as a result of the intervention. Result also support the notion that parent training by school counselors can be an effective method of treatment.

Hall and Rose (1987) studied the merit of parent training by administering an assessment package to measure parent-adolescent conflict and communication to parent-adolescent pairs. Results

show that treated parents viewed their adolescents less negatively at post test, increased the use of positive communication skills, and decreased the use of negative skills. Treated adolescents used fewer negative communication skills than did controls.

Rogers (1981) investigated whether (1) lower-class parents differ in their interaction with and perception of their children from middle and upper class parents and (2) lower-class parents and their children are less responsive to treatment than middle or upper class parents and their children. 31 mother-child pairs were divided into low, medium and high socio-economic (SES) groups with 9, 10 and 12 Ss respectively. Ss mean age was 57.7 - 64 months. Treatment consisted of teaching the parents to use social reinforcement and time-out techniques. Observational behavioral data, Parent Attitude Test, Behavior Rating Scale, and Attitude Check list results were obtained pre- and post treatment. Pre-treatment data revealed no significant difference among groups, but treatment outcome data revealed changes in the desired direction for all dependent variables. All SES groups demonstrated similar changes for all outcome measures.

Parent-training programs conducted by professionals and implemented by parents and books on behavior modification

written for parents to implement with their children were examined by Mara (1982). Four areas of concern are discussed. First, what constitutes an appropriate target for intervention, and are there potential conflicts between parents' and children's right? Many of the programs analyzed offered parents little guidance in selecting significant goals, and most selected goals focused on eliminating undesirable behaviors. Second, problems related to the nature of intervention are discussed, problems associated with positive contingencies and with sanctioned use of punishment. The third issue is that of conflicts between experimentation and therapeutic intervention. Conflicts between parents and researchers concerning the use of techniques (such as reversals, returning to baseline, and the triggering of undesirable behaviors) are analyzed in terms of ethical and methodological ramifications. A final issue concerns the level of training provided to parents who are instructed to design and implement behavior modification programs with their children. How such training is given and evaluated is raised as an ethical concern.

Although parent training generally has been successful sufficient data exist to indicate that treatment outcome is not always positive. Several investigators have suggested that problems in the family system may be responsible for the failures that occur. Griest and

Forehand (1982) reviewed the relationship between three family problem variables (parental maladjustment, marital difficulties, and dysfunctional extra familial interactions) and child behavior problems and their treatment. The available data suggest that there is a positive relationship between child behavior problems and problems in each of the 3 types of family variables. Some data also suggest that the outcome of parent training is affected adversely by poor parental personal, marital, and extra familial adjustment.

Wierson & Forehand (1994) studied the rationale for parent behavioral training program. They say that parent behavioral training based on social principles is an effective intervention strategy for non-compliant children. They further emphasize positive reinforcement strategies and disciplinary techniques. Short-term and long-term follow-up indicate that behavior change is maintained and generalizes across behaviors. They further affirm parent behavior training is an effective clinical strategy for disrupting coercive parent-child interchanges.

Research indicate that parent training produces consistently positive outcome changes in both attitudes and behavior and that it

is cost effective compared with other forms of psychotherapeutic intervention Wright et al. (1993).

Parent Behavioral Training (PBT) is most effective for children that are non-compliant / oppositional or have discrete behavioral problems such as phobias or enuresis Graziano and Diament (1992). They observed that parents also benefit from PBT gaining in knowledge, child-management skills, and attitudinal improvements.

In a study by Firestone and Witt (1982) parents of 83 hyperactive children aged 5-9 years were offered a social learning based parent training program. 40 of the 62 families who agreed to treatment finished the 4 months program. Analyses revealed that those children whose families dropped out were younger and had lower IQs. Parents who dropped out were also significantly younger and had lower IQs. Dropout families had lower mean family income and the mothers in this group had fewer years of education. Several differences in MMPI profiles were found between the parents who completed therapy and those who dropped out.

Forehand (1979) examined the temporal and setting generality of treatment effects resulting from parent behavior training in 2

experiments. In Exp.1, pre-and post treatment and 6-and 12-months follow-up data were collected in the home by independent observers. Ss were 10 mother-child pairs who had been referred for treatment for the child's non-compliance. All treatment occurred in a clinic setting. Results indicate that parent and child behavior changes and parent perception of child behavior change that were achieved by treatment were maintained during follow-up. In Exp.2, 8 children and their mothers were treated in a clinic setting for the child's non-compliance. Data were collected before and after treatment in the home and in each child's school by independent observers. School data were also collected for untreated control Ss. In the home of the treated Ss, both parent and child behaviors and parent perceptions of child behavior changed in the predicted direction. No significant change occurred in the school behavior of the children treated at home or the control children.

The generalization of treatment effects from treated to untreated behavior in a parent-training program was examined by Wells et al (1980). Subjects were 12 noncompliant clinic referred children (mean age 60.3 months) and their mothers. All 12 mother-child pairs participated in a parent-training program and all children demonstrated increases in compliance to maternal commands as determined by home observations prior to and after treatment. A

significant decrease in other child deviant behavior (e.g. tantrums, aggression, crying) that was not treated occurred indicating that treatment effects generalized to untreated behaviors. A non-clinic comparison group (mean age 59.7 months) was also included. These 12 subjects were more compliant and less deviant than the clinic subjects prior to, but not after, treatment of the clinic groups.

Koegel et al (1978) conducted a research study to assess the generalized effects several different parent / teacher training programs. It was found that a brief demonstration of how to teach the autistic child new behaviors were sufficient to teach parents how to teach those children those behaviors. However, generalization to new child-target behavior did not take place. Another parent training program, which did not demonstrate how to teach any one specific child behavior, but was based on teaching the use of general behavior modification procedures, was effective in teaching the parents how to teach new child-target behavior.

In a study Mc Donald (1977) reports a mother who was trained to use contingent positive reinforcement (praising desired behavior) and extinction (ignoring undesirable behavior) to deal with undesirable aspects of her 7-year old daughter's behavior (arguing, yelling, and non-compliance with mother's requests). Prior to the

experimental training the mother seldom praised, and frequently reprimanded her child. 10 days after the beginning of positive reinforcement and extinction the undesirable behavior was markedly less frequent.

Evans (1977) describes how a home-based behavior management project can be effectively maintained to ensure maximum behavioral change in a child with minimum involvement by a consultant if an effective reinforcement net work is established to monitor and reinforce significant adults in the child's environment with the focus being the primary child "shaper".

The effects of parent behavioral training on child non-compliant behavior and on parents behavior and attitude change was examined by Forehand and Elizabeth (1977). 10 boys and 1 girl who had been referred for treatment of non-compliance and their mothers served as subjects. Results show that the short-term laboratory behavioral training program produced significant changes in both parental and child behavior when assessed in the laboratory settings. These changes were maintained at a 3-month follow-up. In addition, after treatment and at the 3 months follow up, the children were perceived by their mothers as being better adjusted than prior to treatment. Comparison of the treatment

group to a non-clinic "normal" sample of 11mother child pairs suggests that the behavioral training produced parent perceptions regarding their children's adjustment that did not differ significantly from those that the parents of the non-clinic sample had towards their children.

In their study, Bollard and Woodroffe (1977) made two substantial modifications to the dry-bed training procedure described by N.H. Azrin et al. The first modification was to have parents administer the intensive all-night training program rather than an outside trainer. With 14 children treated in this manner, nocturnal enuresis was eliminated in all cases. The median time taken to the last night of bed-wetting was only 12 days. There were 2 relapses in a 6-month follow-up. The second modification involved administering the dry-bed procedure without the adjunct of an enuresis machine. This resulted in significantly reduced frequency of bed-wetting, although nocturnal enuresis was not completely stopped in any of 10 children treated.

Forehand et al (1974) examined the effects of a parent centered behavioral training program on the non-compliance of a 7-year-old deaf child. The program, which was designed to alter general parent-child interaction, involved initially teaching the mother

reinforcement skills for desirable behavior and, subsequently, a time-out procedure for deviant behavior. Results indicate that a general behavioral program could be rapidly learned by a mother and applied to the special problems of a deaf child. Changes occurred in both the child's compliance and in the mother behavior and attitude toward the child.

The efficacy of a parent training intervention on coercive discipline, positive parenting practices, and child non compliance was studied by Martinez & Forgatch (2001). Intervention effects were evaluated 5 times from base line to 30 months. They found that the intervention produced ending benefits to coercive discipline, positive parenting and boys' non compliance. These benefits followed a classic prevention effects. Mothers and sons in the experimental group maintained stable outcome trajectories, whereas in the control group deteriorated. The intervention's impact on boys' noncompliance was mediated independently by its impact on coercive discipline and positive parenting. Change in positive parenting was more strongly associated with change in noncompliance than was change in coercive discipline.

According to relational theories, concepts such as compliance, self-regulation and internal control are also determined by dyadic

interaction (Kuczynski & Hilderbrandt, (1997) relational theories, however, tend to deemphasize parental management of child behavior. Rather, the focus is on the parent-child relationship over time, and parental responsiveness is assumed to be crucial to children's receptivity to socialization (Maccoby & Martin, 1983; Parpal & Maccoby, 1985). Responsive parenting incorporates factors such as warmth, involvement, sensitivity, and positive reciprocity (Maccoby & martin, 1983; Parpal & Maccoby, 1985; Shaw Keenan, & Vondra, 1994). Within this perspective, children show increased readiness for socialization if parents show a reciprocal willingness to be influenced. Compliance depends on synchronous interactions (Parpal & Maccoby, 1985), and synchrony develops through monitoring child behavior.

Findings from clinical and prevention studies support the effectiveness of replacing coercive discipline strategies with mild sanctions for noncompliance while increasing contingent encouragement for compliance. In a review of studies using their intervention model for serious child conduct problems, Forehand & McMahon (1981) found that compliance training improved family management and noncompliance, with child effects lasting up to 4-5 years.

Basic experimental studies in responsive parenting show that observed responsive parenting is associated with child compliance and that parents can be taught the skills involved in responsive parenting (Parpal & Maccoby, 1985; Westerman, 1990). Wahler and Bellamy (1997) extended these experimental findings by designing and contrasting a responsive parenting intervention with a compliance training intervention for boys with conduct problems. They found similar improvements in noncompliance after treatment (a 5-week interval) with both compliance training and responsiveness strategies.

Watson and Bassinger (1974) describe the parent training technology system as an operant-type behavior modification system that utilizes parents as behavior modification technicians. The program has been used to eliminate undesirable behavior and to teach self-help, language, motor coordination, social-recreational, and academic skills to mildly, moderately, severely and profoundly retarded children, as well as psychotic and 'emotionally disturbed' children. It is suggested that because parents, siblings, peers and teachers are involved in the program, and training takes place in the child's natural environment, many stimulus control problems inherent in more traditional intervention

clinical strategies are avoided. Indeed parent training technology is a potential service delivery system.

4 mothers of children with a variety of communication disorders received training in behavior change techniques at a 2-day workshop. The goal was to teach the mothers to use a specific instructional approach, which involved an antecedent-behavior-consequence paradigm. For each case, specific child and parental behavior were determined by a speech pathologist. Follow up showed positive changes occurred in 3 of the 4 children over a 2-3 months period. Carpenter and Augustine (1973) suggested that such an approach should be useful where speech pathology services are limited or where daily treatment is required.

Patterson and Patricia (1994) reviewed programmatic studies of resistance during parent training therapy. Analysis of sequential interaction during treatment of 70 pre-adolescent boys and girls show that therapist's efforts to intervene produced immediate parental resistance. From baseline to mid-treatment phases, there were increases in the therapists' efforts to intervene, which were accompanied by increases in parental resistance. Contextual variables such as parent pathology also correlated with higher levels of parental persistence. Decreases in parental resistance

were associated with improvements in parental discipline practices. Parental resistance altered the behavior of the therapists reducing their effectiveness.

20 years of research on processes and outcome of parent training (PT) was reviewed by Wright et al (1993). Topics addressed include the cost effectiveness of PT, PT vs. Parent Behavioral Training (PBT), current status of PT other than PBT, variations in the PT process, types of disorders treated by PT, the demographics of PT consumers, and scientific quality of PT research. Research indicate that PT produces consistently positive outcome changes in both attitudes and behavior and that it is cost effective compared with other forms of psychotherapeutic intervention.

Werle et al (1993) evaluated the effects of a behavioral parent training program on feeding related behaviors in the home for 3 boys aged 21-54 months, and their mothers. Mothers were trained to initiate regular offerings of previously rejected (target) foods and to provide contingent attention (i.e., specific prompts, positive reinforcement) to increase their child's acceptance of no preferred foods. For 1 subject training was also directed at increasing self-feeding. Results sow that, with training, all mothers increased offerings of target foods and use of specific prompts, and 2

mothers increased levels of positive attention. Children increased their acceptance of target foods and self feeding, thus demonstrating the functional effects of parent training on in-home meal times. Temporary increases in food refusals occurred when treatment was initiated but declined as treatment continued.

Changes in parent functioning resulting from parental participation in a behavioral parent training program specifically designed for parents of school aged children with attention deficit hyperactivity disorder (ADHD) was studied by Anastopoulos et al (1993). Relative to 15 wait list controls, the 19 mothers of ADHD children who completed the 9 session's parent training program showed significant post treatment gains, which were maintained 2 months after treatment. There were gains in both child and parent functioning. In particular, there were PT induced reduction in parenting stress and increases in parenting self esteem, which accompanied parent reported improvements in the overall severity of their child's ADHD symptoms.

The rationale for parent behavioral training program was studied by Michelle and Rex (1994). They say that parent behavioral training based on social principles is an effective intervention strategy for noncompliant children. They further emphasize

positive reinforcement strategies and disciplinary techniques. Short-term and long-term follow-up indicate that behavior change is maintained and generalized across behaviors. They further affirm that parent behavior training is an effective clinical strategy for disrupting coercive parent-child interchanges.

The effectiveness of behavioral parent training has been well documented by different researchers (Baum & Forehand, 1981; McMahon & Forehand, 1980; Moreland, Schwebel, Beck, & Wells, 1982). Generally, the goal of parent training is to teach parents to increase their children's compliant and appropriate behavior through contingent delivery of praise, rewards, and time out. Much of the parent training research has been conducted with homogeneous samples and so has limited generalization.

Wahler (1980) states that behavior parent training has met with limited success when employed with low socio economic status (SES), impoverished or socially isolated parents.

In an effort to account for variability in success rates of parent training, researchers have identified parent variables, which differentially influence treatment outcome. For example, parents of a higher SES in comparison to relatively lower SES parents,

exhibit greater proficiency in behavioral management skills following parent training (Kazdin & Frame, 1983; Philips & Ray, 1980; Reisinger, Ora, & Frangia, 1976). In addition, low SES parents are more likely to terminate treatment prematurely than are their higher income counterparts. (Clark & Baker, 1983; Dumas & Wahler, 1983; Firestone & Witt, 1982).

How do we account for the negative relationship between low income and successful parent training outcome? Several authors have suggested that differences between low and middle-income parents reading ability, marital conflict, and pre-treatment child management skills may influence parent-training outcome (O'Dell, 1974; Ollendick & Cerny, 1981). In addition, Dumas & Wahler (1983) suggested coercive interchanges between disadvantaged mothers and adults outside the home might lead to negative parent-child interaction. They also proposed that the disadvantaged, insular mother might lack the social or problem solving skills necessary to benefit from parent training and to generalize her use of the techniques to new situations.

One unexplored hypothesis for the high failure rate of parent training with low income parents may be that different income groups vary in their perceptions of the social validity of treatment

procedures. For example, if lower income parents judge an intervention to be an unacceptable solution to their problems, they may be more likely to drop out of parent training or fail to use the techniques appropriately. Thus, behavioral interventions commonly taught to parents may be less socially valid when taught to low, rather than middle, income mothers.

Researchers who have attempted to socially validate parent-training intervention typically have evaluated parents' perception of the techniques following participation in a parent-training program (McMahon & Forehand, 1983). Parents generally have reported being satisfied with the treatment they received. Satisfaction ratings typically have been obtained from only those individuals who complete treatment. Given that low-income parents are more likely to terminate treatment prematurely, the generality of consumer satisfaction ratings to low income families is not known. An additional limitation of studies assessing consumer satisfaction is that client reactivity to therapist or to treatment outcome may bias respondents' evaluations of treatment (Kazdin, 1980a; Kiesler, 1983; Lebow, 1982).

Heffer & Kelley (1987) in a study assessed the effects of race and income on mothers' ratings of the acceptability of five child

management intervention. Positive reinforcement, response cost, time out, spanking, and medication were evaluated using the Treatment Evaluation Inventory (TEI). It was predicted that income would account for a differential acceptance of treatments between parents groups. The major findings of this study included: (a) parents consistently favoured response cost and positive reinforcement over the other treatments and (b) low and middle-upper income parents differentially rated the treatment.

Certain family characteristics put children at particular risk for developing behavioral problems- poverty, low income, low education, teenage pregnancy, isolation, high levels of stress, single parenthood, parental psychiatric illness, parental criminal history or substance abuse, and high levels of marital discord and depression (Webster-Stratton, 1990). Children whose parents are inconsistent in their discipline, physically abusive, or highly critical and hostile, and whose parents are disengaged from their children's school experience and provide little cognitive stimulation are also at greater risk for behavior problems (Patterson & Stoutahamer-Loeber, 1984; Reid, Taplin, & Loeber, 1981; Haber, 1987; Hawkins, Catalano & miller, 1992). The risk of a child developing behavioral problems seems to increase

exponentially with the child's exposure to each additional risk factor (Coie et al, 19993; Rutter, 1980).

The risk factors for developing behavior problems in children are present at higher than average rates in the socio-economically deprived families (McLoyd, 1990). In addition to parent and family risk factors, child risk factors have been implicated in child behavior disorders. Studies indicate that early academic difficulties, such as reading deficits and cognitive language delays, are associated with behavior problems (Schonfeld, Shaffer, O'Connor & Portnoy, 1988; Sturge, 1982), as are poor social skills and poor problem solving (Asarnov & Callan, 1985; Richard & Dodge, 1982; Rubin & Krasnor, 1986).

The major component of the prevention intervention of behavior problems involved teaching positive discipline strategies and effective parenting skills. Parents were also taught ways to strengthen their children's social skills and pro-social behavior.

Problem behavior in children is always judged by parents, teachers or other adults in the society. They decide whether children need to be referred to treatment or not. This judgement may be related to the degree of distress experienced by them.

The existence of the family depends upon the interaction of family members. Parents who share the primary responsibility in constituting the family have an important role to play in establishing a stable functioning of the family.

Child rearing is the shared responsibility of both father and mother. Often parents come out with complaints about their children's behavior. Some children show a multitude of behavior problems. These behavior problems are consistent headache to parents as well as teachers. Childhood behavior problems are mostly reflection of parent's own problems. These behavior problems can be handled by parents through effective parenting strategies and increasing parenting competency.

Raising children is one of the most difficult and demanding responsibilities of adult life. Yet most people have little preparation or training to be parents. Some adults have emotional problems or life stresses that make it difficult for them to be good parents.

In order to prevent childhood behavioral problems and parenting problems parenting competencies should be strengthened. Parent

management training programs help to strengthen parental competencies (Carolyn, 1998).

Parenting is a major factor influencing child and adolescent deviance. For adolescents, two components of parenting have been identified as important: (1) monitoring i.e., the extent to which a parent knows where an adolescent is and what he or she is doing. (2) Positive communication i.e., the extent to which a parent and adolescent listen to what each other is saying. Poor parent-adolescent communication has been linked to more delinquency and general deviance (Henggeler, 1989; Stewart & Zaenglein-Senger, 1984).

Higher levels of monitoring have been associated with lower levels of adolescent deviance (Lamborn, Dornbusch & Steinberg, 1996). Communication may serve to improve the parent-adolescent relationship, thus increasing the internalization of parental values and decreasing deviance. Whereas monitoring may serve to decrease deviance directly through parental control of adolescent activity.

Forehand et al (1997) studied the role of two parenting variables, monitoring and communication, in adolescent deviant behavior.

The result of the study indicated that higher levels of parental monitoring predicted lower levels of adolescent deviance compared to parent-adolescent communication.

The relative influence of parental monitoring and communication on child deviance has been examined in other studies. Gold (1991) found that both communication and monitoring were related to adolescent deviance and that the two variables contributed in an additive and interactive fashion to adolescent deviance (i.e. high levels of communication and monitoring predicted lower levels of deviance).

Patterson (1984) found that both parenting variables were correlated with adolescent deviance. He suggested that monitoring is the primary parenting variable. When a parent is aware of where an adolescent is spending his or her time and with whom, the opportunity for engaging in deviant behavior is reduced.

Studies have found that there are connections among parent's marital conflict, parenting styles and their children's externalizing or internalizing problems. A number of recent reviews indicate that when parents show high conflict and little positive emotion toward one another, particularly in front of their children we see two kinds of effects on the children, i.e. children internalizing or externalizing their problems (Conger et al, 1992, Cowan, 1991).

The "double whammy" of both direct and indirect effects of their parent's marital conflict contributes to children's socio-emotional developmental difficulties in regulating affect with other adults and with their peers. Quality of parenting behavior is to affect children's development.

Carlo Schuengel et al (1999) found that frightening parental behavior is a predictor of disorganized infant attachment, whereas caring, and sensitive to children's needs parental behavior boost up the self confidence and attachment of children.

Parent's interaction behavior and communication pattern to children should focus on understanding the children. Parents should restrain themselves from extreme criticism and blame, authoritarian or disengaged parenting and low levels of emotional support and cohesion (Liddle, 1995; Patterson, 1986).

In a study on family therapeutic intervention on adolescent problems Diamond and Howard (1996) suggested that parents should shift their attention to trying to better understanding of children rather than trying to control them.

Coercive interaction and aggressive behavior in the family especially of parents tend to stimulate oppositional behavior and conduct disorders in children. Personal adjustment of parents, marital discord, interaction style of the family, maternal depression

are some other factors that determine effective parenting. Studies have consistently shown that parental practices like parental acceptance, inductive discipline, non-punitive punishment practices and consistency in child rearing are associated with positive developmental outcome in children. Gray and Stgeinberg (1999) provides evidence that parental involvement, behavioral control, and autonomy granting contribute in unique and independent ways to psychosocial development, academic competence, behavior problems, and internal distress.

Amato and Rivera (1999) in a study revealed that positive paternal and maternal involvement were independently and significantly associated with children's behavior problems. Father positive involvement with children as reflected in shared activities, supportive behavior, and feelings of affection has beneficial implication for children's behavior and development. Mothers who are effective parents may be supportive of paternal involvement with children.

The patterns of 50/50 parenting in which mothers and fathers contribute equally to child rearing generally benefit everyone. Shared parenting relieves strain and improves their sense of well being. Fathers who adopt this style of parenting have the opportunity to develop closer relationships with their children.

Increased paternal child care is not only possible but also benefits mothers, fathers, and children. Fathers must become actively involved in child rearing in order to ensure healthy child development. Paternal non-involvement has been linked to psychological maladjustment, behavioral disorders, and educational problems (Biller, 1981: 1993; Osherson, 1996). Many scholars argue that qualitative factors such as paternal warmth, support or nurturance are more important for children's development than factors such as the simple amount of time fathers spent in child care (Lamb, 1997).

Indian Studies

Dogra and Veeraraghavan (1994) in a study used a group design to study the effects of play therapy and parent counseling on aggressive behavior disorder. The treatment group showed significant positive change than the no-treatment group. Using an A-B-A-B-design, Jena (1994) in a study, demonstrated successful use of differential reinforcement of incompatible responding in reducing classroom aggressive behavior of a retarded child. The class teacher was used as a mediator of the program. Agarwal (1995) also successfully used teachers as contingency managers in reducing aggressive behavior of a nursery school child. Vahali &

Kapur (1995) used parent training program to enhance pro-social behavior of children with hyperactivity. Basu and Deb (1996) conducted a parent training program for children with hyperactivity and attention deficit disorder. In another study, Jena (2004), attempted to examine the effects of parent-mediated behavioral intervention in aggressive behavior of a 12 year old retarded child. Combinations of three behavioral techniques, such as differential reinforcement, extinction, physical restraint were used for intervention. Three sessions of behavioral counseling and one month of monitoring of the program reduced the target response from 26 to 6. There was generalization of the treatment effect to the school setting. The program is viewed as successful step towards communalization of professional skills and use of community resources for intervention in childhood disability.

Behavior problems can be effectively managed by application of learning principles (Patterson, et al., 1975). Explanation of simple behavioral principles to parents helps to build up and enhance skills in the parents to implement the behavioral programs. Parenting self-efficacy is a crucial component of parenting competence. Parenting self-efficacy can be viewed as a parent's ability to perform a range of valued behaviors that relate to optimal child development. Parenting self-efficacy is a potentially crucial component of both mother and child well being. Individuals who

perceive themselves as high in parenting self-efficacy exhibit greater competency in parenting behaviors including increased monitoring of their children and responsiveness to their children. Dorsey et al (1993) in a study found that HIV infected mothers reported lower levels of parenting self-efficacy than did mothers who were not infected.

In order to prevent childhood behavioral problems and parenting problems, parenting competencies should be strengthened. Parent Management Training programs help to strengthen parental competencies (Carolyn 1998). Effective parenting strategies reduce the parenting problems and childhood behavioral problems. It also helps in positive development of children, positive mental health of the family and increased happiness in the family.

"Let not any child feel that he is unwanted".

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Chapter – III

METHODOLOGY

Background and Formulation of the Problem

Any person desirous of becoming a teacher, doctor, engineer, technician, priest and so on has to undergo a formal training. But for taking up the vital responsibility in life as a 'parent', no formal training has been given to men and women. Lack of training to parenthood is reflected in the child rearing practices of parents. Due to lack of adequate skills in child rearing practices, some parents fail to control the misbehavior among their children and to bring them up in a mentally healthy and disciplined manner. Such parents expose their inadequacies and incompetence to be effective. On account of this, children may show maladjusted and improper behavior patterns and create a real problem for parents as well as for the teachers in the school. Problems created by children are on the increase. The rate of incidence and prevalence of problem behavior among children referred to or brought to child psychologist / clinical psychologist or such professionals manifest the magnitude of this problem. As the literacy level of the society has gone up, parents and elders have become more aware of the child behavior problems and the need for corrective measures and the kind of professional help available. Social awareness and education in this area of child problem behavior was augmented by

the articles, features, and columns published by vernacular periodicals like 'MANASASTRAM', 'VANITHA', and 'GRIHALAKSHMI'. These fortnight weeklies have even published special issues on 'Parenting', besides their occasional articles on related matters. The work done by these publications have been found very much helpful in throwing light to childhood behavior problems and effective parenting. As a result, parents approaching the professionals seeking for the behavior problems among their children have increased. Due to acute shortage of trained professionals, a few clinical psychologists alone are unable to manage the magnitude of these cases. Hence it is thought of decentralization of equipping parents with required skills and development of community resources for intervention with problem children. These community resources can be in the form of giving basic skills training to lay leaders, teachers, parents and volunteers who can deal with them at the initial level. Failure at this level alone warrants highly skilled professional intervention. The behavioral management training given to the parents is expected to prevent problems among children as early as they occur, and to promote better growth and development among these offspring. Especially in developing countries like India, where trained professional man power is scarce in imparting basic skills to parents in order to combat emerging problems at the earliest on

a one-to-one basis, is essential as a preventive step. Hence the present approach in dealing with behavior problems among children by training parents in behavioral management skills is of paramount importance.

Purpose of the study.

The present research was purposively designed to study the feasibility and effectiveness of a training program with the overall aim of training parents in using the principles and techniques of behavior modification and skill empowerment in changing the maladaptive behavior of their children and establishing adaptive and accepted behavior in them. For the above purpose, it was further specified to assess the efficacy of imparting behavioral management skills for parents in the modification of problem behavior observed in their children (behavioral skills training for parents), and to find out the efficacy of behavior management by parents in modifying the behavioral problems among their own children. Operationally, the term "behavior counseling" is often used as a broad label to denote a multitude of behavioral techniques which also includes training of significant persons in behavioral management of problem clients. For the purpose of this

study, the behavioral counseling approach used was the behavioral training for parents in management of problem children or problem behaviors among their own children.

Design of the Research Study.

This research work is an intervention study. Therefore pre intervention and post intervention assessments were planned.

At the pre intervention stage, for gathering a baseline data on the problem for future comparative purposes, behavior problems were first assessed using Achenbach Child Behavior Check List before intervention. This is called the Phase-I assessment or Pre intervention assessment. All children were subjected to this pre intervention assessment as and when they were accepted for therapy.

One month after the intervention, again the same tool was used for assessment. This is called Phase-II or Post intervention assessment-1. Again two more assessments using the same tool were carried out after two months and after four months. These are called Phase-III or Post intervention-2 and Phase-IV or Post intervention-3 consecutively. At the end of the fourth month of

intervention at Phase IV another tool called Therapy Attitude Inventory was given to parents to assess the consumer satisfaction. Personal and demographical details about children and parents were also collected using a Socio-demographic Data Schedule at the time of the pre-assessment (Phase-I). Thus, it is evident from the above details that the design of the present research study falls with in the descriptions of an experimental method with before and after comparisons. However, it is very important to observe that control of all variables including intervening variables may not be possible in social science research as is possible in pure science research. Hence from a pure scientific research perspective, one can mention that a pure experimental procedure is very difficult in most social science researches, thereby rendering it a quasi-experimental nature.

Universe of the Study.

The universe of the present study consisted of parents of children with identifiable behavioral problems in Kannur district and the population from which the samples were selected constituted parents of behaviorally problematic children who sought clinical intervention.

Description of sample.

Thirty (30) parents, both fathers and mothers, and their children with problem behavior were taken as the sample for this study. There were 19 male children and 11 female children and among them 14 children belonged to the age group of 6-11 years and 16 children belonged to the age group 12-16 years of age. Though 60 parents, 30 mothers and 30 fathers were willing and available at the time of pre-assessment, only 30 mothers and 20 fathers participated till the end of the study. Ten (10) fathers were later gone abroad as a part of their employment. These parents were either referred by other professionals or approached directly for the psychological treatment of the behavior problems among their children. The behavior exhibited by their children was also clinically confirmed to be problematic or maladaptive in the family.

Sampling

The following aspects were considered while deciding upon the representative sample for the purposes of this study:

a) ***Sample size.*** As the present work consisted of an intervention, namely behavioral management skills training for parents of children with behavioral difficulties, a larger sample was considered impractical. Also as the number of willing and available parents with problem children were few or limited in a given specific period of time as envisaged for the present study, it was suggested to adopt a manageably limited sample size. Hence, based on discussions with statisticians and other subject experts, it was finally decided to select parents of 30 problem children which was a sufficiently adequate sample for intervention research. This size also permits application of parametric tests.

b) ***Sampling design.*** Considering the specific requirements involved in intervention studies such as the present work, which also included a set of inclusion and exclusion criteria the representative sample of respondents were drawn using the purposive sampling design. As an aid to ensure ease in the purposive sampling, the following inclusion and exclusion criteria were chalked out.

Inclusion Criteria.

i) The respondents should be from Kannur to ensure subsequent attendance and accessibility.

ii) The respondents should be parents of children with identifiable behavioral problems.

iii) Both parents should be alive.

iv) The respondents must be willing to participate in the study giving at least an informed oral consent.

v) The problematic children must be aged between 6-16 years, spanning the stages of late childhood and early adolescence and they should be attending school.

Exclusion criteria

i) Parents of children with very serious and chronic emotional disorders like autism or childhood schizophrenia.

ii) Parents from places other than Kannur district.

iii) Single parents (divorced, separated or widowed) with problem children.

iv) Parents of children who were drop-outs from school, as school drop-out phenomenon is not always exclusively behavioral and often compounded by economic and socio-familial structural factors.

Instrumentation: Tools for data collection.

1. Socio-Demographic Data Schedule.
2. Achenbach Child Behavior Check List.
3. Therapy Attitude Inventory.

Socio-Demographic Data Schedule. The socio-demographic data for the present study was collected using a semi-structured, pre-formulated schedule devised by the researcher himself. This is a detailed schedule which was designed to collect data on the subject's age, sex, education, birth order, parental details like

parent's occupation, education, age, family type, family atmosphere, parent's income, number of children, place of residence, etc. The purpose of administering this schedule was to gather as much data as required for statistical description and analytical purpose.

Achenbach Child Behavior Check List (CBCL)

The Child Behavior Check List (CBCL) was designed to empirically assess the behavior problems of children ranging 4-18 ages. It is designed to assess in a standardized format the behavioral problems and social competencies of children as reported by parents. It is a device by which parents or other individuals who know the child well, rate a child's problem behavior and competencies. This instrument can either be self-administered or administered through an interview. The CBCL can also be used to measure changes in a child's behavior over time or following a treatment. CBCL consists of 118 items related to behavior problems which are scored on a 3-point scale ranging from not true scored as Zero (0), sometimes true scored as One (1), and always true scored as Two (2) of the child. Parents are asked to circle the number of items their child has exhibited the behavior listed during the past 6 months. CBCL has a Test-retest reliability

of .93 and inter parent agreement .76. Several studies have supported the construct validity of the instrument (Tests of criterion-related validity using clinical status as the criterion also support the validity of the instrument). It is suggested that the CBCL is a viable tool for assessing a child's behavior via parent report in a clinical or research environment. As the CBCL was found to successfully differentiate the normal children from the clinic referred children, the CBCL was considered to have adequate criterion-related validity. Scoring is done separately for boys and girls and for 6-11 and 12-16 years of age.

In the present study CBCL was used to assess the base line of behavior problems in the child and later to assess the changes of behavior problems in children after an intervention. Malayalam translation of the CBCL questionnaire was used in the present study. The factor loadings of items on behavior check list is given in the Appendix.

Therapy Attitude Inventory

The assessment of consumer satisfaction with mental health services was unusual a few years ago. Consumer evaluation is found to be a useful method of assessing services. Measures of

consumer satisfaction assess the extent to which treatment gratifies the needs, wants, wishes, and desires of the client. Due to an increasing emphasis on treatment effectiveness in outcome research, consumer satisfaction is becoming recognized as an essential component in the outcome assessment of psychological treatments, including parent training. To evaluate the effectiveness of behavioral counseling, in this study, a consumer satisfaction inventory named Therapy Attitude Inventory developed by Sheila Eyberg (1995) is used as a tool. This inventory consists of 10 items / statements which range on a 5-point scale. Father and mother have to answer it separately. Answering is by circling the appropriate numbers on each items of the inventory.

Intervention Procedure

Parents brought their children for psychological help. The children were creating severe problems for their parents as well as to other family members. Some of the children were referred either by a pediatrician or a medical practitioner for psychological intervention. Others were brought by parents themselves for psychological help. As and when parents came with children, these parents were taken for behavioral management skills training.

Behavior problems can be effectively managed by application of learning principles (Patterson, et al., 1975). Explanation of simple behavioral principles to parents helps to build up skills in the parents in implementing the behavioral programs. Parents served as prime mediators in the program as they were the most important dispersers of reward and punishment in child's natural life situation and have the strongest commitment.

On the first day of the interview parents reported in detail the problem behaviors of their child in different situations. The researcher was listening to the complaints of parents. Some of the parents were very much worried and emotionally upset when they described their children's problem behavior. They explicitly admitted their inability to control the child. The researcher sought clarifications from the parents about the problem behavior of the child. Then the researcher interviewed the child to ascertain and confirm the problem behavior. Parents were informed about the intervention plan and requested to cooperate fully in the treatment. Thus parent's consent and cooperation was ensured. The researcher met each parental couple separately. Later as 10 fathers were employed abroad, those 10 mothers were trained in singles.

On the second day Achenbach Child Behavior Check List was administered to the parents. The researcher read out each item one after another after an initial explanation of the check list. As the parents were answering to the questionnaire the researcher made markings in the appropriate columns. By this, the researcher and parents could get a base line assessment on the child's behavioral problems. Along with Achenbach's Check list, a Performa for collecting personal information about the child and parents was also administered.

The third day was a training session for parents. The researcher explained in that session to the parents the following:

i. How a problem behavior develops.
ii. What are the factors that sustain or maintain the problem behavior
iii. How parent's behavior becomes a reinforcing factor for the child's problem behavior.
iv. The need for skills to control and manage the problem behavior.
v. The role of parental behaviors and skills in the management of the child's problem behavior.

Thus behavioral management skills training sessions were initiated with the parents. The discussions were focused on the child's coercive modes of control over the parent's controlling response. Submission to the child's demands was considered as a maintaining factor behind behavior disorders. In this session the researcher explained and taught different behavioral skills to the parents and how it helps to remedy the problem behavior of the child. The researcher gave training in behavior modification taking examples from their own child's behavior. Parents were given training in the use of reinforcement techniques, both the positive reinforcement and negative reinforcement. They were trained in positively reinforcing desired behaviors and negatively reinforcing undesired behaviors. Parents were instructed to give attention to all desired behaviors (paying attention) and withdraw attention from all undesired behaviors (ignoring). They were taught as to how a negative reinforcement can be used as a consequence to remedy or modify maladaptive or undesirable behavior. Time out technique was taught to parents as a punishment for undesired behavior. They were also trained in Limit-setting, Restricting privileges and Response cost (loosing positive reinforcement) as punishment procedures. Techniques of Contingency Contract and Behavioral Contract were taught to parents to emit and enhance desired behaviors in children. Parents

were given training in the use of Token Economy technique to produce changes in a specific target behavior. The detailed descriptions of the above mentioned technical skills are provided in the introductory chapter.

The researcher gave clarifications to the questions raised by parents after the training during each session. The researcher ensured that parents got enough working knowledge and skills on the behavior modification techniques to be applied to their children.

In the first one month parents were instructed to meet the researcher once in a week for parental training sessions. In each session, the researcher and parents discussed the application of the techniques that were taught in the previous sessions and were encouraged to monitor their child's behavior. Four sessions were conducted in this manner in the first one month. Each session lasted two to two and half hours on an average. There were totally 18 sessions.

At the end of one week after the first month parents were administered Achenbach Child Behavior Check List (CBCL) for the first post assessment of the child behavior. The researcher read

out each item one after another. As the parents responded to questions, the researcher recorded their responses in the test sheet. Parents were again encouraged to continue the behavior modification procedures.

The researcher continued to meet the parents in the second month. Three booster sessions summarizing the contents of training were conducted in the second month with 10 days interval in between. The researcher ensured that parents were monitoring the behavior of their children according to the behavior modification principles. At the end of the second month Achenbach Child Behavior Check List was again administered to parents for the second post-assessment.

Parents were encouraged to continue applying the behavioral skills and monitoring their child's behavior. Any doubts and queries of parents were cleared. In the third and fourth months parents were asked to meet the researcher every 15 days. Likewise the researcher met parents 4 times in the last two months.

At the end of the fourth month Achenbach Child Behavior Check List was given to parents to assess the present condition of the behavior problems in the child. Along with CBCL, another

questionnaire called Therapy Attitude Inventory was administered to parents, separately to father and mother. This was meant to assess the satisfaction of parents – the consumers – on the effectiveness of the parental training and methods as well as the outcome.

Summery of the Procedural Sequences of Intervention.

- Intake interview – 2 sessions: one each with parents and child.
- Pre-assessment (Phase-I).
- Four sessions parental training: weekly once (First month).
- Post-assessment – 1 (Phase-II).
- Three Booster and Feedback sessions: once in 10 days (Second month).
- Post-assessment – 2 (Phase-III).
- Four Booster and Feedback sessions: once in 15 days (Third and Fourth month).
- Post-assessment – 3 (Phase-IV).
- Consumer Satisfaction Assessment.

Pilot Study.

Pilot study is an essential ingredient of all research programs. It is an unavoidable requirement in all researches. For the purpose of the present study, a pilot study was carried out with a view to pre-test and ensures the validity and utility of the research instruments and the intervention package. For the pilot study of this intervention program, the researcher recruited five (5) willing parents with problem children in his routine clinical practice. It is through this pre-testing that it was finalized to hold 18 sessions in total with each session lasting for two to two and half hours. Further, through this pilot study, the researcher also confirmed the feasibility of the training package for parents. In addition, the pilot study helped in assessing the utility of the research instruments.

Moreover, the experience through this exercise helped the researcher to develop an ease, familiarity and skill to interview the respondents and to train them. In short, it can be safely concluded that the pilot study provided confidence to this researcher to pursue and complete the present research work successfully. Besides it provided one more opportunity and a context for this researcher to brush up his knowledge, practice and training skills. With out this

exercise of pre-testing, the present research could not have been completed meaningfully and satisfactorily.

Data Collection.

The data required for the present research was gathered through five sessions, besides the two intake sessions. The data was collected using the three instruments which were already described earlier through interview method. To ensure completion of data collection, the interview method is found to be superior to self-report methods. Further, interview method of data collection helps respondents to clarify any doubts regarding any items in the tools on spot with the help of the researcher.

Data Processing

The data thus gathered as mentioned above was coded and subsequently entered into a computer based data sheet. Consequently the data was analyzed applying various statistical techniques with the help of SPSS (Statistical Package for Social Sciences). The results were presented in tabular as well as graphical forms besides giving written explanations. These results are provided in the subsequent chapter.

Statistical Analysis

Data obtained from the intervention study was subjected to statistical methods for processing and analysis using SPSS. The different statistical methods used for analyzing the data are:

1. Frequencies and Percentages
2. Summary Statistics
3. Chi Square Test
4. Independent Sample Test
5. Paired t-test
6. One Way ANOVA
7. Graphical representations

Reporting

The results and findings derived through statistical analyses are reported and their implications are discussed in the following chapters. For the written report, U.S. English style was adopted using M.S. word document.

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Chapter – IV

RESULT AND DISCUSSION

This chapter presents the results of the analyses and discussion of the results obtained. In a clinical study characteristics of the sample are crucial with respect to the outcome of intervention used in it. Therefore as a preliminary step in the analyses, an overview of the sample characteristics is provided with the help of the tables from 1 to 16. These tables while presenting the frequency distributions and percentages of subjects in different subgroups of the samples of parents and problem children gives a critical appraisal of the significant features of these groups of subjects.

Table – 1. Age Group: Frequency distribution

Age	Frequency	Percent
6-11 years	14	46.7
12-16 Years	16	53.3
Total	30	100.0

Table.1 shows the frequency distribution of the subjects according to the age group. The age categorization as seen in the table is in accordance with Achenbach's age-vise categorization. Accordingly the subjects are categorized into two groups such as 6-11 years and 12-16 years. The above table follows this categorization. As seen by the table 14 children (46.7%) belong to the age group of 6-11 years and 16 children (53.3%) belong to the age group of 12-16 years. This may be due to the fact that parents

tend to view certain and milder forms of misbehavior as child's prank and hence often ignored. Only very serious issues they view as problems. Others are often forgiven and forgotten. Whereas it is not true in the case of pubescent and adolescent children during which period parents expect more responsible and socially appropriate behavior.

Table – 2. Sex Group: Frequency distribution

Sex	Frequency	Percent
Male	19	63.3
Female	11	36.7
Total	30	100.0

Distribution of subjects in terms of gender is given in Table – 2. It is observable from the table that there are 19 male children (63.3%) and11 female children (36.7%). There is a preponderance of male children compared to female children among the subjects. This may be due to the Indian cultural factor that male children are given more care compared to female children. Parents invest more in male children than female children. Culture heavily controls the behavior of girls through socialization, whereas boys are expected to be more aggressive. This culturally biased socialization and social expectations explains the variations in problem behavior.

Table – 3. Sex cum Age group frequency distribution

Sex & Age	Frequency	Percent
Females 6-11 Years	5	16.7
Females 12-16 Years	6	20.0
Males 6-11 Years	9	30.0
Males 12-16 Years	10	33.3
Total	30	100.0

Table.3 displays the frequency distribution of the subject in accordance with categorization made on the basis of gender and age groups. Accordingly there are four groups such as female aged 6-11 years, females aged 12-16 years, males aged 6-11 years and males aged 12-16 years. It can be seen from the above table that there are 5 children (16.7%) belonging to the group of females aged 6-11 years, 6 children (20%) in the group of females aged 12-16 years, 9 children (30%) in the group of males aged 6-11 years and 10 children (33.3%) in the group of males aged 12-16 years. Younger age group in both gender categories tend to be lesser perceived by parents as problem behavior. Male's problem behaviors are most often observed and female behaviors is not given much attention.

Table – 4. School Level.

Class	Frequency	Percent
Primary School	9	30.0
Middle School	10	33.3
High School	11	36.7
Total	30	100.0

The frequency distribution of children studying in different levels of schooling is presented in Table – 4. 30% of the children (9) are studying in the primary school level, 33.3% of children (10) studying in middle school classes and 36.7% of children (11) studying in the high school classes.

Table – 5. Parental Presence

Parental Presence		Frequency	Percent
Father	Alive & Staying with	20	66.7
	Alive& Abroad	10	33.3
	Total	30	100.0
Mother	Alive & Staying with	30	100.0
	Alive & Abroad	0	0.0
	Total	30	100.0

Table - 5 illustrates the frequency distribution of parental presence with the children in the family. It is evident from the above table that 20 children (66.7%) have their father's physical presence in the home. Whereas for 10 children (33.3%) though their fathers are alive do not stay with them and are abroad due to their employment. All children have their mothers living with them and enjoy their physical presence. It is a common scenario in the Keralite families that quite a number of fathers are away from the family and are working abroad. Mother alone is looking after the children and the household. Thus many families have become partially single parenting.

Table – 6 Place of Domicile

Place	Frequency	Percent
Urban	14	46.7
Rural	16	53.3
Total	30	100.0

Table.6 describes the geographical area of their residence. Fourteen (14) children (46.7%) have come from urban area and 16 children (53.3%) come from rural area. This shows that rural

people are also becoming more sensitized about the behavioral problems of children.

Table – 7 Parental Employments

Parental Employment Status		Frequency	Percent
Father	Employed	30	100.0
	Unemployed	0	0
	Total	30	100.0
Mother	Employed	11	36.7
	Unemployed	19	63.3
	Total	30	100.0

The frequency distribution of parents' employment status is depicted in Table – 7. From the table it can be understood that all the fathers are employed. Eleven (11) mothers (36.7%) are employed and 19 mothers (63.3%) are not employed. Father is the conventional bread winner of the family and has to be necessarily employed. Due to the increasing financial demand to maintain the standard of living a good number of mothers are also going out for work. In addition to the workload in their workplace mothers have to look after the household and children. Unemployed mothers are more available to their children to look after their basic needs and

to give more attention to the behavioral and personality development of their children. They have much more physical presence when the compared to the employed mothers.

FIGURE: 1. MATERNAL EDUCATION & EMPLOYMENT

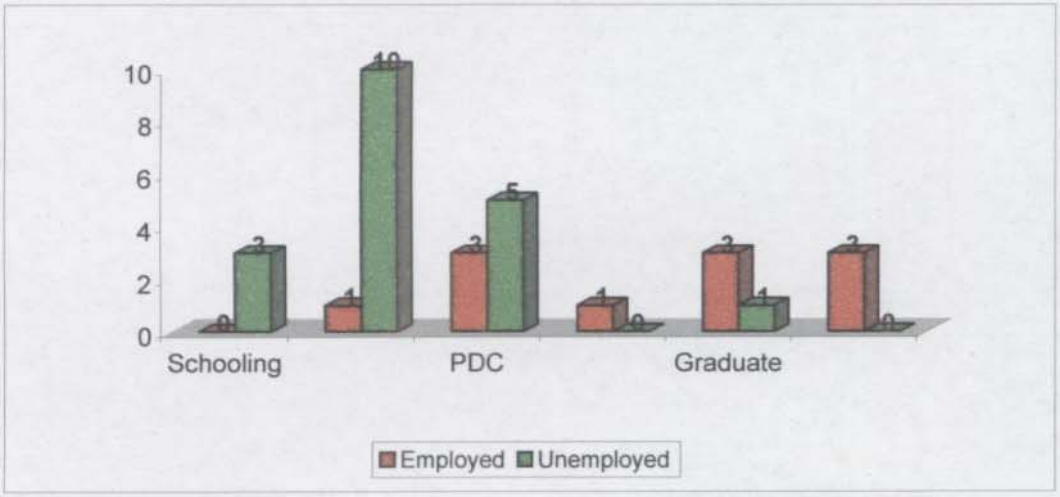

Figure-2 displays the educational and occupational background of mothers of the problem children. Though only 7 among them were had an education at graduate or higher levels, 6 out of this seven were employed too, showing an association between education and employment. Among the lesser educated, only few (4 out of 23) were employed.

Table – 8. Family income groups

Income	Frequency	Percent
Rs. 1000 – 5000	5	16.7
Rs. 5001 – 10000	10	33.3
Rs. 10001 – 20000	9	30.0
Rs. 20001 & Above	6	20.0
Total	30	100.0

The frequency distribution of the income of the family is illustrated in Table – 8. Five (5) families (16.7%) have an income below Rs.5000/- per month. Ten (10) families (33.3%) have an income between Rs.5001–10,000/- per month. Nine (9) families (30%) have an income Rs.10, 001/- to Rs.20, 000/- and 6 families (20%) have income above Rs.20, 001/- and above. The above table shows the socio-economic status of the families. It also indicates that the lower class families may not be giving much attention to the behavior problems of their children. Whereas the middle class families are much more aware of their children's problems and they seek professional help. It is also evident from the table that as the income increases and families come to the upper class they may not perceive their children's problems or they may tend to hide the problems from others to keep up the family status.

Table – 9. Family Types.

Type	Frequency	Percent
Nuclear Family	21	70.0
Joint / Extended	9	30.0
Total	30	100.0

Table.9 displays the type of the families in this study. 70% of the families (21) are nuclear families and 30% of the families (9) are

either Joint families or Extended families. In the present social set up nuclear families are increasing due to the social change of industrialization and urbanization. Due to the nature of their work parents are not able to spend more time with their children for their proper socialization especially when there are dual earning parents. In such situation children are likely to follow faulty models and thus develop behavior problems. In joint or extended families absence of parents is not felt by children because there are other members who substitute the deficiency.

Table – 10. Home Atmosphere

Home Atmosphere	Frequency	Percent
Not Cordial	8	26.7
Cordial	22	73.3
Total	30	100.0

Table.10 depicts the home atmosphere in the family. Table shows that in 8 families (26.7%) home atmosphere is not cordial whereas 22 families (73%) have cordial home atmosphere. When the family relationship is cordial each member of the family is given special attention and special consideration. In such situation when the child shows some non-socialized or 'abnormal' behavior it may easily be sensed by parents as problem behavior and they tend to seek professional help. Whereas in a non-cordial family

relationship even if children's problems may tend to increase it may not be properly heeded to.

Table –11. Number of children

Number	Frequency	Percent
One Child	4	13.3
Two Children	18	60.0
3 or More Children	8	26.7
Total	30	100.0

The frequency position of the number of children in the family is presented in Table – 11. It is evident from the above table that 4 families (13.3%) are one child families and 18 families (60%) are two children families. There are 8 families (26.7%) who have 3 or more children. As the decline of the joint family system nuclear families have become more prevalent in our society. Nuclear family consisted of father, mother and their children only. The norms of small family are deep rooted among Keralites, restricting the number of children into one or two. Very few Keralites have more than two children. Parents tend to compare their children with the siblings and a particular behavioral difference is judged by parents as problem behavior.

Table -- 12. Birth Order

Birth order	Frequency	Percent
First	21	70.0
Second	8	26.7
Third	0	0
Fourth	1	3.3
Total	30	100.0

Table.12 shows that 21 children (70%) are first born child, 8 children (26.7%) are the second born and 1 child (3.3%) is the forth child of the family. First born children tend to show more behavioral problem because parents place more expectations and demands from the elder child.

Table – 13. Sibling Problem

Sibling Problem	Frequency	Percent
Absent	20	66.7
Present	10	33.3
Total	30	100.0

Table.13 depicts the presence or absence of sibling problem in the family. In 66.7% families (20) sibling problem is not reported whereas in 33.3% families (30) sibling problem is reported in this study. In a predominantly nuclear family set up, children are looked after in a better way and thus may tend to decrease sibling rivalry and related problems.

Table – 14 Parental Educations

Parental Educational Level		Frequency	Percent
Father	1.<SSLC	3	10.0
	2. SSLC	14	46.6
	3. PDC	2	6.7
	4. Technical	5	16.7
	5. Degree	4	13.3
	6. PG / Professional	2	6.7
	Total	30	100.0
Mother	1.<SSLC	3	10.0
	2. SSLC	11	36.7
	3. PDC	8	26.7
	4. Technical	1	3.3
	5. Degree	4	13.3
	6. PG / Professional	3	10.0
	Total	30	100.0

Table.14 is an illustration of parent's educational level. Three (3) fathers (10%) have their education less than SSLC. Fourteen (14) fathers (46.6%) have SSLC education. Two (2) fathers (6.7%) have studied up to PDC. Five (5) fathers (16.7%) are technically educated and four (4) fathers (13.3%) are degree holders. Only 2 fathers (6.7%) have post graduate or professional qualification. Three (3) mothers (10%) are less than SSLC and 11 mothers (36.7%) are SSLC. Eight (8) mothers (26.7%) have studied up to PDC and 1 mother (3.3%) is technically qualified. Four (4) mothers (13.3%) have a degree qualification and 3 mothers (10%) are post graduate or professionally qualified. Kerala is a state where 100% literacy is achieved. Due to this, both men and

women are almost equally educated. Sometimes females are better educated than men. Many men after basic education go for technical education which facilitates to get a job. From the above table it can be seen that only one mother is technically educated whereas 5 fathers are technically educated.

Figure: 2. PATERNAL EDUCATION

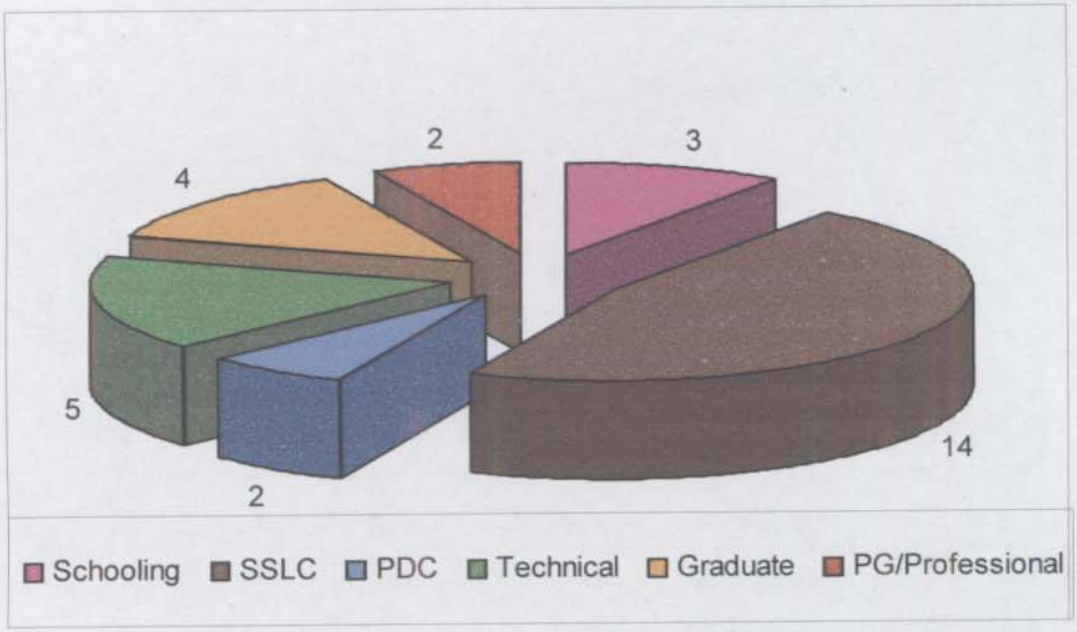

Figure-1 depicts the educational background of the fathers of the problem children. Accordingly, only few among the fathers were educated at graduate levels or above, while majority among them did not have higher education though all were employed

Table – 15 Parental Age

Parental Age group		Frequency	Percent
Father	Up to 39 yrs	14	46.7
	40 yrs & above	16	53.3
	Total	30	100.0
Mother	Up to 35 yrs	17	56.7
	36 yrs & above	13	43.3
	Total	30	100.0

The frequency distribution of parental age group is represented in Table – 15. Fourteen (14) fathers (46.7%) are aged up to 39 years. Sixteen (16) fathers (53.3%) are aged 40 years and above. Seventeen (17) mothers (56.7%) are aged up to 35 years and 13 mothers (43.3%) are aged 36 years and above. It is seen that while majority of fathers belonged to the group of '40 years and above', majority of mothers were in the group of 'up to 35 years' It is conventional in this society that men marry women younger to their age and so this age discrepancy.

Figure: 3. AGES OF PARENTS.

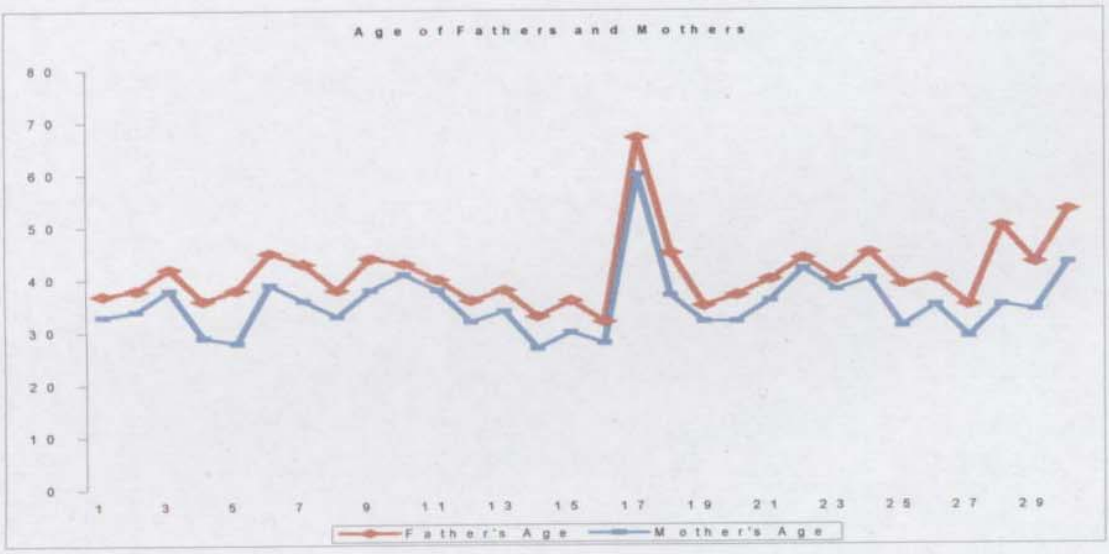

Figure-3 demonstrates the age distribution of fathers and mothers of the problem children in this study. The line graph presents the remarkable association between the ages of fathers and mothers. This association is in fine tune with the prevalent socio-cultural patterns of age in marriage in Indian Society.

Table – 16. Cross tabulation between Age Group and Sex.

Age		Sex		Total
		Male	Female	
Age Group	6-11 Years Nos.	9	5	14
	% of Total	30.3%	16.7%	46.7%
	12-16 Years Nos.	10	6	16
	% of Total	33.3%	20.0%	53.3%
	Total Nos.	19	11	30
	Total %	63.3%	36.7%	100.0%

$X^2 = 0.010$, df = 1, Sig.Level = 0.919 (Not Significant)

Table.16 illustrates the cross tabulation of children according to sex and age group. Out of 14 children (46.7%) belonging to the age group of 6-11 years, there were 9 male children (30.3%) and 5 female children (16.7%). Out of 16 children (53.3%) belonging to the age group of 12-16 years old, there were 10 male children (33.3%) and 6 (20%) female children. The chi-square test result shows that there was not any statistically significant association between the variables, age group and sex ($X^2 = 0.01$, $P<0.919$). These findings mean that age and sex are not associated and hence independent.

One of the objectives of the present study was to assess whether children having behavior problems benefited from the behavioral interventions provided through their parents or not. There were 12 problem areas identified by Achenbach in the behavior problems of children. These are Schizoid traits, Somatic complaints, Aggressiveness, Delinquency, Obsessiveness, Hyperactivity, Withdrawal, Sex Problems, Depression, Cruelty, Uncommunicativeness and Immaturity. These problem areas were investigated and assessed. After pre assessment, the effectiveness of intervention is assessed thrice i.e. at the end of 1 month, 2 months and at the end of 4 months for each variable in the study. Thus for each problem there were 4 phases of assessments namely;

Phase I- Pre-assessment (before intervention)
Phase II- Post-assessment-1 (at the end of one month)
Phase III- Post-assessment-2 (at the end of two months) and,
Phase IV- Post-assessment-3 (at the end of four months)

Data were analyzed using Paired t-test for repeated measures. For each problem six t-tests were performed to test the significance of difference in the mean scores for assessment Phases I & II, I & III, I & IV, II & III, II & IV, and III & IV.

Table-17. Comparison of mean scores for Schizoid traits at different phases of assessment: Paired t-test results.

Pairs	Assessment Phases	Mean	N	SD	Pair's Mean	Pair's S D	df	Paired t value
Pair 1	I	4.47	30	2.69				**
	II	1.20	30	1.13	3.27	2.10	29	8.521
Pair 2	I	4.47	30	2.69				**
	III	.50	30	1.31	3.97	2.77	29	7.835
Pair 3	I	4.47	30	2.69				**
	IV	.20	30	1.10	4.27	2.79	29	8.374
Pair 4	II	1.20	30	1.13				*
	III	.50	30	1.31	0.70	1.62	29	2.364
Pair 5	II	1.20	30	1.13				**
	IV	.20	30	1.10	1.00	1.60	29	3.429
Pair 6	III	.50	30	1.31				**
	IV	.20	30	1.10	0.30	0.47	29	3.525

** Significant at 0.01 level
* Significant at 0.05 level

Results presented in the table-17 clearly indicate that the pre-assessment (Phase-I) schizoid mean score differed significantly ($p<0.01$) from the mean score for post-assessment 1 (phase-II) at the end of 1 month, post-assessment 2 (phase-III) at the end of 2 month, and post-assessment 3 (phase-IV) at the end of 4 months. In all these cases, pre-assessment mean score was higher than the mean scores obtained for the other assessments at phase II, III, and IV.

A comparison of the mean scores for schizoid traits among the subjects between II and III phases of assessment shows a difference significant at 0.05 level, where as the difference in its mean score between II and IV phases as well as between III and IV phases were significant at 0.01 level. In all the comparisons, schizoid mean score at the end of four months (phase-IV) was found lower than the mean scores at the end of one month (phase-II) and two months (phase-III).

The results reveal that there are gradual reductions in the schizoid mean scores of the children as with the progress of intervention program through their parents. At the end of 4 months, i.e., post-assessment 3 (phase-IV), the mean scores have come down from 4.47(SD=2.69) to 0.20 (SD=1.10) with a t-value of 8.37 significant at 0.01 level. The findings suggest that the children with schizoid tendency could benefit significantly by behavioral interventions applied through involving parents.

FIGURE: 4. SCHIZOID STYLES AT FOUR ASSESSMENT LEVELS

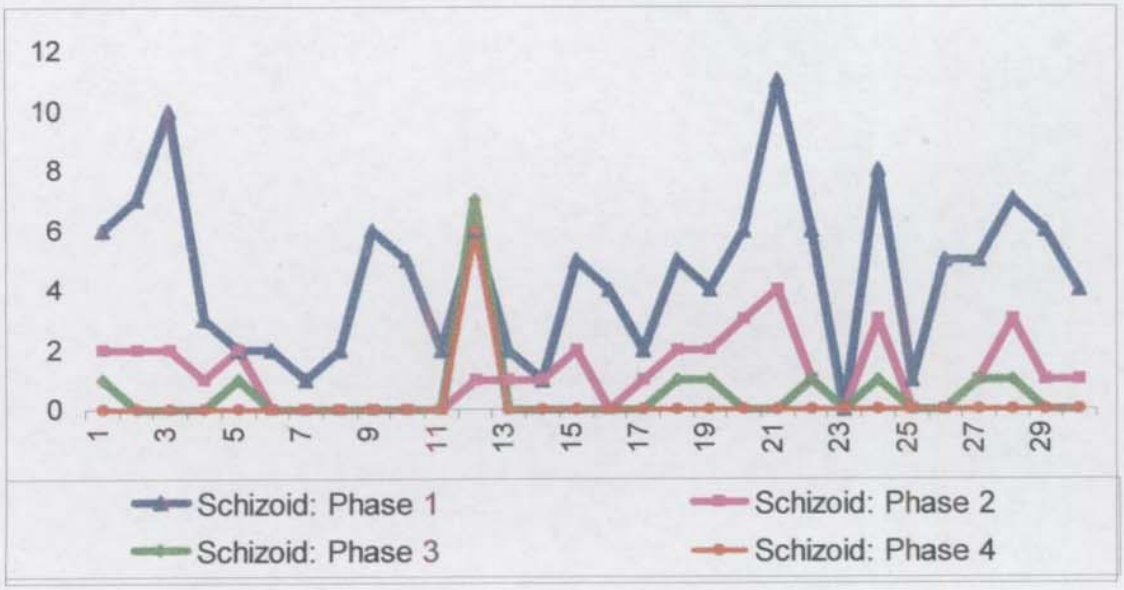

Figure-4 illustrates the remarkable reduction in schizoid styles of behavior among the problem children as a result of the behavioral intervention through training the parents, as evidenced from the various assessments. Maximum changes have occurred by the time of assessment at phase-3, and there after there was only little, if not no more change possible.

Table-18. Comparison of mean scores for Somatic complaints at different phases of assessment: Paired t-test results

Pairs	Assessment Phases	Mean	N	SD	Pair's Mean	Pair's S D	df	Paired t value
Pair 1	I	4.83	30	4.41				**
	II	1.60	30	1.99	3.23	3.32	29	6.337
Pair 2	I	4.83	30	4.41				**
	III	.20	30	.92	4.63	4.55	29	5.575
Pair 3	I	4.83	30	4.41				**
	IV	.10	30	.55	4.73	4.46	29	5.808
Pair 4	II	1.60	30	1.99				**
	III	.20	30	.92	1.40	2.18	29	3.525
Pair 5	II	1.60	30	1.99				**
	IV	.10	30	.55	1.50	2.05	29	4.014
Pair 6	III	.20	30	.92				
	IV	.10	30	.55	.10	.40	29	1.361

** Significant at 0.01 level

Results provided in the table-18 evidently demonstrate that the pre-assessment (Phase-I) mean score for somatic complaints differed significantly ($p<0.01$) from the mean scores in post-assessment 1 (phase-II) at the end of 1 month, post-assessment 2 (phase-III) at the end of 2 month, and post-assessment 3 (phase-IV) at the end of 4 months. In all these comparisons, pre-assessment mean score was more than the mean scores obtained in the other assessments at phase II, III, and IV.

Similarly, the test for comparing the mean scores for somatic complaints among the subjects between II and III phases of assessment shows the difference as significant at 0.01 level, whereas the difference in its mean score between II and IV phases as well as between III and IV phases were significant at 0.01 level. While comparing the mean scores for somatic complaints at phases III and IV, no statistically significant differences were observed between them. However, in all the comparisons, mean score for somatic complaints at the end of four months (phase-IV) is apparently lesser than the mean scores at the end of one month (phase-II) and two months (phase-III).

The results unveil that, as the intervention progressed from first to last sessions, there was an obvious drop in the mean scores for somatic complaints. Towards the completion of the intervention at the fourth month (Phase-IV / post-assessment 3) the mean score for somatic complaints have dropped to 0.10 (SD= 0.55) from 4.83 (SD= 4.41), which was the mean score at the pre-assessment level (Phase-I), with a t-value of 5.808 significant at 0.01. This outcome demonstrates that behavioral interventions through parents were advantageous at notable levels in managing the behavioral problems of children.

FIGURE: 5. SOMATIC COMPLAINTS AT FOUR ASSESSMENT LEVELS

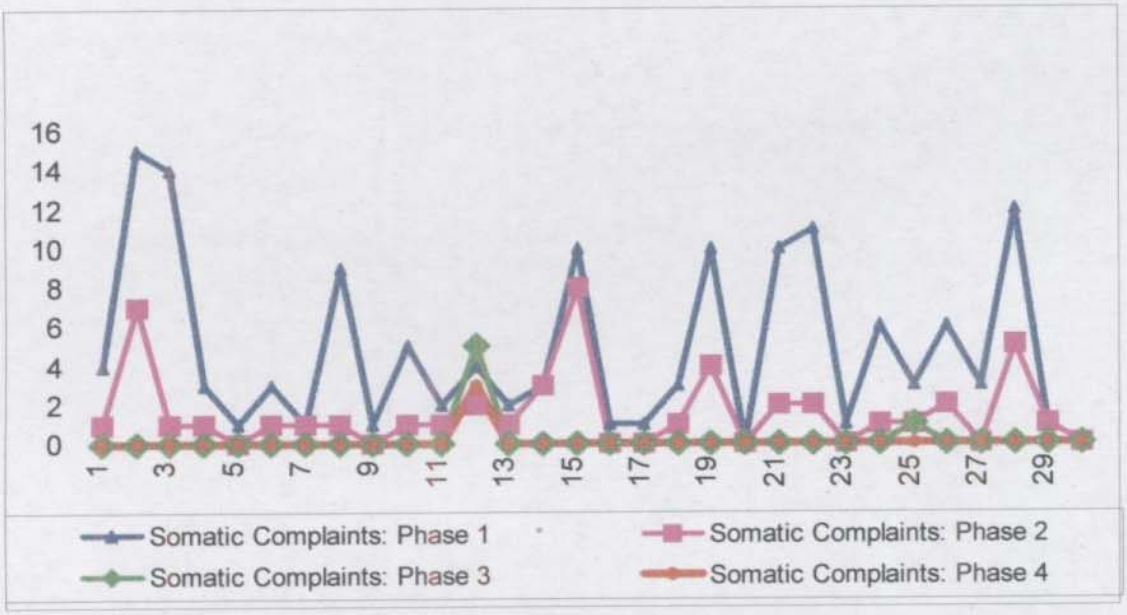

Figure-5 reveals the marked improvement in terms of notable drop in somatic complaints among the problem children as a result of the behavioral management by trained parents, mostly gained by the time of the assessment at Phase-3.

Table-19. Comparison of mean scores for Aggressiveness at different phases of assessment: Paired t-test results

Pairs	Assessment Phases	Mean	N	SD	Pair's Mean	Pair's SD	df	Paired t value
Pair 1	I	26.13	30	8.89				**
	II	11.63	30	5.26	14.60	5.35	29	14.850
Pair 2	I	26.13	30	8.89				**
	III	2.43	30	4.78	23.70	10.02	29	12.958
Pair 3	I	26.13	30	8.89				**
	IV	1.23	30	3.97	24.90	9.72	29	14.034
Pair 4	II	11.63	30	5.26				**
	III	2.43	30	4.78	9.20	7.47	29	6.745
Pair 5	II	11.63	30	5.26				**
	IV	1.23	30	3.97	10.40	7.00	29	8.143
Pair 6	III	2.43	30	4.78				**
	IV	1.23	30	3.97	1.20	1.21	29	5.410

** Significant at 0.01 level

The table-19 noticeably display that the pre-assessment (Phase-I) mean score for aggressiveness differed significantly ($p<0.01$) from the mean scores in post-assessment 1 (phase-II) at the end of 1 month, post-assessment 2 (phase-III) at the end of 2 month, and post-assessment 3 (phase-IV) at the end of 4 months. Pre-assessment mean score for aggressiveness was comparatively greater than the mean scores found in the further assessments at phase II, III, and IV.

Similarly, on comparing the mean scores for aggressiveness among the subjects between II and III, II and IV, and III and IV phases of assessment, the table illustrates that there were significant variations at 0.01 levels. Nevertheless, in all the comparisons, mean score for aggressiveness at the end of four months (phase-IV) is actually smaller than the mean scores at the pre-assessment, end of one month (phase-II), and two months (phase-III).

The results show that as training the parents to manage the behavioral problems in children advanced through various sessions, there was a remarkable reduction in the mean scores for aggressiveness in their children. As the intervention reached the fourth month (Phase-IV / post-assessment 3) the mean score for aggressiveness have decreased to 1.23 (SD= 3.97) from 26.13 (SD= 8.89), which was the mean score at the pre-assessment level (Phase-I), with a t-value of 14.034 significant at 0.01. This result discloses that behavioral interventions through parents were useful at considerable levels in managing the behavioral problems of children.

Similar results were obtained by early researchers like Dogra and Veeraraghavan (1994); Jena (1994); and Agarwal (1995). Dogra and Veeraraghavan (1994) studied the effect of parent counseling on aggressive behavior disorder and found significant positive change. Jena (2004) demonstrated successful use of behavior modification program to change and reduce aggressive behavior of a child. Agarwal (1995) use behavior modification techniques to reduce aggressive behavior of a nursery school child. The present study is also in tune with earlier studies in this area.

FIGURE: 6. AGGRESSIVENESS AT FOUR ASSESSMENT LEVELS

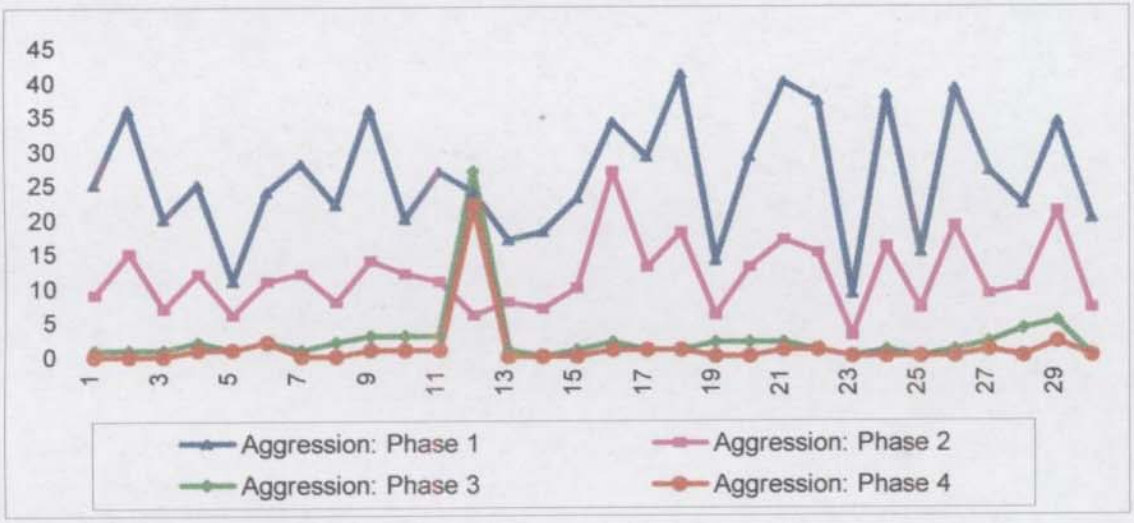

Figure-6 presents a graphic display of decline in the aggressive behavior among problem children resulting from the behavioral management by trained parents (intervention), almost by the point of Phase-3 assessment.

Table - 20. Comparison of mean scores for Delinquency at different phases of assessment: Paired t-test results

Pairs	Assessment Phases	Mean	N	SD	Pair's Mean	Pair's SD	df	Paired t value
Pair 1	I	11.20	30	7.30				**
	II	4.53	30	3.88	6.67	4.60	29	7.931
Pair 2	I	11.20	30	7.30				**
	III	.30	30	.84	10.90	7.49	29	7.971
Pair 3	I	11.20	30	7.30				**
	IV	.20	30	.76	11.00	7.52	29	8.017
Pair 4	II	4.53	30	3.88				**
	III	.30	30	.84	4.23	4.06	29	5.715
Pair 5	II	4.53	30	3.88				**
	IV	.20	30	.76	4.33	4.10	29	5.782
Pair 6	III	.30	30	.84				
	IV	.20	30	.76	1.00E.01	.40	29	1.361

** Significant at 0.01 level

Results presented in the table-20 clearly indicate that the pre-assessment (Phase-I) mean score for delinquency differed significantly ($p<0.01$) from the mean score for post-assessment 1 (phase-II) at the end of 1 month, post-assessment 2 (phase-III) at the end of 2 month, and post-assessment 3 (phase-IV) at the end of 4 months. In all these cases, pre-assessment mean score was higher than the mean scores obtained for the other assessments at phase II, III, and IV. A comparison of the mean scores for delinquency among the subjects between II and III, and II and IV phases of assessment also shows the difference as significant at 0.01 levels, whereas the difference in its mean score between III and IV phases

were not statistically significant at all. In the above comparisons, mean score for delinquency at the end of four months (phase-IV) was found to be markedly lesser than the mean scores at the end of one month (phase-II). The results reveal that there is a noteworthy reduction in the mean scores for delinquency among the children along with the progress of behavioral training programmed for the parents in the management of their problem children. At the end of 4 months, i.e., post-assessment 3 (phase-IV), the mean scores have come down from 11.20(SD=7.30) to 0.20 (SD=0.76) with a t-value of 8.017 significant at 0.01 level. The findings suggest that the children with delinquent tendency could benefit significantly by behavioral interventions applied through involving parents.

FIGURE: 7. DELINQUENCY AT FOUR ASSESSMENT LEVELS

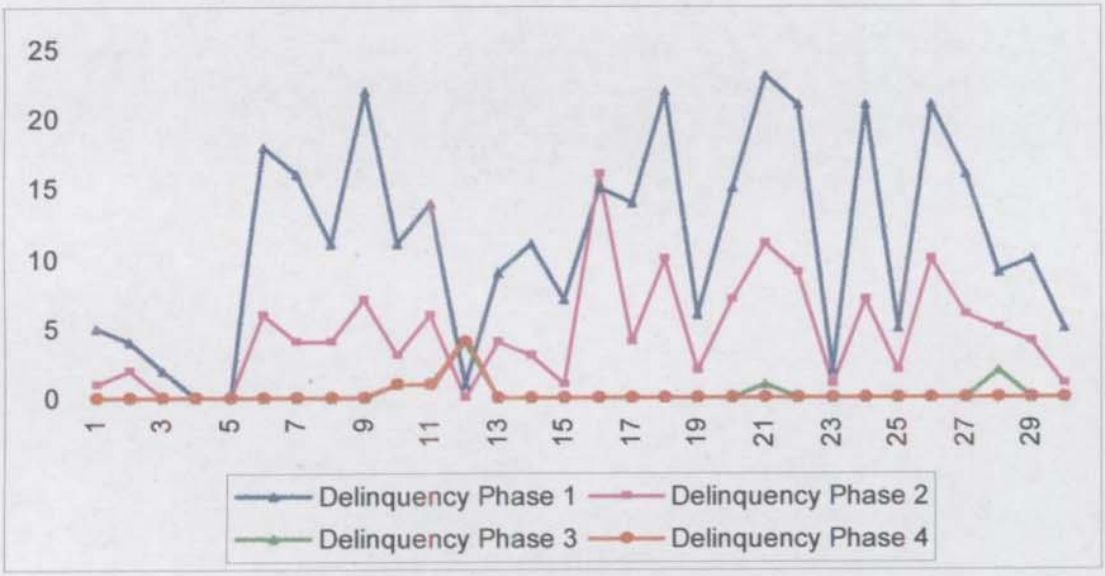

Figure-7 portrays the amount of diminution in delinquent behavioral styles among problem children consequent to the behavioral intervention by parents (parental management training). Most changes have already taken place by the time of the Phase-3 assessment itself.

Table-21. Comparison of mean scores for Obsessive ness at different phases of assessment: Paired t-test results

Pairs	Assessment Phases	Mean	N	SD	Pair's Mean	Pair's SD	df	Paired t value
Pair 1	I	8.70	30	5.03				**
	II	2.50	30	1.80	6.20	3.96	29	8.594
Pair 2	I	8.70	30	5.03				**
	III	.83	30	2.91	7.87	5.14	29	8.387
Pair 3	I	8.70	30	5.03				**
	IV	.47	30	2.01	8.23	4.93	29	9.144
Pair 4	II	2.50	30	1.80				*
	III	.83	30	2.91	1.67	3.37	29	2.712
Pair 5	II	2.50	30	1.80				**
	IV	.47	30	2.01	2.03	2.67	29	4.189
Pair 6	III	.83	30	2.91				*
	IV	.47	30	2.01	.37	.96	29	2.083

** Significant at 0.01 level
* Significant at 0.05 level

The results presented in the table-21 evidently demonstrate that the pre-assessment (Phase-I) mean score for obsession differed significantly ($p<0.01$) from the mean scores in post-assessment 1 (phase-II) at the end of 1 month, post-assessment 2 (phase-III) at the end of 2 month, and post-assessment 3 (phase-IV) at the end of

4 months. In all these comparisons, pre-assessment mean score for obsession was more than the mean scores obtained in the other assessments at phase II, III, and IV.

Similarly, the paired t-test results for comparing the mean scores of obsession among the subjects between II and III phases of assessment shows the difference as significant at 0.05 level, while the difference in its mean scores between II and IV phases was significant at 0.01 level. When comparing the mean scores for obsession at phases III and IV, statistically significant difference was observed at 0.05 levels. However, in all the above comparisons, mean score for obsession at the end of fourth month (phase-IV) was apparently lesser than the mean scores at the end of first (phase-II) and second (phase-III) months.

The results indicate that, as the intervention progressed over a four month period, there was an obvious decline in the mean scores for obsession. Towards the completion of the intervention at the fourth month (Phase-IV / post-assessment 3) the mean score for obsession have dropped to 0.47 (SD= 2.01) from 8.70 (SD= 5.03), which was the mean score at the pre-assessment level (Phase-I), with a t-value of 9.144 significant at 0.01. This outcome demonstrates that

behavioral interventions through parents were helpful at significant levels in managing the obsessive problems of children.

FIGURE: 8. OBSESSIVE BEHAVIOURAL STYLES AT FOUR ASSESSMENT LEVELS

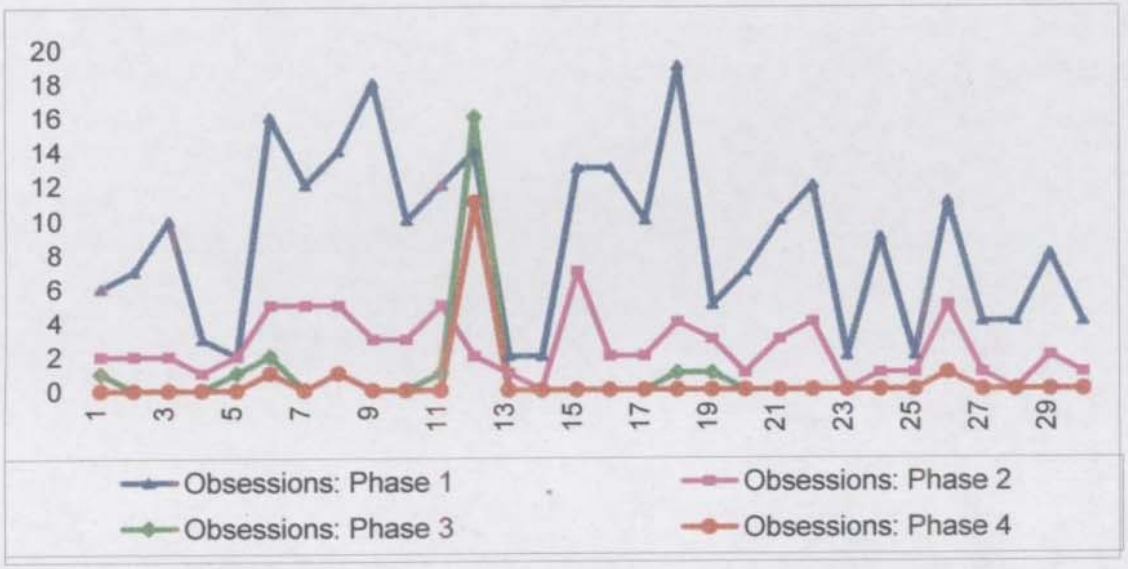

Figure-8 represents the attenuation in the quantity of change in obsessive behavioral styles among the problematic children after the behavioral intervention by trained parents. The graphic presentation clearly evidences the outstanding reduction in the obsessive styles of behavior among the most children with behavioral problems.

Table- 22. Comparison of mean scores for Hyperactivity at different phases of assessment: Paired t-test results.

Pairs	Assessment Phases	Mean	N	SD	Pair's Mean	Pair's SD.	df	Paired t value
Pair 1	I	11.67	30	3.40				**
	II	5.20	30	2.14	6.47	2.47	29	14.318
Pair 2	I	11.67	30	3.40				**
	III	1.17	30	2.29	10.50	4.10	29	14.027
Pair 3	I	11.67	30	3.40				**
	IV	.53	30	1.85	11.13	4.07	29	14.966
Pair 4	II	5.20	30	2.14				**
	III	1.17	30	2.29	4.03	2.94	29	7.510
Pair 5	II	5.20	30	2.14				**
	IV	.53	30	1.85	4.67	3.01	29	8.493
Pair 6	III	1.17	30	2.29				**
	IV	.53	30	1.85	.63	.89	29	3.898

** Significant at 0.01 level

The table-22 noticeably display that the pre-assessment (Phase-I) mean score for hyperactivity differed significantly ($p<0.01$) from the mean scores in post-assessment 1 (phase-II) at the end of 1 month, post-assessment 2 (phase-III) at the end of 2 month, and post-assessment 3 (phase-IV) at the end of 4 months. Pre-assessment mean score for hyperactivity was comparatively greater than the mean scores found in the further assessments at phase II, III, and IV.

Similarly, on comparing the mean scores for hyperactivity among the subjects between II and III, and II and IV phases of assessment, the table illustrates that there were significant variations in the mean ratings at 0.01 levels. The difference in mean ratings between III and IV phases was significant at 0.01 level. Nevertheless, in all the above evaluations, mean score for hyperactivity at the end of four months (phase-IV) was actually smaller than the mean scores at the pre-assessment, end of one month (phase-II), and two months (phase-III).

The results explain that as parental training in the behavioral management of problem children progressed through various sessions, there was a considerable reduction in the mean scores for hyperactivity in their children. Towards the fourth month of intervention (Phase-IV / post-assessment 3) the mean score for hyperactivity have dwindled to 0.53 (SD= 1.85) from 11.67 (SD= 3.40) that was the mean score at the pre-assessment level (Phase-I), with a t-value of 14.966 significant at 0.01. This result means that parents trained in behavioral interventions were effective at considerable levels in bringing about changes in the hyperactive behavior of children.

Earlier studies by Anastopoulos et al. (1993); Vahali & Kapur (1995); and Deb (1996) showed similar results. Anastopoulos et al. (1993) treated hyperactive children with parent training program and showed significant post treatment gains, which were maintained two months after treatment. Vahali & Kapur (1995) used parent training program to enhance pro-social behavior among children with hyperactivity and was found effective. Deb (1996) also found similar results in children with hyperactivity by parent training program. The present study also agrees with earlier studies in bringing out positive changes in hyperactivity in children by behavior parent training.

FIGURE: 9. HYPERACTIVITY AT FOUR ASSESSMENT LEVELS

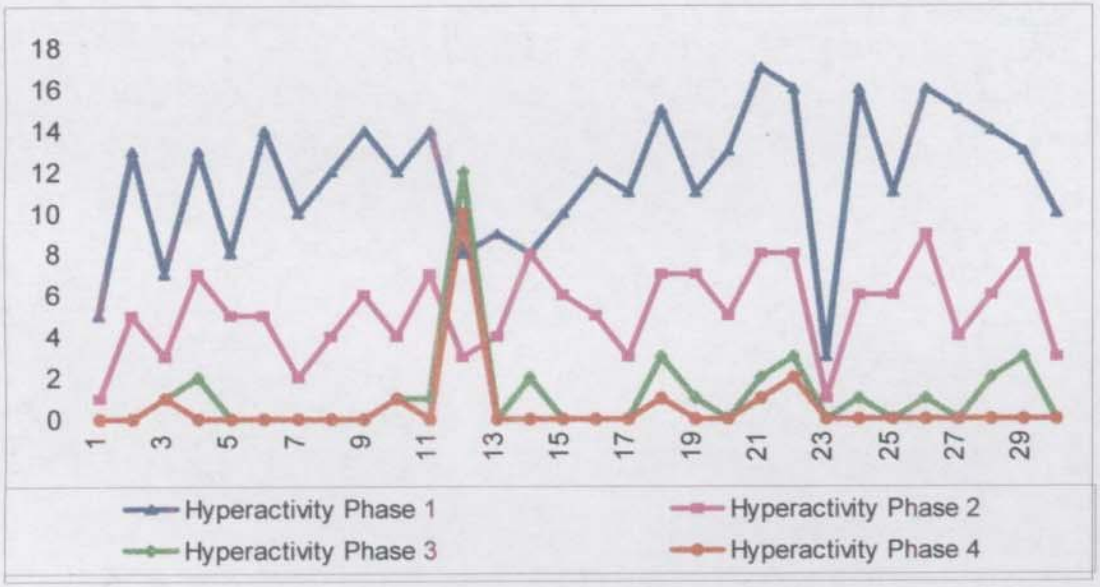

Figure-9 shows the obvious improvement among a great number of problem children such as a marked reduction in their hyperactive styles of behavior to almost or near normal levels already by the time of the phase-3 stage of assessment.

Table-23 . Comparison of mean scores for Withdrawal at different phases of assessment: Paired t-test results

Pairs	Assessment Phases	Mean	N	SD	Pair's Mean	Pair's SD	df	Paired t value
Pair 1	I II	9.23 3.13	30 30	6.25 2.61	6.10	4.02	29	** 8.311
Pair 2	I III	9.23 .43	30 30	6.25 .68	8.80	6.22	29	** 7.746
Pair 3	I IV	9.23 .47	30 30	6.25 2.37	8.77	7.19	29	** 6.678
Pair 4	II III	3.13 .43	30 30	2.61 .68	2.70	2.55	29	** 5.804
Pair 5	II IV	3.13 .47	30 30	2.61 2.37	2.67	3.89	29	** 3.755
Pair 6	III IV	.43 .47	30 30	.68 2.37	3.E02	2.14	29	 -.085

** Significant at 0.01 level

Results presented in the table-23 clearly indicate that the pre-assessment (Phase-I) mean score of withdrawal differed significantly ($p<0.01$) from the mean score for post-assessment 1 (phase-II) at the end of 1 month, post-assessment 2 (phase-III) at the end of 2 months, and post-assessment 3 (phase-IV) at the end of 4 months. In all these cases, pre-assessment mean score was

higher than the mean scores obtained for the other assessments at phase II, III, and IV.

Comparisons of the mean scores for withdrawal traits among the subjects between II and III, and II and IV phases of assessment shows differences significant at 0.01 levels, where as the difference in its mean score between III and IV phases were not significant statistically. Mean score for withdrawal at the end of four months (phase-IV) was found lower than the mean score at the pre-assessment and the mean score at the end of one month (phase-II), and there was no marked difference between the mean scores at two months (phase-III) and four months (phase-IV). The results reveal that there was a gradual reduction in the mean scores of withdrawal among the children with the progress of intervention programme through their parents. At the end of 4 months, i.e., post-assessment 3 (phase-IV), the mean scores have come down from 9.23 (SD=6.25) to 0.47 (SD=2.37) with a t-value of 6.678 significant at 0.01 level. The findings suggest that the children with withdrawal tendency could benefit significantly by behavioral interventions applied through involving parents.

FIGURE: 10. WITHDRAWAL AT FOUR ASSESSMENT LEVELS

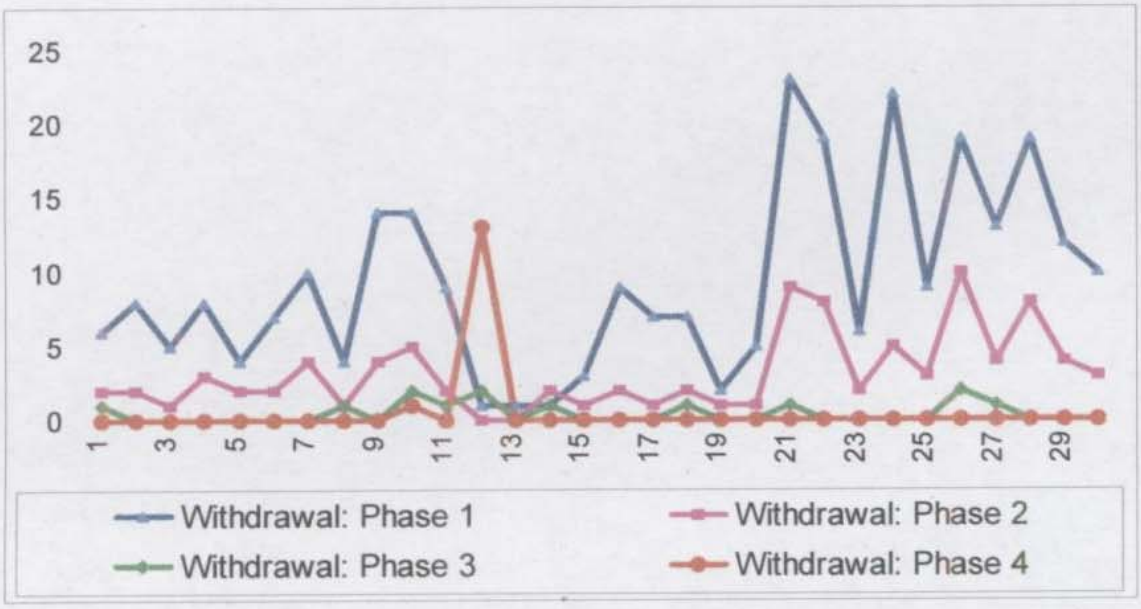

Figure-10 illustrates the course of change in the style of withdrawal behavior among children with behavioral problems as a result of the intervention through parents. Maximum change has almost occurred by the period of Phase-3 assessment.

Table-24. Comparison of mean scores for Sex Problems at different phases of assessment: Paired t-test results

Pairs	Assessment Phases	Mean	N	SD	Pair's Mean	Pair's SD	df	Paired t value
Pair 1	I II	1.80 .60	5 5	1.79 .55	1.20	1.30	4	2.058
Pair 2	I III	1.80 .20	5 5	1.79 .45	1.60	1.67	4	2.138
Pair 3	I IV	1.80 .00	5 5	1.79 .00	1.80	1.79	4	2.250
Pair 4	II III	.60 .20	5 5	.55 .45	0.40	0.55	4	1.633
Pair 5	II IV	.60 .00	5 5	.55 .00	0.60	0.55	4	2.449
Pair 6	III IV	.20 .00	5 5	.45 .00	0.20	0.45	4	1.000

Results provided in the table-24 evidently demonstrate that the pre-assessment (Phase-I) mean score for sex problems did not differ significantly from the mean scores in post-assessment 1 (phase-II) at the end of 1 month, post-assessment 2 (phase-III) at the end of 2 months, and post-assessment 3 (phase-IV) at the end of 4 months. In all these comparisons, pre-assessment mean score was numerically more than the mean scores obtained in the other assessments at phase II, III, and IV; but statistically not varying at any levels of significance. Similarly, the test for comparing the mean scores for sex problems among the subjects between II and III, II and IV, and between III and IV phases of assessment shows the mere arithmetical differences as non-significant statistically.

The results show that though the mean ratings were arithmetically diminishing from phase-I to phase-IV, the variations were not important. This outcome demonstrates that sex problems among children are few in number and negligible compared to their other behavioral problems. But this finding also may mean that whatever the quantum of the childhood / adolescent sex problems be, parents may not be the appropriate agents for intervention.

FIGURE: 11. SEX PROBLEMS AT FOUR ASSESSMENT LEVELS

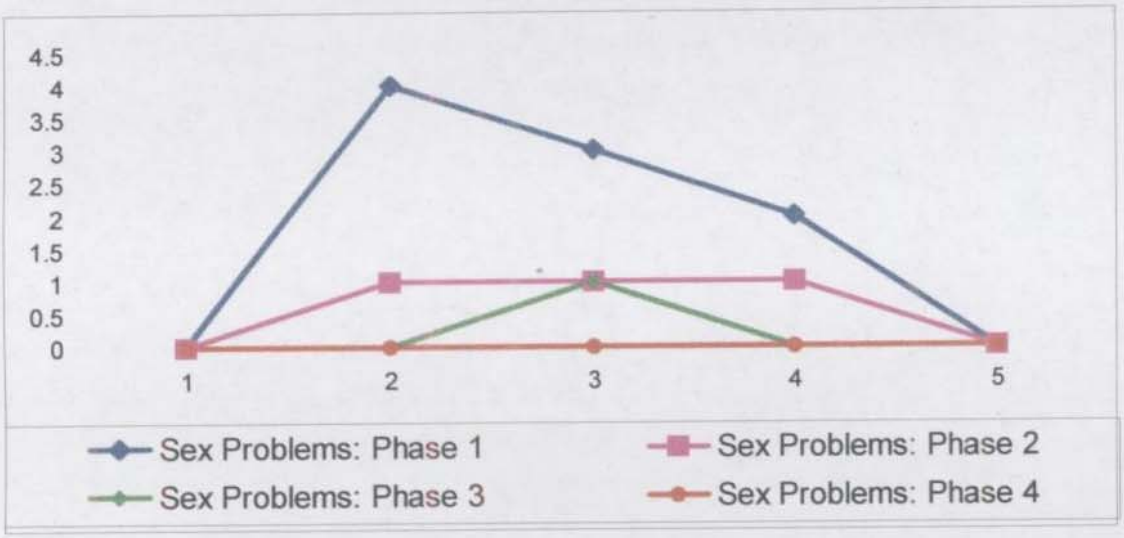

Figure-11 provides a graphic representation of decrease in sex problems from the time of assessment at Phase-1 to the assessment at Phase-4, as an outcome of the behavioral intervention by trained parents.

Table-25. Comparison of mean scores for Depression at different phases of assessment: Paired t-test results

Pairs	Assessment Phases	Mean	N	SD	Pair's Mean	Pair's SD	df	Paired t value
Pair 1	I	11.93	14	4.97				**
	II	4.07	14	1.59	7.86	4.02	13	7.320
Pair 2	I	11.93	14	4.97				**
	III	2.14	14	4.93	9.79	6.04	13	6.061
Pair 3	I	11.93	14	4.97				**
	IV	1.29	14	3.97	10.64	5.72	13	6.963
Pair 4	II	4.07	14	1.59				
	III	2.14	14	4.93	1.93	5.34	13	1.351
Pair 5	II	4.07	14	1.59				*
	IV	1.29	14	3.97	2.79	4.51	13	2.311
Pair 6	III	2.14	14	4.93				*
	IV	1.29	14	3.97	0.66	1.17	13	2.747

** Significant at 0.01 level
* Significant at 0.05 level

The table-25 clearly presents that the pre-assessment (Phase-I) mean score for depression differed significantly ($p<0.01$) from the mean scores in post-assessment 1 (phase-II) at the end of 1 month, post-assessment 2 (phase-III) at the end of 2 months, and post-assessment 3 (phase-IV) at the end of 4 months. Pre-assessment mean score for depression was comparatively higher than the mean scores found in the further assessments at phases II, III, and IV.

Similarly, on comparing the mean scores for depressed among the subjects between II and IV, and III and IV phases of assessment,

the table illustrates that there were significant variations at 0.05 levels. However, there were no statistically significant differences between the mean ratings of depression at second and third phases. Nevertheless, in all the comparisons, mean score for depression at the end of four months (phase-IV) was observably lesser than the mean scores at the pre-assessment, end of one month (phase-II), and two months (phase-III).

The results show that at the completion of the parental training for management of the behavioral problems in children, there was a remarkable reduction in the mean scores for depression in their children. As the intervention reached the fourth month (Phase-IV / post-assessment 3) the mean score for depressed have decreased to 1.29 (SD= 3.97) from 11.93 (SD= 4.97), which was the mean score at the pre-assessment level (Phase-I), with a t-value of 6.963 significant at 0.01. This result illustrates that behavioral interventions through parents were useful at considerable levels in managing the behavioral problems of children.

FIGURE: 12. DEPRESSION AT FOUR ASSESSMENT LEVELS

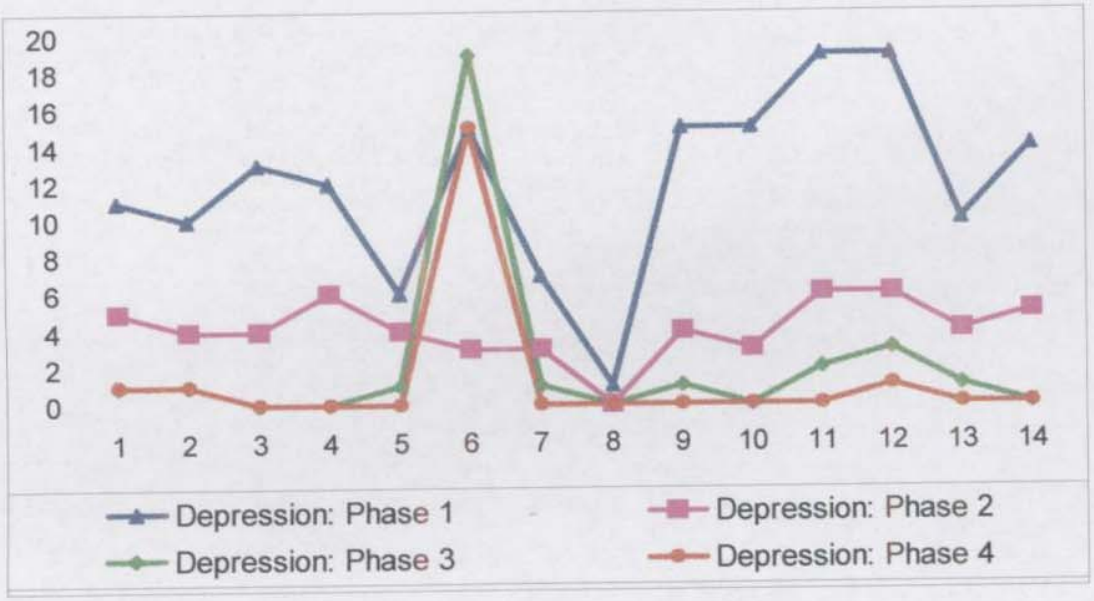

Figure-12 exemplifies graphically the noteworthy levels of recovery from depressive styles among the children with behavioral problems, as an effect of the intervention by trained parents applying behavioral management techniques. A large amount of the recovery has taken place among a majority of the children by the time of the Phase-3 assessment itself.

Table-26. Comparison of mean scores for Cruelty at different phases of assessment: Paired t-test results

Pairs	Assessment Phases	Mean	N	SD	Pair's Mean	Pair's SD	df	Paired t value
Pair 1	I	6.45	11	5.07				**
	II	1.91	11	1.64	4.55	3.62	10	4.170
Pair 2	I	6.45	11	5.07				**
	III	.45	11	.69	6.00	4.47	10	4.450
Pair 3	I	6.45	11	5.07				**
	IV	.27	11	.65	6.18	4.64	10	4.415
Pair 4	II	1.91	11	1.64				**
	III	.45	11	.69	1.45	1.21	10	3.975
Pair 5	II	1.91	11	1.64				**
	IV	.27	11	.65	1.64	1.29	10	4.219
Pair 6	III	.45	11	.69				
	IV	.27	11	.65	0.18	0.40	10	1.491

** Significant at 0.01 level

Results presented in the table-26 clearly indicate that the pre-assessment (Phase-I) mean score for cruelty differed significantly from the mean score for post-assessment 1 (phase-II) at the end of 1 month ($p<0.01$), post-assessment 2 (phase-III) at the end of 2 months ($p<0.01$), and post-assessment 3 (phase-IV) at the end of 4 months ($p<0.01$). In all these cases, pre-assessment mean score was higher than the mean scores obtained for the other assessments at phase II, III, and IV. A comparison of the mean scores for cruelty among the subjects between II and III, and II and IV phases of assessment also shows the difference as significant at 0.01 levels, whereas the difference in its mean score between III and IV

phases were not statistically significant at all. In the above comparisons, mean score for cruelty at the end of four months (phase-IV) was found to be markedly lesser than the mean scores at the end of one month (phase-II).The results reveal that there is a noteworthy reduction in the mean scores for cruelty among the children along with the progress of behavioral training program for the parents in the management of their problem children. At the end of 4 months, i.e., post-assessment 3 (phase-IV), the mean scores have come down from 6.45 (SD=5.07) to 0.27 (SD=0.65) with a t-value of 4.415 at statistically significant levels. The findings suggest that the children with cruel tendencies could benefit significantly by behavioral interventions applied through involving parents.

FIGURE: 13. CRUELTY AT FOUR ASSESSMENT LEVELS

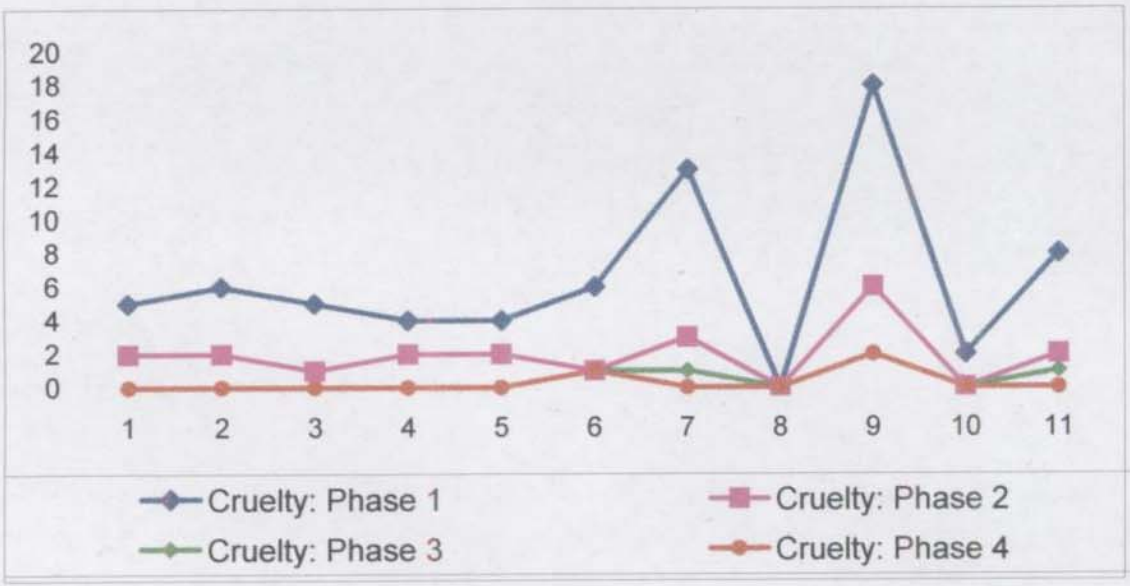

Figure-13 explicitly portrays the outcome of a behavioural intervention by trained parents. Problem children with cruel behavioural styles have made clearly visible benefits in terms of substantial recovery from their inconsiderate cruel behavioural styles due to this intervention almost by the time of assessment at Phase-3 itself.

Table-27.Comparison of mean scores for Uncommunicativeness at different phases of assessment: Paired t-test results

Pairs	Assessment Phases	Mean	N	SD	Pair's Mean	Pair's SD	df	Paired t value
Pair 1	I	8.68	19	5.57				**
	II	2.95	19	2.22	5.74	3.78	18	6.609
Pair 2	I	8.68	19	5.57				**
	III	.63	19	1.16	8.05	5.84	18	6.005
Pair 3	I	8.68	19	5.57				**
	IV	.32	19	.95	8.37	5.82	18	6.264
Pair 4	II	2.95	19	2.22				**
	III	.63	19	1.16	2.32	2.58	18	3.908
Pair 5	II	2.95	19	2.22				**
	IV	.32	19	.95	2.63	2.52	18	4.550
Pair 6	III	.63	19	1.16				**
	IV	.32	19	.95	0.48	0.48	18	2.882

** Significant at 0.01 level

The results presented in the table-27 manifestly present that the pre-assessment (Phase-I) mean score for communication problems (uncommunicative) differed significantly ($p<0.01$) from the mean

scores in post-assessment 1 (phase-II) at the end of 1 month, post-assessment 2 (phase-III) at the end of 2 months, and post-assessment 3 (phase-IV) at the end of 4 months. In all these comparisons, pre-assessment mean score for communication problems was more than the mean scores obtained in the other assessments at phase II, III, and IV.

Similarly, the paired t-test results for comparing the mean scores of communication problems among the subjects between II and III phases of assessment shows the difference as significant at 0.01 level, while the difference in its mean scores between II and IV phases was significant at 0.01 level. When comparing the mean scores for communication problems at phases III and IV, statistically significant difference was observed at 0.01 levels. However, in all the above comparisons, mean score for communication problems at the end of fourth month (phase-IV) was apparently lesser than the mean scores at the end of first (phase-II) and second (phase-III) months.

The results indicate that, as the intervention progressed over a four months period, there was an obvious decline in the mean scores for communication problems. Towards the completion of the intervention at the fourth month (Phase-IV / post-assessment 3) the

mean score for communication problems has dropped to 0.32 (SD= 0.95) from 8.68 (SD= 5.57), which was the mean score at the pre-assessment level (Phase-I), with a t-value of 6.264 significant at 0.01. This outcome demonstrates that behavioral interventions through parents were helpful at significant levels in managing the communication problems of children. Carpenter and Augustine (1973) found that in communication disorders, training mothers in behavior modification techniques was useful and effective. Hall and Rose (1987) also showed that in communication problems, parent training was useful in developing communication skills in children. Similar results are obtained in the present study also.

FIGURE:14. COMMUNICATION PROBLEMS AT FOUR LEVELS OF ASSESSMENT

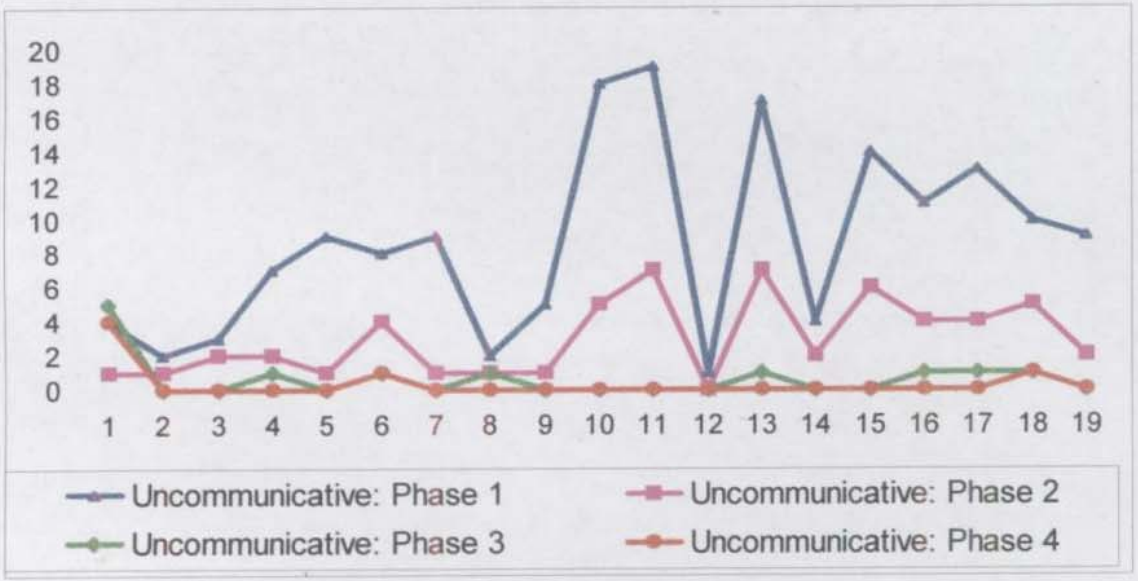

Figure-14 communicates graphically that marked progress was achieved by the problematic children in recovering from their uncommunicative styles of behavior by the time of assessment at Phase-3 itself, as a product of the behavioural intervention by the parents.

Table- 28. Comparison of mean scores for Immaturity at different phases of assessment: Paired t-test results

Pairs	Assessment Phases	Mean	N	SD	Pair's Mean	Pair's SD	df	Paired t value
Pair 1	I	5.60	10	2.67				**
	II	2.00	10	1.05	3.60	1.90	9	6.000
Pair 2	I	5.60	10	2.67				**
	III	.40	10	.70	5.20	2.44	9	6.738
Pair 3	I	5.60	10	2.67				**
	IV	.00	10	.00	5.60	2.67	9	6.620
Pair 4	II	2.00	10	1.05				**
	III	.40	10	.70	1.60	0.70	9	7.236
Pair 5	II	2.00	10	1.05				**
	IV	.00	10	.00	2.00	1.05	9	6.000
Pair 6	III	.40	10	.70				
	IV	.00	10	.00	0.40	0.70	9	1.809

** Significant at 0.01 level

The table-28 noticeably display that the pre-assessment (Phase-I) mean score for immaturity differed significantly ($p<0.01$) from the mean scores in post-assessment 1 (phase-II) at the end of 1 month, post-assessment 2 (phase-III) at the end of 2 months, and post-

assessment 3 (phase-IV) at the end of 4 months. Pre-assessment mean score for immaturity was comparatively greater than the mean scores found in the further assessments at phase II, III, and IV. Similarly, on comparing the mean scores for immaturity among the subjects between II and III, and II and IV phases of assessment, the table illustrates that there were significant variations in the mean ratings at 0.01 levels. The difference in mean ratings between III and IV phases was not significant statistically. Nevertheless, in all the above evaluations, mean score for immaturity at the end of four months (phase-IV) was actually lesser than the mean scores at the pre-assessment, end of one month (phase-II), and two months (phase-III). The results explain that as parental training in the behavioral management of problem children progressed through various sessions and completed, there was a considerable reduction in the mean scores for immaturity in their children. Towards the fourth month of intervention (Phase-IV / post-assessment 3) the mean score for immature have dwindled to 0.00 (SD= 0.00) from 5.60 (SD= 2.67) that was the mean score at the pre-assessment level (Phase-I), with a t-value of 6.620 significant at 0.01. This result means that parents trained in behavioral interventions were effective at considerable levels in bringing about changes in the immature behaviour of their children.

FIGURE: 15. IMMATURITY AT FOUR ASSESSMENT LEVELS

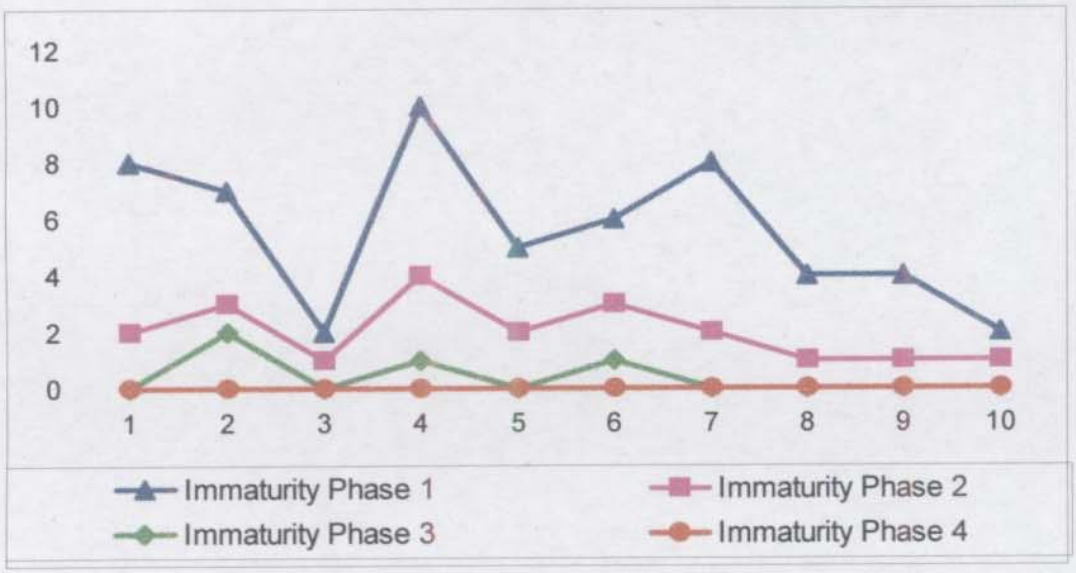

Figure-15 conveys the effect of the behavioral intervention by the trained parents in terms of the modifications in immature behavior among their problematic children at various levels of assessment. Most problematic children improved a great deal by the time of the assessment at Phase-3.

Table- 29. Effect of Gender cum Age categories on change in problem behaviors: One Way ANOVA test results. (Pre—Post 3)

Sl. No	Variable	Particulars	Sum of squares	df	Mean square	F-value
1	Change in Schizoid	Between groups	39.011	3	13.004	
		Within groups	186.856	26	7.187	1.809
		Total	225.867	29		
2	Change in Somatic complaints	Between groups	62.844	3	20.948	
		Within groups	515/022	26	19.809	1.058
		Total	577.867	29		
3	Change in Aggressiveness	Between groups	136.967	3	45.656	
		Within groups	2601.733	26	100.067	.456
		Total	2738.700	29		
4	Change in Delinquency	Between groups	537.100	3	179.033	*
		Within groups	1100.900	26	42.342	4.228
		Total	1638.000	29		
5	Change in Obsessiveness	Between groups	220.778	3	73.593	*
		Within groups	484.589	26	18.638	3.949
		Total	705.367	29		
6	Change in Hyperactivity	Between groups	84.144	3	28.048	
		Within groups	397.322	26	15.282	1.835
		Total	481.486	29		
7	Change in Withdrawal	Between groups	797.244	3	265.748	**
		Within groups	702.122	26	27.005	9.841
		Total	1499.367	29		

** Significant at 0.01 level
* Significant at 0.05 level

The following pages describe the results of Analysis of Variance (one-way) conducted to examine the effects of background variables on effectiveness of intervention. In cases where F-ratios were significant t-test was conducted to test the significance of difference between the groups compared.

Table 29 displays the findings of One-Way Analysis of Variance computed to study whether the change in rating of the various problem domains such as schizoid behaviour, somatic complaints, aggressiveness, delinquency, obsessiveness, hyperactivity and withdrawal – the dependant variables, differ at significant levels across the category of subjects divided on the basis of their sex and age.

The results reveal that there were statistically significant differences both within the groups and between the groups in relation to three dependant variables such as changes in the ratings of delinquency ($F=4.228$, $P<0.05$), obsessiveness ($F=3.949$, $P< 0.05$), and withdrawal ($F=9.841$, $P<0.01$).There were no statistically significant differences either between the groups or with in the groups categorized on the basis of sex and age. These variables include schizoid, somatic complaints, aggressiveness, and hyperactivity. These findings reveal that when the subjects were grouped on the basis of sex and age, these groups had an effect on the change in the ratings of delinquency, obsessiveness and withdrawal as a result of the behavioural intervention through parents. This implies that the change in ratings, in other words the rate of improvement was not uniform across these categories.

Table- 30. Change in Delinquency ratings (Post Intervention (PI): Pre-Post 3) across Gender cum Age groups: t- test results.

Groups	N	Mean	SD	df	t- value
Girls 6-11 yrs.	5	2.20	2.26		**
Girls 12-16 yrs.	6	15.00	4.50	9	-5.677
Girls 6-11 yrs.	5	2.20	2.28		*
Boys 6-11 yrs.	9	10.67	7.09	12	-2.557
Girls 6-11 yrs.	5	2.20	2.28		**
Boys 12-16 yrs.	10	13.30	7.99	13	-2.996
Girls 12-16 yrs.	6	15.00	4.56		
Boys 6-11 yrs	9	10.67	7.09	13	1.318
Girls 12-16 yrs.	6	15.00	4.56		
Boys 12- 16 yrs	10	13.30	7.99	14	0.473
Boys 6-11 yrs.	9	10.67	7.09		
Boys 12-16 yrs.	10	13.30	7.99	17	-0.756

** Significant at 0.01 level
* Significant at 0.05 level

Table-30 illustrates the findings of t- test carried out on change in Delinquency ratings on post intervention across Sex cum Age groups. The results show that there are statistically significant change in the ratings of change in Delinquency between the groups of Girls 6-11 years and Girls 12-16 years ($P<0.01$); Girls 6-11 years and Boys 6-11 years group ($P<0.05$); and Girls 6-11 years and Boys 12-16 years group ($P<0.01$). All the other three groups such as Girls 12-16 years and Boys 6-11 years ($P>0.05$); Girls 12-16 years and Boys 12-16 years group ($P>0.05$); and Boys 6-11

years and Boys 12-16 years group (P>0.05) show no statistically significant change in the ratings of change in Delinquency.

Table- 31. Change in Obsessive ness ratings (PI) across Gender cum Age groups: t- test results.

Groups	N	Mean	SD	df	t- value
Girls 6-11 yrs.	5	5.80	3.21		**
Girls 12-16 yrs.	6	13.33	2.80	9	-4.269
Girls 6-11 yrs.	5	5.60	3.21		
Boys 6-11 yrs.	9	8.22	5.93	12	-.906
Girls 6-11 yrs.	5	5.60	3.21		
Boys 12-16 yrs.	10	6.60	3.69	13	-.463
Girls 12-16 yrs.	6	13.33	2.80		
Boys 6-11 yrs	9	8.22	5.93	13	1.952
Girls 12-16 yrs.	6	13.33	2.80		**
Boys 12- 16 yrs	10	6.50	3.69	14	3.892
Boys 6-11 yrs.	9	8.22	5.93		
Boys 12-16 yrs.	10	6.50	3.69	17	.769

** Significant at 0.01 level

Table-31 presents the findings of t- test results computed to show the change in Obsessiveness ratings across Sex cum Age groups. The results reveal that there is a statistically significant difference in the ratings of change in Obsessiveness between the groups of Girls 6-11 years and Girls 12-16 years (P<0.01); and Girls 12-16 years and Boys 12-16 years group (P<0.01). In the other groups such as Girls 6-11 years and Boys 6-11 years (P>0.05); Girls 6-11 years and Boys 12-16 years group (P>0.05); Girls12-16 years and

Boys 6-11 years group (P>0.05); and Boys 6-11 years and Boys 12-16 years group (P>0.05) no significant difference was found in the ratings of change in Obsessiveness.

Table- 32. Change in Withdrawal ratings (PI) across Gender cum Age groups: t- test results.

Groups	N	Mean	SD	df	t- value
Girls 6-11 yrs.	5	6.20	1.79		
Girls 12-16 yrs.	6	9.50	3.73	9	-1.802
Girls 6-11 yrs.	5	6.20	1.79		
Boys 6-11 yrs.	9	2.56	6.17	12	1.271
Girls 6-11 yrs.	5	6.20	1.79		**
Boys 12-16 yrs.	10	15.20	5.92	13	-3.269
Girls 12-16 yrs.	6	9.50	3.73		*
Boys 6-11 yrs	9	2.56	6.17	13	2.457
Girls 12-16 yrs.	6	9.50	3.73		*
Boys 12- 16 yrs	10	15.20	5.92	14	-2.165
Boys 6-11 yrs.	9	2.56	6.17		**
Boys 12-16 yrs.	10	15.20	5.92	17	-4.558

** Significant at 0.01 level
* Significant at 0.05 level

Table-32 displays the findings of t- test results comparing Sex cum Age groups in the change in Withdrawal ratings. The results indicate that there is no statistically significant difference in Withdrawal ratings across the groups o Girls 6-11 years and Girls12-16 years (P>0.05); and Girls 6-11 years and Boys 6-11 years (P>0.05). Whereas in other groups like Girls 6-11 years and Boys12-16 years group (P<0.01); Girls 12-16 years and Boys 6-

11years group (P<0.05); Girls 12-16 years and Boys 12-16 years group (P<0.05); and Boys 6-11 years and Boys12-16 years group (P< 0.01) the change in Withdrawal ratings shows statistically significant difference.

Table-33. Effect of Level of Schooling on change in problem behaviors: One Way ANOVA test results. (Pre—Post 3)

Sl. No	Variable	Particulars	Sum of squares	df	Mean square	F-value
1	Change in Schizoid	Between groups	14.684	2	7.342	
		Within groups	211.183	27	7.822	.939
		Total	225.867	29		
2	Change in Somatic complaints	Between groups	55.830	2	27.915	
		Within groups	522.036	27	19.335	1.44
		Total	577.867	29		
3	Change in Aggressiveness	Between groups	216.729	2	108.36	
		Within groups	2521.971	27	93.408	1.16
		Total	2736.700	29		
4	Change in Delinquency	Between groups	404.555	2	202.28	*
		Within groups	1233.445	27	45.683	4.43
		Total	1638.000	29		
5	Change in Obsessiveness	Between groups	104.366	2	52.183	
		Within groups	601.001	27	22.259	2.34
		Total	705.367	29		
6	Change in Hyperactivity	Between groups	47.617	2	23.809	
		Within groups	433.849	27	16.068	1.48
		Total	481.467	29		
7	Change in Withdrawal	Between groups	592.341	2	296.17	**
		Within groups	907.025	27	33.594	8.82
		Total	1499.366	29		

** Significant at 0.01 level
* Significant at 0.05 level

Table - 33 presents the findings of statistical analysis using one way analysis of variance to study the effects of level of schooling

on change in problem behaviour. The results reveal that there were statistically significant difference both within the groups and between the groups in accordance with two dependent variables such as change in the ratings of delinquency ($F = 4.43$, $P<0.05$), and withdrawal ($F = 8.82$, $P<0.01$). There were no statistically significant differences either between the groups or within the groups in all the problem areas when categorized according to the level of schooling. These findings reveal that when the subjects were grouped on the basis of level of schooling, these groups had an effect on the changes in the ratings of delinquency and withdrawal as a result of behavioural intervention through parents.

Table- 34. Change in Delinquency ratings (PI) across School Level groups: t- test results.

Groups	N	Mean	SD	df	t- value
Primary School	9	9.67	7.94		
Middle School	10	7.10	4.77	17	0.865
Primary School	9	9.67	7.94		
High School	11	15.64	7.24	18	-1.757
Middle School	10	7.10	4.77		**
High School	11	15.64	7.24	19	-3.153

** Significant at 0.01 level

Table-34 shows the findings of t- test results comparing different School Levels in the change in Delinquency ratings. It is found that between Middle School and High School groups ($P<0.01$)

there is a statistically significant difference in the change in Delinquency ratings. Whereas between other groups like Primary School and Middle School (P>0.05); between Primary School and High School groups (P>0.05) there is no statistical difference in the ratings of change in Delinquency.

Table - 35. Change in Withdrawal ratings (PI) across School Level groups: t- test results.

Groups	N	Mean	SD	df	t- value
Primary School	9	2.89	6.16		*
Middle School	10	8.50	5.16	17	-2.164
Primary School	9	2.89	6.16		**
High School	11	13.82	6.05	18	-3.990
Middle School	10	8.50	5.16		*
High School	11	13.82	6.05	19	-2.159

** Significant at 0.01 level
* Significant at 0.05 level

Table- 35 presents the findings of t- test results comparing different School Levels in the change in Withdrawal ratings. It is indicated that there is statistically significant difference between all the groups such as between Primary School and Middle School (P<0.05); between Primary School and High School (P<0.01); and between Middle School and High School (P<0.05).

Table-36. Effect of Family Income on change in problem behaviors: One Way ANOVA test results. (Pre—Post 3)

Sl. No	Variable	Particulars	Sum of squares	df	Mean square	F-value
1	Change in Schizoid	Between groups	20.744	3	6.915	
		Within groups	202.122	26	7.889	.876
		Total	225.867	29		
2	Change in Somatic complaints	Between groups	14.633	3	4.878	
		Within groups	563.233	26	21.663	.225
		Total	577.867	29		
3	Change in Aggressiveness	Between groups	346.167	3	115.39	
		Within groups	2392.533	26	92.021	1.3
		Total	2738.700	29		
4	Change in Delinquency	Between groups	15.100	3	5.033	.
		Within groups	1622.900	26	62.419	081
		Total	1638.000	29		
5	Change in Obsessiveness	Between groups	30.911	3	10.304	.
		Within groups	674.456	26	25.941	397
		Total	705.367	29		
6	Change in Hyperactivity	Between groups	82.633	3	20.844	
		Within groups	418.933	26	16.113	1.3
		Total	481.467	29		
7	Change in Withdrawal	Between groups	160.967	3	53.656	
		Within groups	1338.400	26	51.477	1.0
		Total	1499.367	29		

Table – 36 depicts the results of one way analysis of variance calculated to find out whether the dependant factors that is changes in the ratings after intervention among the variables such as schizoid behaviour, somatic complainants, aggressiveness, delinquency, obsessiveness, hyperactivity and withdrawal, vary at statistically significant levels across various income groups of the subjects. The results indicate that none of the dependent variables differed at significant statistical levels. This implies that family

income as a variable had no effect on the dependant variables as listed above. In other words, the intervention per se has not been influenced by the family income of subjects. Behavioural counselling through parents has been effective in all behavioural problem domains within groups and between groups in all subjects regardless of family income of the clients. Rogers (1981) investigated whether there is any change in the interaction of the parents among the families of lower socio economic groups and higher socio economic groups according to income and the responsiveness to treatment for their children's behavioural problems. He found out that there was no significant difference among different family groups and treatment outcome demonstrated similar changes for all outcome measures. Contrary to this result some investigators like Wahler (1980), Kazdin & Frame (1983), Philip & Ray (1980) found parent training has differentially influenced the treatment outcome with different socio economic family groups. They found that parents of a higher socio economic status in comparison to relatively lower socio economic status parents exhibit greater proficiency in behavioural management skills following parent training.

Table-37. Effect of Number of Children (Sibling size) on change in problem behaviors: One Way ANOVA test results (Pre—Post 3)

Sl. No	Variable	Particulars	Sum of squares	df	Mean square	F-value
1	Change in Schizoid	Between groups	26.492	2	13.246	
		Within groups	199.375	27	7.384	1.794
		Total	225.867	29		
2	Change in Somatic complaints	Between groups	82.672	2	41.336	
		Within groups	496.194	27	18.341	2.254
		Total	577.867	29		
3	Change in Aggressiveness	Between groups	135.825	2	67.913	
		Within groups	2602.875	27	96.403	.704
		Total	2738.700	29		
4	Change in Delinquency	Between groups	59.931	2	29.965	
		Within groups	1578.069	27	58.447	.513
		Total	1638.000	29		
5	Change in Obsessiveness	Between groups	68.588	2	34.794	
		Within groups	635.778	27	23.547	1.478
		Total	705.367	29		
6	Change in Hyperactivity	Between groups	61.356	2	30.678	
		Within groups	420.111	27	15.560	1.972
		Total	481.467	29		
7	Change in Withdrawal	Between groups	284.172	2	142.09	
		Within groups	1215.194	27	45.007	3.157
		Total	1499.366	29		

Table – 37 shows the results of one way analyses of variance computed to find out whether the sibling size in the family has made any statistical difference in changes in ratings after intervention in various problem areas such as schizoid behaviour, somatic complaints, aggressiveness, delinquency, obsessiveness, hyperactivity and withdrawal. The results demonstrate that none of the dependent variables showed difference at statistically significant levels. This means that the number of children or the

size of the family did not matter in making changes or showing improvement in children in their behaviour problems when intervention was given through parents.

Table-38. Effect of Gender on change in problem behaviour: t- test results

Sl. No.	Variables		N	Mean	SD	df	t-value
	Dependent variable	Sex					
1	Change in Schizoid	Male Female	19 11	4.32 4.18	2.85 2.82	28	.125
2	Change in Somatic Complaints	Male Female	19 11	4.42 5.27	4.15 5.12	28	0.487
3	Change in Aggressiveness	Male Female	19 11	25.26 24.27	11.06 7.28	28	0.285
4	Change in Delinquency	Male Female	19 11	12.05 9.18	7.49 7.56	28	1.009
5	Change in Obsessiveness	Male Female	19 11	7.32 9.82	4.82 4.94	28	1.360
6	Change in Hyperactivity	Male Female	19 11	11.28 10.91	4.58 3.27	28	0.226
7	Change in Withdrawal	Male Female	19 11	9.21 8.00	8.76 3.35	28	0.438
8	Change in Depression	Male Female	9 5	11.00 10.00	7.00 2.74	12	0.302

Table – 38 illustrates the finding of independent samples t-test carried out on change in problem behaviours, comparing the group means of male and female subjects, in order to arrive at whether there were any statistically significant differences in the change ratings between the two sex groups. The results show that there are no statistically significant differences in the group means of change in ratings between males and females. This denotes that

sex had no effect in change in ratings on the various aspects of problematic behaviours across both these sex groups.

Table-39. Effect of Age on change in problem behaviors: t- test results

** Significant at 0.01 level

Sl. No.	Variables		N	Mean	SD	df	t-value
	Dependent variable	Age group					
1	Change in Schizoid	6–11 yrs	14	4.07	2.67	28	
		12-16 yrs	16	4.44	2.97		-.353
2	Change in Somatic Complaints	6–11 yrs	14	4.86	5.13	28	
		12-16 yrs	16	4.63	3.96		.140
3	Change in Aggressiveness	6–11 yrs	14	22.79	10.32	28	
		12-16 yrs	16	26.75	9.08		-1.120
4	Change in Delinquency	6–11 yrs	14	7.64	7.09	28	*
		12-16 yrs	16	13.94	6.78		-2.484
5	Change in Obsessiveness	6–11 yrs	14	7.29	5.15	28	
		12-16 yrs	16	8.06	4.74		-.984
6	Change in Hyperactivity	6–11 yrs	14	9.36	4.27	28	*
		12-16 yrs	16	12.69	3,28		-2.412
7	Change in Withdrawal	6–11 yrs	14	3.86	5.26	28	**
		12-16 yrs	16	13.06	5.81		-4.521

* Significant at 0.05 level

Table – 39 depicts the results of independent sample's t-test to find out whether there were any differences in the mean change in ratings of the dependent variables between the two groups of children categorized on the basis of their age. The subjects in this study were divided into two age groups such as 6-11 years and 12-16 years of age. The dependent variables constitute the change in ratings of problem aspects such as schizoid behaviour, somatic

complaints, aggressiveness, delinquency, obsessiveness, hyperactivity, and withdrawal among these behaviourally disturbed children. As seen from the table, there were three problem areas that were significantly impacted by the age factor. These problem areas where the groups means of change in ratings following intervention differed significantly were delinquency ($t = -2.484$, $P<0.05$), hyperactivity ($t = -2.412$, $P<0.05$), and withdrawal ($t = -4.521$, $P<0.01$). In other problem areas such as schizoid behaviour, somatic complaints, aggressiveness, and obsessiveness; there were no statistically significant differences in the group mean ratings of change between the children belonging to the two age groups (6-11 years and 12-16 years). Ratings of change in depression could not be subjected to this test because all the children belonged to 6-11 years of age, with none in the 12-16 years of age group. The group means evidences that senior children (12-16 years) had higher rates of change in the above three problem areas compared to junior children (6-11 years).It implies that age level is also an important factor in modification of problem behaviour in the areas of delinquency, hyperactivity and withdrawal; besides the effect of behavioural intervention through parents. This is not to denote that there were no changes in the other areas. On the other hand it means that changes were similar in the areas of schizoid behaviour, somatic complaints, aggressive and obsessiveness across the

children belonging to both the age groups. Moreover the parents might have been more concessional in implementing the intervention program while dealing with younger children.

Table-40. Effect of Paternal presence / absence on change in problem behaviors: t- test results

Sl. No.	Variables		N	Mean	SD	df	t-value
	Dependent variable	Father					
1	Change in Schizoid	Staying with Staying Abroad	20 10	4.75 3.30	2.75 2.76	28	1.361
2	Change in Somatic Complaints	Staying with Staying Abroad	20 10	4.80 4.80	4.62 4.38	28	.114
3	Change in Aggressiveness	Staying with Staying Abroad	20 10	24.25 25.80	9.21 11.13	28	.353
4	Change in Delinquency	Staying with Staying Abroad	20 10	10.05 12.90	7.44 7.89	28	.978
5	Change in Obsessiveness	Staying with Staying Abroad	20 10	7.55 9.60	4.57 5.58	28	-1.078
6	Change in Hyperactivity	Staying with Staying Abroad	20 10	11.00 11.40	3.48 5.27	28	.249
7	Change in Withdrawal	Staying with Staying Abroad	20 10	9.70 8.90	6.36 8.70	28	1.006
8	Change in Depression	Staying with Staying Abroad	10 4	12.10 7.00	3.96 8.37	12	1.594

Table – 40 presents the findings of independent sample's t-test calculated on behaviour problem areas such as schizoid, somatic complaints, aggressiveness, delinquency, obsessiveness, hyperactivity, withdrawal and depression; comparing the group means of ratings of change in paternal presence and absence in the

family with children, in order to study whether there were any statistically significant differences in the change of ratings of two groups. The result indicates that there are no statistically significant differences in the group means of changes in ratings between paternal presence group and paternal absence group. This implies that paternal presence or absence had no effect in changes in ratings on the various aspects of problematic behaviours across both these groups. Behaviour counselling through parents had been effective in children even if it was carried out only through mothers. Among the 30 families included in this study only in 20 families father was present and in 10 families father was absent due to their employment abroad. In all families mother was present. The result given in the above table 38 shows that irrespective of the father absent or present in the family mother alone also can bring out positive changes in children through behavioural intervention in their children's various behavioural problem areas. Budd et al. (1982) reviewed research studies from 1970 to1981 on father involvement in parent training. These studies indicate that father participation does not substantially increase the effectiveness of parent training. But therapists judged that the inclusion of fathers was beneficial since it led to more consistent treatment of the child and support for the mother. Horten (1984) suggested that research has failed to demonstrate a

clear benefit from including fathers in the training program possibly due to mother's assumption of the bulk of child care responsibilities. However he said that father's support of his wife's acquisition of skill may be crucial to the effectiveness of parent training. The results of the present study also agree with the former studies. Even if father was absent or not participated, mother alone could bring out positive changes in children.

Table - 41. Effect of Domicile on change in problem behaviors: t- test results

Sl. No.	Variables		N	Mean	SD	df	t-value
	Dependent variable	Resident					
1	Change in Schizoid	Urban Rural	14 16	3.00 5.38	2.32 2.75	28	* -2.533
2	Change in Somatic Complaints	Urban Rural	14 16	3.64 5.89	3.95 4.78	28	-1.264
3	Change in Aggressiveness	Urban Rural	14 16	22.43 27.06	10.11 9.12	28	-1.320
4	Change in Delinquency	Urban Rural	14 16	10.64 11.31	7.26 7.96	28	-239
5	Change in Obsessiveness	Urban Rural	14 16	8.43 8.06	5.18 4.86	28	.199
6	Change in Hyperactivity	Urban Rural	14 16	10.79 11.44	4.81 3.44	28	-.431
7	Change in Withdrawal	Urban Rural	14 16	8.29 9.19	7.65 6.99	28	-.337
8	Change in Depression	Urban Rural	3 11	9.67 10.91	9.50 4.91	12	-.322

* Significant at 0.05 level

Table-41 displays the finding of independent samples t-test computed on change in problem behaviours such as schizoid, somatic complaints, aggressiveness, delinquency, obsessiveness, hyperactivity, withdrawal and depression comparing the group means of urban families and rural families in order to find out whether there were any statistically significant differences in the change of ratings between the two domicile groups. The results denote that there are no statistically significant differences in the group means of change in ratings in behaviour problem areas except in schizoid behaviour between the urban and rural families. This reveals that domicile had no effect in the change in ratings on different aspects of problematic behaviour such as somatic complaints, aggressiveness, delinquency obsessiveness, hyperactivity, withdrawal and depression. Whereas from the table it is seen that there was one problem area, schizoid behaviour, which has made statistically significant difference by the domicile of the family. In this problem area of schizoid behaviour the urban group and rural group means change in ratings after intervention differed significantly ($t = -2.533$, $P<0.05$) rural children are comparatively less forthcoming, more inhibited, shy and diffident. The result from the table shows that rural children benefited much more than the urban children from the availability of their parents being in the rural domicile.

Table-42. Effect of Maternal Employment on change in problem behaviors: t- test results

Sl. No.	Variables		N	Mean	SD	df	t-value
	Dependent variable	Mother					
1	Change in Schizoid	Unemployed	19	4.00	2.65	28	
		Employed	11	4.79	3.10		-.681
2	Change in Somatic Complaints	Unemployed	19	5.42	4.72	28	
		Employed	11	3.66	3.91		1.11
3	Change in Aggressiveness	Unemployed	19	25.84	8.92	28	
		Employed	11	23.27	11.23		.692
4	Change in Delinquency	Unemployed	19	11.63	7.33	28	
		Employed	11	9.91	8.06		.598
5	Change in Obsessiveness	Unemployed	19	8.53	5.00	28	
		Employed	11	7.73	5.00		.422
6	Change in Hyperactivity	Unemployed	19	13.21	2.37	28	*
		Employed	11	9.27	5.66		2.05
7	Change in Withdrawal	Unemployed	19	9.16	6.35	28	
		Employed	11	8.09	8.75		.386
8	Change in Depression	Unemployed	9	11.56	5.77	12	
		Employed	5	9.00	5.87		.789

* Significant at 0.05 level

Table – 42 shows the findings of independent sample's t-test carried out on change in problem behaviour areas comparing the group means of unemployed mothers and employed mothers in order to arrive at a conclusion whether there was any statistically significant difference in the ratings of change on problem

behaviour between the two groups of mothers. The results indicate that there are no statistically significant differences in the group means of change of ratings in different problem areas, except in the ratings of change in hyperactivity between two groups of unemployed and employed mothers. This denotes that maternal employment had no effect in the change in ratings on various aspects of problem behaviour except in hyperactivity. Whereas statistically significant difference is found in the group means of change in ratings following intervention by unemployed and employed mothers in the problem area of hyperactivity ($t = 2.05$, $P<0.05$). This means that maternal employment had a definite effect in the change in ratings of children's hyperactivity. Unemployed mothers' children showed better improvement compared to employed mothers children in the problematic area of hyperactivity, after behavioural intervention. This may be explained that employed mothers are at disadvantage in giving care and attention to their hyperactive children, while unemployed mothers are in a better position having more time to share with children in the management of their hyperactive children. All fathers of children in this study are employed and hence had not affected the change positively or negatively.

Table-43. Effect of Family Type on change in problem behaviors: t- test results

Sl. No.	Variables		N	Mean	SD	df	t-value
	Dependent variable	Family					
1	Change in Schizoid	Nuclear Joint/Extended	21 9	4.67 3.33	2.97 2.18	28	1.209
2	Change in Somatic Complaints	Nuclear Joint/Extended	21 9	4.81 4.56	4.91 3.47	28	.140
3	Change in Aggressiveness	Nuclear Joint/Extended	21 9	24.57 25.67	10.53 8.02	28	-.278
4	Change in Delinquency	Nuclear Joint/Extended	21 9	10.71 11.67	7.52 7.91	28	-.313
5	Change in Obsessiveness	Nuclear Joint/Extended	21 9	7.76 9.33	4.35 6.24	28	-.795
6	Change in Hyperactivity	Nuclear Joint/Extended	21 9	11.19 11.00	4.49 3.12	28	.116
7	Change in Withdrawal	Nuclear Joint/Extended	21 9	9.19 7.78	8.00 5.07	28	.487
8	Change in Depression	Nuclear Joint/Extended	9 5	10.33 11.20	5.66 6.46	12	-.282

Table – 43 illustrates the findings of independent sample's t-test conducted on change in different behaviour problem areas. The test was to compare the group means of two family types such as Nuclear families and Joint or Extended families in their ratings of change in problem areas after the behavioural intervention. It is found that there were no statistically significant differences in the group means of nuclear and joint or extended families. This implies that family type had not affected in the progress made by children after the behavioural counselling by parents on their children's various behaviour problems.

Table-44. Effect of Home Atmosphere on change in problem behaviors: t- test results

Sl. No.	Variables		N	Mean	SD	df	t-value
	Dependent variable	Home atmosphere					
1	Change in Schizoid	Not Cordial Cordial	8 22	5.00 4.00	3.30 2.62	28	.864
2	Change in Somatic Complaints	Not Cordial Cordial	8 22	5.88 4.32	5.14 4.25	28	.840
3	Change in Aggressiveness	Not Cordial Cordial	8 22	26.25 24.41	13.04 8.53	28	.452
4	Change in Delinquency	Not Cordial Cordial	8 22	10.88 11.05	9.30 7.01	28	-.05
5	Change in Obsessiveness	Not Cordial Cordial	8 22	8.00 8.32	5.13 4.98	28	-.15
6	Change in Hyperactivity	Not Cordial Cordial	8 22	10.38 11.41	6.05 3.23	28	-.61
7	Change in Withdrawal	Not Cordial Cordial	8 22	6.75 9.60	9.86 6.08	28	-.92
8	Change in Depression	Not Cordial Cordial	6 8	11.00 10.38	6.93 5.13	12	-.196

Table – 44 depicts the statistical test findings on change in behaviour problems such as schizoid behaviour, somatic complaints, aggressiveness, delinquency, obsessiveness, hyperactivity, withdrawal, and depression. t-test was used to compare the group means of two types of home atmosphere such as not cordial home atmosphere and cordial home atmosphere and to study whether there were any statistically significant differences in the change in ratings between these two types of families. The results indicate that there is no statistically significant difference in the group means of change in ratings between these two cordial

and non cordial home atmospheres. This shows that home atmosphere whether cordial or not cordial has not affected the progress of children in various behaviour problems after the behavioural intervention by parents. Several investigators have suggested that there is a positive relationship between child behaviour and problems in the family system may affect the treatment. Griest, Douglas and Forehand Rex (1982) suggested that the outcome of parent training is affected adversely by poor parental personal, marital and extra familial adjustment.

Table-45: Effect of Sibling Problems on change in problem behaviors: t- test results

Sl. No.	Variables		N	Mean	SD	df	t-value
	Dependent variable	Sibling problem					
1	Change in Schizoid	Absent	20	4.05	2.72	28	
		Present	10	4.70	3.02		-.595
2	Change in Somatic Complaints	Absent	20	3.55	3.41		
		Present	10	7.10	5.51	28	-1.867
3	Change in Aggressiveness	Absent	20	25.85	10.59	28	
		Present	10	23.00	7.83		.752
4	Change in Delinquency	Absent	20	13.40	7.88	28	*
		Present	10	6.20	4.37		2.736
5	Change in Obsessiveness	Absent	20	8.85	5.41	28	
		Present	10	7.00	3.74		.987
6	Change in Hyperactivity	Absent	20	11.50	4.11	28	
		Present	10	10.40	4.12		.691
7	Change in Withdrawal	Absent	20	9.20	8.21	28	
		Present	10	7.90	4.79		.460
8	Change in Depression	Absent	9	10.56	7.20	12	
		Present	5	10.80	1.64		-.074

* Significant at 0.05 level

Table – 45 displays the findings of independent sample's t-test calculated on change in various behaviour problem areas comparing the group means of families where sibling problem is absent and sibling is present. This test was carried out to arrive at a conclusion whether there were any statistically significant difference in the ratings of change on different areas of problem behaviour between the sibling problem absent and sibling present family groups after the behavioural intervention. It is evident from the results that there is statistically significant difference in the group means of change in rating in the problem area of delinquency ($t = 2.736$, $P < 0.05$). This means that sibling problem had a definite effect in the improvement on delinquency after the behavioural intervention. Children with delinquency problem did not show the same rate of change or improvement compared to other problem areas. It may be due to that delinquency is masked by sibling problems because of which parents do not identify delinquency as such. The test result also shows that there is no statistically significant difference in the group means of change in ratings in all other problem areas, between family groups where sibling problem is absent and sibling problem is present. This shows that sibling problem has not affected in the change of problem behaviour except in delinquency.

Table-46. Effect of Father's Education on change in problem behaviors: t- test results

Sl. No.	Variables		N	Mean	SD	df	t-value
	Dependent variable	Father					
1	Change in Schizoid	Up to PDC Grad. etc	19 11	4.21 4.36	2. 68 3.11	28	-.142
2	Change in Somatic Complaints	Up to PDC Grad. etc	19 11	5.16 4.00	4.43 4.85	28	.678
3	Change in Aggressiveness	Up to PDC Grad. etc	19 11	25.42 24.00	8.82 11.51	28	.380
4	Change in Delinquency	Up to PDC Grad. etc	19 11	11.63 9.91	6.53 9.21	28	.598
5	Change in Obsessiveness	Up to PDC Grad. etc	19 11	8.05 8.55	5.01 5.03	28	-.259
6	Change in Hyperactivity	Up to PDC Grad. etc	19 11	11.89 9.82	2.98 5.40	28	1.365
7	Change in Withdrawal	Up to PDC Grad. etc	19 11	8.53 9.18	6.30 8.84	28	-.237
8	Change in Depression	Up to PDC Grad. etc	9 5	10.00 11.80	5.15 7.12	12	-.549

Table – 46 illustrates the findings of independent variables t-test computed on change in problematic behaviour, comparing the group means of low educated (up to PDC) and high educated (graduate and above) fathers groups. Testing was done to find out whether there were any statistically significant differences in the change of ratings between these two paternal education groups. The results show that there are no statistically significant differences in the group means of change in ratings between these two paternal education groups. This denotes that father's education whatsoever may be had made no effect on change in ratings on the various aspects of problematic behaviours.

Table-47. Effect of Mothers Education on change in problem behaviors:

t- test results

Sl. No.	Variables		N	Mean	SD	df	t-value
	Dependent variable	Mother					
1	Change in Schizoid	Up to PDC Grad. etc	22 8	4.14 4.63	2.49 3.66	28	-.418
2	Change in Somatic Complaints	Up to PDC Grad. etc	22 8	4.95 4.13	4.54 4.49	28	.444
3	Change in Aggressiveness	Up to PDC Grad. etc	22 8	25.95 22.00	8.71 12.26	28	.985
4	Change in Delinquency	Up to PDC Grad. etc	22 8	11.68 9.13	6.91 9.23	28	.819
5	Change in Obsessiveness	Up to PDC Grad. etc	22 8	8.14 8.50	5.02 5.01	28	-.176
6	Change in Hyperactivity	Up to PDC Grad. etc	22 8	12.27 8.00	2.37 6.05	28	** 2.830
7	Change in Withdrawal	Up to PDC Grad. etc	22 8	9.18 7.83	6.22 9.81	28	.518
8	Change in Depression	Up to PDC Grad. etc	10 4	10.70 10.50	5.12 7.94	12	.057

** Significant at 0.01 level

Table – 47 depicts the findings of independent sample's t-test carried out on change in problem behaviours, comparing the group means of low educated (Up to PDC) and high educated (Graduate and above) mother groups. This was to arrive at a conclusion whether there were any statistically significant differences in the change of ratings between these two maternal education groups. The results give evidence that there is no statistically significant difference in the ratings of change in all problem areas except in hyperactivity. The impact of this result is that mother's education

whatever may be had no effect on change in ratings on problem behaviour. But it is seen from the table that there is a problem area namely hyperactivity which was significantly impacted by the mother's education. The group means of change in ratings following intervention differed significantly in hyperactivity ($t = 2.830$, $P<0.01$). More educated (Graduate and above) mothers are assumed to be the majority among employed mothers, thereby not having sufficient time as other mothers (education up to PDC and unemployed) in giving more care and attention on their children including management of their hyperactivity.

Table-48. Effect of Father's Age on change in problem behaviors: t- test results

Sl. No.	Variables		N	Mean	SD	df	t-value
	Dependent variable	Father					
1	Change in Schizoid	> 39 yrs	14	3.43	2.17	28	
		40 yrs +	16	5.00	3.12		-1.578
2	Change in Somatic Complaints	> 39 yrs	14	4.64	4.50	28	
		40 yrs +	16	4.81	4.58		-.102
3	Change in Aggressiveness	> 39 yrs	14	21.00	9.11	28	*
		40 yrs +	16	28.31	9.16		-2.188
4	Change in Delinquency	> 39 yrs	14	7.21	6.96	28	**
		40 yrs +	16	14.31	7.31		-2.888
5	Change in Obsessiveness	> 39 yrs	14	5.86	4.26	28	*
		40 yrs +	16	10.31	4.63		-2.729
6	Change in Hyperactivity	> 39 yrs	14	9.86	4.29	28	
		40 yrs +	16	12.25	3.64		-1.652
7	Change in Withdrawal	> 39 yrs	14	4.36	6.85	28	**
		40 yrs +	16	12.63	8.02		-3.801
8	Change in Depression	> 39 yrs	11	9.00	5.16	12	*
		40 yrs +	3	16.67	3.21		-2.408

** Significant at 0.01 level
* Significant at 0.05 level

Table – 48 illustrates the results of independent sample's t-test to find out whether there were any differences in the mean change in ratings of the dependent variables between the two groups of fathers aged up to 39 years and fathers above 40 years of age. From the above table it is seen that there were five problem areas that were significantly impacted by the age factor of fathers. These problem areas where the group means of change in ratings following intervention differed significantly were aggressiveness ($t = -2.188$, $P<0.05$), delinquency ($t = -2.888$, $P<0.01$), obsessiveness ($t = -2.729$, $P<.05$), withdrawal ($t = -3.801$, $P<0.01$) and depression ($t = -2.408$, $P<0.05$). In the other problem areas such as schizoid, somatic complaints and hyperactivity there no statistically significant differences in the group mean ratings of change between the fathers belonging to the two age groups (up to 39 years and above 40 years). These results shows that children of younger fathers yielded lesser change in all the domains of problem behaviour whereas children of middle aged fathers (40 years and above) tended to show higher levels of change in these domains. Such differences were statistically evident particularly in the five problem areas mentioned above. This may be due to the fact that younger fathers may be more aggressively over involved and goal driven in their approaches to correct the children whereas older fathers by virtue of their long life experience they may be

milder, tolerant and supportive besides positively guiding their children towards the goal. Younger fathers being least experienced in parenting tend to over do while older fathers being experienced with probably more children that too over many years tend to be cautious and supportive while correcting their children. This appears to be function of age.

Table – 49. Effect of Mother's Age on change in problem behaviors: t- test results

Sl. No.	Variables		N	Mean	SD	df	t-value
	Dependent variable	Mother					
1	Change in Schizoid	> 35 yrs 36 yrs +	17 13	3.88 4.77	2.23 3.42	28	-8.59
2	Change in Somatic Complaints	> 35 yrs 36 yrs +	17 13	4.94 4.48	4.55 4.52	28	.287
3	Change in Aggressiveness	> 35 yrs 36 yrs +	17 13	22.76 27.69	9.60 9.52	28	-1.399
4	Change in Delinquency	> 35 yrs 36 yrs +	17 13	8.29 14.54	6.33 7.69	28	* -2.440
5	Change in Obsessiveness	> 35 yrs 36 yrs +	17 13	6.12 11.00	4.03 4.74	28	** -3.047
6	Change in Hyperactivity	> 35 yrs 36 yrs +	17 13	10.65 11.77	4.29 3.85	28	-.742
7	Change in Withdrawal	> 35 yrs 36 yrs +	17 13	6.53 7.69	7.30 6.13	28	* -2.054
8	Change in Depression	> 35 yrs 36 yrs +	11 3	9.00 16.67	5.16 3.21	12	* -2.408

** Significant at 0.01 level
* Significant at 0.05 level

Table – 49 presents the results of independent sample's t-test carried out to study the effect of mother's age in rating the changes

of dependent variables i.e., the different areas problem behaviour after the intervention by parents. There were significant differences in the mean change in the ratings between the two groups of mothers aged up to 35 years and mothers aged 36 and above years. The difference were in four problem domains such as delinquency ($t = -2.440$, $P< .05$), obsessiveness ($t = -3.047$, $P<0.01$) withdrawal ($t = -2.054$, $P<.05$) and depression ($t = -2.408$, $P< 0.05$). In other problem domains such as schizoid, somatic complaints, aggressiveness and hyperactivity there were no statistically significant differences in the group mean ratings of change between the mothers belonging to the two age groups, up to 35 years and above 36 years of age. This result also is in par with the fathers age factor showing that children of younger mothers yielded lesser changes in all the areas of problem behaviour whereas children of middle aged mothers (36 and above) tended to show higher levels of changes in these problem areas. Statistical evidence for the difference is explicit in the four problem areas indicated above. Younger mothers may be more concerned, over involved and anxious in correcting their children whereas older mothers through their long life experience have acquired better child rearing skills to bring the children towards positive mental health and behaviour adaptability. Younger mothers get lesser exposure and experience in parenting when compared to older

mothers. This shows that mother's age is an important factor in effecting changes in problem behaviour of children and acquiring and implementing behaviour modification skills in a behavioural intervention programme.

Behavioral parent training has been well studied by many researchers. In a study Wierson and Forehand (1994) reported that parent behavioral training based on social principles is an effective intervention strategy for non compliant children. They further emphasized positive reinforcement strategies and disciplinary techniques. Short-term and long-term follow up indicated that behavior change was maintained and generalized across behaviors. They further affirmed that parent behavior training is an effective clinical strategy for behavior disorders in children. Forehand and Elizabeth (1977) examined the effects of parent behavioral training on child non compliant behavior and found that behavioral training program produced significant changes in child behavior problems. These changes were maintained at a three months follow up. Children were better adjusted after treatment. Earlier researchers like Wright et al. (1993) indicated that parent training produced consistently positive outcome changes in both attitude and behavior of children. They also said that it is cost effective compared to other forms of intervention. Graziano and Diament

(1992) were of the opinion that parent behavioral training is most effective for children who are non compliant or oppositional behavior problem. Forehand Rex (1979) found in his research that a definite behavioral change was achieved through parental training and the change was maintained during follow up. In a parent training program Wells et al. (1980) demonstrated observable positive change in children's behavior problems and increased compliance to maternal commands. Koegal et al. (1978) were of the opinion that teaching parents the use of general behavior modification procedures was effective in changing child target behavior. McDonald (1977) in a study reported behavioral change in children through mothers training in using behavioral techniques. Evans (1977) also described how effective is home-based behavior management in maintaining and ensuring maximum behavioral change in children's behavior problems. In an earlier research Forehand et al. (1974) found that a general behavioral program could be rapidly learned by a mother and applied to the special problems of children. Changes occurred in both children's compliance and in mother's behavior and attitude towards children. Watson and Bassinger (1974) are of the opinion that parent-training technology is a potential service system. The effectiveness of behavioral parent training has been well documented by different researchers (Baum & Forehand, 1981;

McMahon & Forehand, 1980; Moreland, Schwebel, Beck, and Wells, 1982).The present study is also in agreement and complimentary to the above illustrated earlier researches. A definite effectiveness of behavioral change through parent training was observed in the present study also.

Although parent training generally has been successful, sufficient data exists to indicate that treatment outcome is not always positive. Griest and Forehand (1982) suggested that problems in the family system such as parental maladjustment, marital difficulties, and dysfunctional extra familial interactions may be responsible for the failure to occur. There is a positive relationship with child behavior problems and problems in the family. Rios and Gutierrez (1985) noted that although behavior parent training has been shown to be effective with a variety of child behavior problems, this treatment technique has not met with consistent success and cannot be generalized with all family population. Family characteristics and interfamilial factors have to be considered. Helm and Kozloff (1986) reported that parent training programs typically help families with respect to only a limited number of their short-term needs. Although as described above earlier researches have shown limitations of parent behavioral training, the present study has not come across any major and

substantial limitations. Only in one case where mother was alone looking after the child and father was not cooperative and the wedlock was in the threshold of divorce the target behavior change could not be achieved. Former researchers (Kazdin & Fame, 1983; Philips & Ray, 1980; Reisinger et al. 1976) have pointed out that those parents of a higher Socio-Economic Status (SES) in comparison to relatively lower SES parent's exhibit greater proficiency in behavioral management skills following parent training. Low SES parents are more likely to terminate treatment prematurely than are their higher income counter parts. (Clark & Baker, 1983; Dumas & whaler, 1983; Firestone & Witt, 1983) In the present study irrespective of low or high SES all parents cooperated and the treatment was effective in making change in their child's problem behavior. The reason for the high rate of success may be that the particular population in the study was neither very low nor very high in SES. Though there may be economical disparity, educationally and culturally the Keralite society is well advanced. Literacy level is high and female literacy also is on the higher side. Mothers share the major responsibility of child rearing. Parents are well aware of the childhood behavior problems. Therefore contrary to the findings of earlier researches, limitations in the present study are very minimal.

It has now become a common practice that in intervention studies the beneficiary's likes or dislikes, satisfaction or dissatisfaction is being assessed. This is commonly known as consumer satisfaction assessment. Measures of consumer satisfaction assess the extent to which treatment satisfies the wants, wishes and desires of clients for service (Lebow, 1982). Due to an increasing emphasis on treatment effectiveness in outcome research, consumer satisfaction is becoming recognized as an essential component in the outcome assessment of psychological treatments including parent training (Plante, Couchman & Diaz, 1995; Seligman. 1995). Measures of consumer satisfaction are considered the most subjective measures of treatment effectiveness (Eyberg, 1993). In this present study, also such an attempt was made to assess the satisfaction of the clients (consumer satisfaction). The tool employed to assess the consumer satisfaction in this study is Therapy Attitude Inventory development by Eyberg (1993).

Table - 50. Consumer Satisfaction Assessment

Sl No.	Consumer Items.	Rating points	Mother			Father		
			No.	%	Total %	No.	%	Total %
1	Techniques of Discipline	4 5	1 29	3.3 96.7	30 (100)	10 10	50 50	20 (100)
2	Imparting New Skills	4 5	1 29	3.3 96.7	30 (100)	11 9	55 45	20 (100)
3	Relation	3 5	1 29	3.3 96.7	30 (100)	-- 20	-- 100	20 (100)
4	Self-confidence	4 5	2 28	6.7 93.3	30 (100)	11 9	55 45	20 (100)
5	Change in problem	3 5	1 29	3.3 96.7	30 (100)	-- 20	-- 100	20 (100)
6	Response of child	3 5	1 29	3.3 96.7	30 (100)	-- 20	-- 100	20 (100)
7	Child's general behavior	2 5	1 29	3.3 96.7	30 (100)	-- 20	-- 100	20 (100)
8	Other aspects of behavior	3 4 5	1 1 28	3.3 3.3 93.3	30 (100)	-- 1 19	-- 5 95	20 (100)
9	Effectiveness of program	2 5	1 29	3.3 96.7	30 (100)	-- 20	-- 100	20 (100)
10	General Rating of the Program	4 5	1 29	3.3 96.7	30 (100)	2 18	10 90	20 (100)

Table – 50 (consumer satisfaction) displays the results in the form of frequency tabulation in relation to the number of responses on each rating points in the Therapy Attitude Inventory. There were totally ten items in the scale, each item with five rating points. As seen from the table, on the first item of the scale, expressing satisfaction with techniques of discipline that they learned, while one (1) mother and ten (10) fathers reported that they learned several useful techniques 29 mothers and 10 fathers reported that

they learned very many useful techniques. McMahon & Forehand (1983) have evaluated parents' perception of the techniques following participation in parent-training programme. In their study, parents generally have reported being satisfied with the treatment they received.

Coming to the second item of the Therapy Attitude Inventory on imparting new skills one (1) mother and eleven (11) fathers reported satisfaction that they learned several useful techniques, twenty nine (29) mothers and nine (9) fathers reported that they learned very many useful techniques.

With regard to the item 3 on the relationship between the parent and the child, while only one mother reported that the relationship was same as before the intervention, 29 mothers and all fathers (20) reported that their relationships with index child were very much better than before the intervention.

Pertaining to the item 4 on self confidence twenty eight (28) mothers and nine (9) fathers felt much more self confidence in their ability to discipline their child. Two mothers and eleven fathers reported somewhat more confidence in their ability to discipline their child. Giannotti & Doyle (1982) in their study on

the effectiveness of parental training found significant improvement on all 5 scales with parents reporting more confidence in themselves as parents, greater awareness of the effects of their behaviour on children, and more acceptance, understanding and trust of their children.

With reference to the item 5 on the scale on change in behaviour problems twenty nine (29) mothers and all fathers (20) reported that the major behaviour problems the child presented at home before the programme started had greatly improved after the intervention therapy. One (1) mother reported that there was no change in the behaviour problem of the child. It remained the same as before the programme started after the intervention. Behaviour counselling programme could not be benefited in the index child in changing the major behaviour problems presented at home before the programme started.

Pertaining to the item 6 on the response of the child only one mother reported that the child's compliance to mother's commands or requests even after the intervention programme was the same. Twenty-nine (29) mothers and all fathers were of the opinion that their child's compliance to their commands or requests had greatly improved after the intervention.

With reference to item 7 on the progress in the general behaviour of the index child, 29 mothers and all fathers reported that they were very satisfied with it. Only one mother reported that she was somewhat dissatisfied with the progress in her child.

Pertaining to item 8 on improvement in the degree of general personal or family problems other than the child's problem, 28 mothers and 19 fathers reported that the program helped them very much in improving their general personal or family problems. Whereas one mother and one father reported that, the programme helped them somewhat. However, one mother rated the programme as neither helped or hindered in this regard.

With reference to the item 9 on the effectiveness of the programme twenty nine (29) mothers and all fathers expressed that the type of programme used in this intervention was very good in helping them to improve the behaviours of their child. Whereas one mother reported that, the type of programme used had poorly helped her to improve the behaviour of her child.

With reference to the item 10 on the general rating of the programme twenty nine (29) mothers and eighteen (18) fathers

reported that they liked the programme very much. One mother and two fathers reported that they somewhat liked the programme.

Many outcome studies that have included assessment of consumer satisfaction have suggested that greater satisfaction is related to greater efficacy of treatment (Bradley & Clark, 1993). Parents' ratings of satisfaction on the outcome of treatment is studied by Heffer & Kelly (1987) and found that parents consistently favoured response cost and positive reinforcement over the other treatments.

From the descriptions above, almost all parents, both mothers and fathers apparently seem to have benefited from the intervention program and expressed their satisfaction with it, except one mother. This parent, the mother who was satisfied with many aspects of the intervention, however had problems in her relationship with her husband. As this behavioural intervention training for parents focussed exclusively on management of difficult children and did not cater to marital problem or conflict resolution, she had her difficulties in acquiring the behavioural management skills. Because of their breaking marriage, especially towards the later part of the present parental intervention programme, due to lack of cooperation and supportive involvement

from her spouse, though there were remarkable initial gains from the intervention, she could not sustain and augment the gain. This she has projected as a limitation of the intervention programme. This report is in line with the findings of Forehand et al. (1984) and Horten Lee (1984). Forehand et al. (1984) reviewed the effects of maternal distress in a parent-training programme and found that maternal distress can make a set back in the positive effect of the intervention outcome. This has happened in the case of this above-mentioned mother also. Horten Lee (1984) found that father's non-cooperation or non-participation and marital conflict could hinder positive outcome. In the present case, also father was not cooperative in the intervention programme and so mother could not maintain the positive change in behaviour of the child towards the end and through out the intervention programme.

Parents generally have reported being satisfied with the treatment they received. Satisfaction ratings have been received from all the parents who were available. All 30 mothers and 20 fathers participated in assessing consumer satisfaction. 10 fathers who work abroad were not available for this assessment. A limitation of studies assessing consumer satisfaction is that client reactivity to therapist or to treatment outcome may bias respondent's evaluation of treatment (Kazdin, 1980a; Kiesler, 1983; Lebow, 1982). In this

study maximum care and effort were taken to prevent any kind of biased evaluation. In order to attain this goal, parents were adequately trained and educated before administering Therapy Attitude Inventory for an ingenuous evaluation of the program.

Concluding Remarks

Parents who use positive parenting strategies in lieu of coercive ones effectively break cycles of coercive exchanges between themselves and their children and increase the probability that their children will reciprocate with positive behavior. The present findings are consistent with decades of research on parent management interventions. Parenting practices are malleable and can produce lasting effects on child adjustment. As the present study has shown, behavioral intervention with behavior modification techniques designed to affect parenting practices can produce lasting benefits to parenting practices and positive change in child behavior problems. The present study proves that behavioral counseling with parents is a strong treatment strategy to deal with behavioral problems of children and parents are satisfied with the outcome of the treatment and the technique used for achieving this goal.

BEHAVIOURAL COUNSELLING: A TREATMENT MODALITY FOR BEHAVIOURAL PROBLEMS IN CHILDREN

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E.D.JOSEPH

DEPARTMENT OF PSYCHOLOGY

UNIVRSITY OF CALICUT

2005

Chapter – V

SUMMARY AND CONCLUSION

The problems created by children's troublesome behavior constitute one of the most serious sources of difficulty in our society. Behavior problems in children has become a matter of grave concern to parents and significant others. Bringing up children in a mentally healthy and disciplined manner is a vital responsibility of parenthood. But due to lack of adequate skills in child rearing practices, some parents fail to control the misbehavior among their children. In being so, such parents expose their inadequacies and incompetence to be effective parents. Unhealthy parent-child relationship may also contribute to the disturbed behavior in children. Literature review reveals that behavioral intervention procedures such as Behavior Counseling to parents which are otherwise known as Parent Management Training have been utilized with a wide variety of childhood behavior problems and is an effective treatment approach for behavior problems among children. Most of the intervention procedures are aimed at reprogramming the social environment of the child through parent behavior training. Parents are given training in the management of problem children. Parent training involves the child's parents or caregivers as 'behavior change agents' or as administrators of the treatment program in the home setting. Parent behavior and child behavior are modified as a result of

parent training. Behavioral counseling of parents was geared toward teaching parents to modify their responses to the child in order to influence the child's subsequent behavior. Parental skill training programs have been shown to bring about improvements in parenting practices and to lead to reduction in childhood problem behaviors. Early researchers in this area are of the opinion that Behavioral Management Training for parents is an effective method for modifying the behavioral problems among children.

Behavioral parent training has been well studied by many researchers. In a study Wierson and Forehand (1994) reported that parent behavioral training based on social principles is an effective intervention strategy for non compliant children. They further emphasized positive reinforcement strategies and disciplinary techniques. Short-term and long-term follow up indicated that behavior change was maintained and generalized across behaviors. They further affirmed that parent behavior training is an effective clinical strategy for behavior disorders in children. Earlier researchers like Wright et al. (1993) indicated that parent training produced consistently positive outcome changes in both attitude and behavior of children. They also said that it is cost effective compared to other forms of intervention.

Aim and Objectives

The aim of the present study was to assess the efficacy of imparting behavioral management skills for parents in the modification of problem behavior observed in their children, and to find out the efficacy of behavior management by parents in modifying the behavioral problems among their own children. Thus, the present study was conducted with the specific objectives to give training to parents to develop the skills in behavior modification techniques, and thereby to empower and equip them in changing, modifying, or managing the problem behaviors in their children. Exposure and training of parents to simple behavioral principles help to build up skills in the parents to implement the behavioral programs. Parents served as the prime 'behavioral change agents' in this program. Operationally, the term "behavior counseling" is often used as a broad label to denote a multitude of behavioral techniques which also includes training of significant persons in behavioral management of problem clients. For the purpose of this study, the behavioral counseling approach used was the behavioral training for parents in management of problem children or problem behaviors among their own children.

Design of the Study

The present research being an intervention study falls within the purview of an experimental design with before and after comparisons. However, as all intervening variables are not always identifiable or controllable in social science researches, it renders a quasi-experimental nature.

Universe of the Study

The universe of the present study consisted of parents of children with identifiable behavioral problems in Kannur District.

Sampling

Thirty (30) parental couples and their children with behavior problems participated in this study. The parents were recruited using a purposive sampling design also with an inclusion and exclusion criteria. Parents were given training in the application of a behavior modification package (in the use of various behavior

modification techniques) that will enhance the skill of parents to modify or change the problem behavior of their children.

Instruments used

A socio-demographic data schedule, Achenbach Child Behavior Check List, and Therapy Attitude Inventory were utilized as tools for the study. Achenbach Child Behavior Check List was used to assess the problem behavior in children. The same Child Behavior Check List was utilized to assess and find out the rate of change in behavior problems in children after the intervention. To find out the efficacy and success of the treatment modality, a Consumer Satisfaction scale called Therapy Attitude Inventory was also utilized.

Intervention and Assessment Package

The intervention was carried out in the following format.

- Intake interview – 2 sessions: one each with parents and child.
- Pre-assessment (Phase-I).
- Four sessions parental training: weekly once (First month).

- Post-assessment – 1 (Phase-II).
- Three Booster and Feedback sessions: once in 10 days (Second month).
- Post-assessment – 2 (Phase-III).
- Four Booster and Feedback sessions: once in 15 days (Third and Fourth month).
- Post-assessment – 3 (Phase-IV).
- Consumer Satisfaction Assessment.

After the initial interview with parents and children and after the pre intervention assessment, parents were given training in behavior modification techniques taking examples from their own child's behavior. Parents were given training in the use of reinforcement techniques, both the positive reinforcement and negative reinforcement. They were trained in positively reinforcing desired behaviors and negatively reinforcing undesired behaviors. Parents were instructed to give attention to all desired behaviors (paying attention) and withdraw attention from all undesired behaviors (ignoring). They were taught as to how a negative reinforcement can be used as a consequence to remedy or modify maladaptive or undesirable behavior. Time out technique was taught to parents as a punishment for undesired behavior. They

were also trained in Limit-setting, Restricting privileges and Response cost (loosing positive reinforcement) as punishment procedures. Techniques of Contingency Contract and Behavioral Contract were taught to parents to emit and enhance desired behaviors in children. Parents were given training in the use of Token Economy technique to produce changes in a specific target behavior.

Pilot Study

A pilot study was conducted in order to pre test and ascertain the validity, utility and feasibility of the research design, instruments and intervention package, recruiting five (5) willing parents with problem children. This pre testing helped in finalizing the numbers and contents of sessions during the intervention, besides confirming the feasibility of instrumentation.

Data Collection

The data was collected administering the already mentioned instruments using interview method and in four phases.

Phase – I. Pre intervention assessment.

Phase – II. Post intervention assessment-1. (At the end of 1 month)

Phase – III. Post intervention assessment-2.

Phase – IV. Post intervention assessment-3.

In all the Phases, Achenbach Child Behavior Check List was administered to parents, first to get a base line assessment on the child's behavioral problems and then to assess the rate of change in behavior problems after the intervention at Phase – II, Phase – III, and Phase – IV.

Data Analysis

Data obtained from the intervention study was subjected to statistical methods for processing and analysis using SPSS. The statistical methods used for analyzing the data are:

1. Frequencies and Percentages
2. Summary Statistics
3. Chi Square Test
4. Independent Sample Test
5. Paired t-test

6. One Way ANOVA
7. Graphical representations

Major Findings.

1. Schizoid traits at different phases of assessment revealed marked improvements in this problem domain among the affected children as a result of intervention (table.17).

2. Significant changes in somatic complaints were found among the children with the new ways of behavioral management by the parents (table.18).

3. As a result of the behavioral management by the parents, there were drastic reductions in the aggressive behavior among the problem children (table.19).

4. Notably significant modifications were found in the delinquent behavior among the problem children as a result of intervention through parents with training in behavioral management (table.20).

5. Statistically pertinent changes were reportedly observed by parents in the obsessive behavioral styles among the problem children after the intervention through the behaviorally trained parents (table.21).

6. Hyperactive styles of behavior among problem children were significantly modified as an outcome of parental training in behavioral management of children (table.22).

7. Withdrawal styles of behavior was remarkably changed among the problem children, consequent to the behavioral intervention through trained parents (table.23).

8. Depressive patterns of behavior among the problem children were significantly modified subsequent to parental management (table.25).

9. Cruel behavioral styles were notably modified among the problem children after the behavioral management by parents (table.26).

10. Uncommunicative patterns among the problem children demonstrated noticeable changes consequent to the behavioral management by parents (table.27).

11. Immature styles in behavior among the problem children were substantially modified through the behavioral management by parents (table.28).

12. Sex problems were not significantly observed among the problem children, in contrast to the other evident problem behaviors (table.24).

13. Remarkably observable behavioral changes have taken place by the third phase (before second booster sessions) itself in the domains of somatic complaints, delinquency, withdrawal, cruelty, and immaturity among the problem children (tables 18, 20, 23, 26, and 28).

14. There were statistically significant differences in the rate of change of problem behaviors such as delinquency, obsessiveness and withdrawal among the four gender cum age groups of problem children, where as such significant

differences in the rate of change were absent in other problem domains among these groups (table.29).

15. The level of schooling played an important role in the differences in change in two problem domains such as delinquency and withdrawal among the problem children. (table.33).

16. The age of children was observed to have a significant effect in the variations in change across three problem domains such as delinquency, hyperactivity and withdrawal among the problem children (table.39).

17. Domicile (urban vs. rural) was found to have a statistical effect in the differences in change of schizoid patterns of behavior (table. 41).

18. Maternal employment was found to affect the variations in change of hyperactive behavior among problem children (table.42).

19. Presence of sibling problems was seen to have a statistically significant effect on the variations in the change of delinquent behavior among problem children (table.45).

20. Mother's educational level was observed to have influenced the variations in the change of hyperactive behavior among problem children (table.47).

21. Paternal age was noticed to have played a significant role in the variations of change in problem domains such as aggressiveness, delinquency, obsessiveness, withdrawal and depression among the problem children (table.48).

22. Similarly maternal age was also found to have significantly influenced the differences in change of delinquency, obsessiveness, withdrawal and depression (table.49).

23. Variables such as home atmosphere, family type, family income, number of children, gender of the child, parental presence, and level of father's education were not found to have any statistically significant effect in the change in ratings of any problem domains such as schizoid, somatic complaints,

aggressiveness, delinquency, obsessiveness, hyperactivity, withdrawal, sex problems, depression, cruelty, uncommunicativeness and immaturity.

24. Pertaining to the effectiveness of Behavioral Management, as measured through the Consumer Satisfaction Assessment, the following findings are notable (table.50).

a). Overall satisfaction with the effect and training for parents in behavioral management of their children was very high among parents and especially mothers.

b). In general, mothers reported to have more benefits than the fathers.

c). The fathers have generally rated the program as effective, while one mother reported mild dissatisfaction about change in child's general behavior and the effectiveness of the program.

Limitations of the Study.

1. The sample in the present study consisted of parental couple of 30 problem children belonging to both genders (male and female) and two age groups (6-11 and 12-16 years) resulting in 4 groups with smaller sample size, thereby limiting the generalizability of results.

2. Achenbach's Child Behavior Check List consisted of different factor domains with varying items for different age-cum-gender groups thereby rendering data analysis a cumbersome activity.

3. The names of domains in Achenbach's Child Behavior Check List may be misconstrued as diagnostic entities thereby causing the subjects to suffer from effects of labeling, whereas the items in this check list are actually meant to identify only behavioral styles.

4. The present study was made among parents with children having multiple behavioral issues and problems. The present study being an initial endeavor in the field in India, no specific diagnostic category for children was focused.

5. As 10 fathers took up outside work assignments in between the phases of study, they were unavailable to participate in the assessment of effectiveness of intervention.

6. The present study utilized a purposive sampling design with specific inclusion and exclusion criteria due to practical considerations, and the sample thus obtained cannot be considered as typically representative in nature.

7. The final post assessment (phase-IV) was done at the end of four months, thereby unable to study long-term effects.

Suggestions for Future Research.

1. Similar studies can be repeatedly conducted preferably in different places, to confirm the reliability and stability of outcome.
2. More studies of the type of present work need to be held in other settings such as the community and educational settings.

3. Studies like the present one can also be carried out with school teachers as the behavioral change agents.

4. Future studies can be considered to be conducted exclusively among specific age and gender groups such as male children of 6-11 years, female children of 6-11 years, male children of 12-16 years, and female children of 12-16 years, with sufficiently larger sample sizes.

5. Research work also can be undertaken to develop and test more appropriate, locally sensitive and simple as well as short instruments to gather data.

6. Identical research work can be carried out with specific and exclusive clinical /diagnostic categories such as conduct disordered children, children with school refusal / phobia and such.

7. Studies in future can seriously consider adopting a more scientific random sampling method, whereby generalizations of findings can easily be made.

8. More long term studies (with 2 years, 5 years, etc.) can be carried out to ensure long-term efficacy of interventions such as in the present work.

Conclusion.

The results revealed that there was a reduction in the problem behaviors exhibited by children as the therapy progressed. The findings of the Therapy Attitude Inventory indicated that parents are satisfied with the change and progress shown in their children's behavior and the techniques used in bringing out these changes. Parents also agreed that they could learn the method easily and acquired the necessary skills to modify their child's behavior.

The results can be summarized as:

(1) Imparting behavioral management skills training for parents is effective in modifying the behavioral problems of their children, and

(2) Behavioral management by parents is effective in modifying the behavioral problems of their children. It can be concluded that behavioral counseling with parents in the form of behavioral management training is an effective method for the treatment of behavioral problems in children.

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BEHAVIOURAL COUNSELLING: A TREATMENT MODALITY FOR BEHAVIOURAL PROBLEMS IN CHILDREN

THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY

IN

PSYCHOLOGY

By

E.D.JOSEPH

DEPARTMENT OF PSYCHOLOGY

UNIVRSITY OF CALICUT

2005

APPENDIX - I

SOCIO-DEMOGRAPHIC DATA SHEET

Name of the child

Age Sex: M ☐ F ☐

School Class

Father alive ☐ not alive ☐ abroad ☐ staying with ☐

Mother alive ☐ not alive ☐ abroad ☐ staying with ☐

Father's name.

Address

Place of Residence: Rural ☐ Urban ☐

Father: employed ☐ unemployed ☐

Mother: employed ☐ unemployed ☐

Type of Family: Nuclear family ☐ Joint family ☐

Home atmosphere: Cordial ☐ Non-cordial ☐

Sibling Problem: Present ☐ Absent ☐

Number of children:

Birth Order:

Family income

Father's education <SSLC ☐ SSLC ☐ PDC ☐ Degree ☐ Technical ☐ Professional ☐

Mother's education <SSLC ☐ SSLC ☐ PDC ☐ Degree ☐ Technical ☐ Professional ☐

Father's Age: Mother's Age:

APPENDIX - II

ACHENBACH'S REVISED CHILD BEHAVIOR CHECK LIST FOR PARENTS

Below is a list of items that describe children. For each item that describes your child now or within the past 6 months, please encircle the 2 if the item is very true or often true of your child. Circle the 1 if the item is somewhat or sometimes true of your child. If the item is not true of your child, circle the 0. please answer all items as well as you can , even if some do not seem to apply to your child.

0 = Not True (as far as you know) 1 = Somewhat or Sometimes True 2 = Very True or Often True

1. Acts too young for his/her age	0	1	2	29. Fears certain animals, situations, or places other than school	0	1	2
2. Allergy (describe): ----------	0	1	2	30. Fears going to school	0	1	2
3. Argues a lot	0	1	2	31. Fears he/she might think or do something bad	0	1	2
4. Asthma	0	1	2	32. Feels he/she has to be perfect	0	1	2
5. Behaves like opposite sex	0	1	2	33. Feel or complaints that no one loves him/her	0	1	2
6. Bowel movements outside toilet	0	1	2	34. Feels others are out to get him/her	0	1	2
7. Bragging, boasting	0	1	2	35. Feels worthless or inferior	0	1	2
8. Can't concentrate, can't pay attention for long	0	1	2	36.Gets hurt a lot, accident-prone	0	1	2
9. Can't get his/her mind off certain thoughts; obsessions (describe) ------	0	1	2	37. Gets in many fights	0	1	2
10. Can't sit still, restless, or hyperactive	0	1	2	38. Gets tensed a lot	0	1	2
11. Clings to adults or too dependent	0	1	2	39. Hangs around with children who get in trouble	0	1	2
12. Complaints of loneliness	0	1	2	40. Hears things that aren't there (describe): ----------	0	1	2
13. Confused or seems to be in a fog	0	1	2	41. Impulsive or acts without thinking	0	1	2
14. Cries a lot	0	1	2	42. Likes to be alone	0	1	2
15. Cruel to animals	0	1	2	43. Lying or cheating	0	1	2
16. Cruelty, bullying, or meanness to others	0	1	2	44. Bites fingernails	0	1	2
17. Day-dreams or gets lost in his/her thoughts	0	1	2	45. Nervous, high strung, or tense	0	1	2
18. Deliberately harms self or attempts suicide	0	1	2	46. Nervous movements or twitching (describe): ----------	0	1	2
19. Demands a lot of attention	0	1	2	47. Nightmares	0	1	2
20. Destroys his/her own things	0	1	2	48. Not liked by other children	0	1	2
21. Destroys things belonging to his/her family or other children	0	1	2	49. Constipated, doesn't move bowels	0	1	2
22. Disobedient at home	0	1	2	50. Too fearful or anxious	0	1	2
23. Disobedient at school	0	1	2	51. Feels dizzy	0	1	2
24. Doesn't eat well	0	1	2	52. Feels too guilty	0	1	2
25. Doesn't get along with other children	0	1	2	53. Overeating	0	1	2
26. Doesn't seem to feel guilty after misbehaving	0	1	2	54. Overtired	0	1	2
27. Easily jealous	0	1	2	55. Overweight	0	1	2
28. Eats or drinks things that are not food (describe): ----------	0	1	2	56. Physical problems without known medical cause: a. Aches or pains	0	1	2

Please see the other side

0 = Not True (as far as you know) 1 = Somewhat or Sometimes True 2 = Very True or Often True

56. b. Headaches 0 1 2
c. Nausea, feels sick 0 1 2
d. Problems with eyes (describe): 0 1 2
e. Rashes or other skin problems 0 1 2
f. Stomachaches or cramps 0 1 2
g. Vomiting, throwing up 0 1 2
h. Other (describe): ---------- 0 1 2
57. Physically attacks people 0 1 2
58. Picks nose, skin, or other parts of body (describe): -------- 0 1 2
59. Plays with own sex parts in public 0 1 2
60. Plays with own sex parts too much 0 1 2
61. Poor school work 0 1 2
62. Poorly coordinated or clumsy 0 1 2
63. Prefers playing with older children 0 1 2
64. Prefers playing with younger children 0 1 2
65. Refuses to talk 0 1 2
66. Repeats certain acts over and over compulsions (describe): 0 1 2
67. Runs away from home 0 1 2
68. Screams a lot 0 1 2
69. Secretive, keeps things to self 0 1 2
70. Sees things that aren't there (describe): --------- 0 1 2
71. Self-conscious or easily embarrassed 0 1 2
72. Sets fires 0 1 2
73. Sexual problems (describe): 0 1 2
74. Showing off or clowning 0 1 2
75. Shy or timid 0 1 2
76. Sleeps less than most children 0 1 2
77. Sleeps more than most children during day and/or night (describe): 0 1 2
78. Smears or plays with bowel movements 0 1 2
79. Speech problem (describe): 0 1 2
80. Stares blankly 0 1 2
81. Steals at home 0 1 2
82. Steals outside the home 0 1 2
83. Stores up things he/she doesn't need (describe): 0 1 2
84. Strange behavior (describe): 0 1 2
85. Strange ideas (describe): 0 1 2
86. Stubborn, sullen or irritable 0 1 2
87. Sudden changes in mood or feelings 0 1 2
88. Sulks a lot 0 1 2
89. Suspicious 0 1 2
90. Swearing or obscene language 0 1 2
91. Talks about killing self 0 1 2
92. Talks or walks in sleep (describe): ------ 0 1 2
93. Talks too much 0 1 2
94. Teases a lot 0 1 2
95. Temper tantrums or hot temper 0 1 2
96. Thinks about sex too much 0 1 2
97. Threatens people 0 1 2
98. Thumb-sucking 0 1 2
99. Too concerned with neatness or cleanliness 0 1 2
100. Trouble sleeping (describe): --------- 0 1 2
101. Truancy, skips school 0 1 2
102. Under active, slow moving, or lacks energy 0 1 2
103. Unhappy, sad or depressed 0 1 2
104. Unusually loud 0 1 2
105. Uses alcohol or drugs 0 1 2
(describe): ------- 0 1 2
106. Vandalism 0 1 2
107. Wets self during the day 0 1 2
108. Wets the bed 0 1 2
109. Whining 0 1 2
110. Wishes to be of opposite sex 0 1 2
111. Withdrawn, doesn't get involved with others 0 1 2
112. Worrying 0 1 2
113. Please write in any problems your child has that were not listed above
---------- 0 1 2
---------- 0 1 2
---------- 0 1 2

PLEASE BE SURE YOU HAVE ANSWERED ALL ITEMS. UNDERLINE ANY YOU ARE CONCERNED ABOUT

APPENDIX - III

CHILD BEHAVIOUR CHECKLIST FOR PARENTS

കുട്ടികളെക്കുറിച്ചുള്ള ചില വിവരങ്ങളാണ് താഴെ കൊടുത്തിരിക്കുന്നത്. ഇപ്പോഴോ കഴിഞ്ഞ ആറുമാസമായോ കുട്ടി എങ്ങിനെയൊക്കെയാണെന്ന് വിവരിക്കുന്നതാണ് ഓരോ ഇനവും. നിങ്ങളുടെ കുട്ടിയെ സംബന്ധിച്ച് ഓരോ ഇനവും പൂർണ്ണമായോ മിക്കപ്പോഴുമോ ശരിയാണെങ്കിൽ '2' നു ചുറ്റും ഒരു വൃത്തം വരയ്ക്കുക. വല്ലപ്പോഴുമോ ചിലപ്പോൾ മാത്രമോ ശരിയാണെങ്കിൽ '1' നു ചുറ്റും വൃത്തം വരയ്ക്കുക, ഏതെങ്കിലും ഇനം നിങ്ങളുടെ കുട്ടിയെ സംബന്ധിച്ച് ശരിയല്ലെങ്കിൽ '0' ന് ചുറ്റും വൃത്തം വരയ്ക്കുക. ചില ഇനം നിങ്ങളുടെ കുട്ടിയെ സംബന്ധിക്കുന്നതെല്ലെങ്കിൽപോലും എല്ലാ ഇനങ്ങൾക്കും നിങ്ങളാൽ കഴിയുന്നതുപോലെ ഉത്തരം ചെയ്യുക.

0 : നിങ്ങളുടെ അറിവിൽ ശരിയല്ല. 1 : വല്ലപ്പോഴും ചിലപ്പോൾ ശരി. 2 : പൂർണ്ണമായും, മിക്കപ്പോഴും ശരി

1. പ്രായത്തിനു ചേർന്ന പക്വതയില്ലാതെ പ്രവർത്തിക്കുക/ പെരുമാറുക — 0 1 2
2. അലർജി. വിവരിക്കുക. — 0 1 2
3. ഒരുപാട് വാഗ്വാദങ്ങൾ നടത്തുന്നു. — 0 1 2
4. ആസ്തമ — 0 1 2
5. എതിർ ലിംഗത്തിൽ പെട്ടവരെ പോലെ പെരുമാറുക. — 0 1 2
6. ധിക്കാരത്തോടെ അദ്ധ്യാപകരോട് തർക്കുത്തരം പറയുക — 0 1 2
7. സ്വയം പുകഴ്ത്തുകയും വീരവാദം മുഴുക്കുകയും ചെയ്യുന്നു. — 0 1 2
8. ഒന്നിലും ശ്രദ്ധ കേന്ദ്രീകരിക്കാനാവുന്നില്ല, ഒരു കാര്യത്തിലും കുറേനേരം ശ്രദ്ധചെലുത്താനാവുന്നില്ല. — 0 1 2
9. അവനോ അവൾക്കോ ചില കാര്യങ്ങളിലുള്ള താല്പര്യത്തിൽനിന്ന് ശ്രദ്ധ മാറ്റാനാവുന്നില്ല. — 0 1 2
   പിഡകൾ ബാധകൾ (വിവരിക്കുക)
10. അടങ്ങിയിരിക്കാനാവുന്നില്ല. അസ്വസ്തചിത്തനാവുക/ അത്യധികം കർമ്മോദ്യുക്തനാവുക. — 0 1 2
11. മുതിർന്നവരെ ചുറ്റിപറ്റി നിൽക്കുക. — 0 1 2
    കൂടുതൽ ആശ്രിതഭാവം കാണിക്കുക.
12. ഏകാന്തതയെ കുറിച്ച് പരാതിപറയുക. — 0 1 2
13. ചിന്താകുഴപ്പത്തിലാവുക. — 0 1 2
    അന്തംവിട്ട അവസ്ഥയിലാവുക.
14. ഒരുപാട് കരയുക. — 0 1 2
15. മൃഗങ്ങളോട് ക്രൂരത കാണിക്കുക. — 0 1 2
16. ക്രൂരത, മറ്റുള്ളവരെ ഭയപ്പെടുത്തി കീഴ്പെടുത്തുക. മറ്റുള്ളവരോട് തരം താണരീതിയിൽ പെരുമാറുക. — 0 1 2
17. ദിവാസ്വപ്നം കാണുക. അവന്റെയോ അവളുടേയോ ചിന്തകളിൽ ലയിച്ചിരുന്നുപോവുക. — 0 1 2
18. കരുതിക്കൂട്ടി സ്വയം നാശം വരുത്തുക. — 0 1 2
    ആത്മഹത്യക്ക് ശ്രമിക്കുക.
19. മറ്റുള്ളവരിൽ നിന്ന് ഒരുപാട് ദാക്ഷിണ്യം (ശ്രദ്ധ) പ്രതീക്ഷിക്കുക. — 0 1 2
20. അവളുടേയോ/അവന്റെയോ തന്നെ വസ്തുക്കൾ നശിപ്പിക്കുക. — 0 1 2
21. മറ്റുകുട്ടികളുടെ വസ്തുക്കൾ നശിപ്പിക്കുക. — 0 1 2
22. വീട്ടിൽ അനുസരണക്കേട് കാണിക്കുക. — 0 1 2
23. സ്കൂളിൽ അനുസരണക്കേട് കാണിക്കുക. — 0 1 2
24. വേണ്ടത്ര ഭക്ഷണം കഴിക്കാതിരിക്കുക. — 0 1 2
25. മറ്റുകുട്ടികളോട് രമ്യതയിൽ കൂടെ ചേർന്നുപോകാൻ കഴിയാതിരിക്കുക. — 0 1 2
26. തെറ്റ് ചെയ്താലും കുറ്റബോധം ഇല്ലാതിരിക്കുക. — 0 1 2
27. കൂടുതൽ അസൂയാലുക്കളായിരിക്കുക. — 0 1 2
28. ഭക്ഷ്യയോഗ്യമല്ലാത്തവ കഴിക്കുക. — 0 1 2
    (വിവരിക്കുക).....
29. ചില മൃഗങ്ങളെ സന്ദർഭങ്ങളെ സ്കൂളല്ലാത്ത സ്ഥലങ്ങളിൽ ഭയപ്പെടുക. — 0 1 2
    (വിവരിക്കുക).....
30. സ്കൂളിൽ പോകുന്നതിനെ ഭയപ്പെടുക. — 0 1 2
31. അവൻ/അവൾ മോശമായി ചിന്തിക്കുകയോ എന്തെങ്കിലും ചെയ്യുകയോ ചെയ്യുമെന്ന് ഭയപ്പെടുക. — 0 1 2
32. അവൻ/അവൾ പരിപൂർണ്ണത കൈവരിക്കണമെന്ന് ആഗ്രഹിക്കുക. — 0 1 2
33. തന്നെ ആരും ഇഷ്ടപ്പെടുന്നില്ലെന്ന് പരാതി പറയുക. — 0 1 2
34. മറ്റുള്ളവർ തന്നെ വശപ്പെടുത്താൻ ശ്രമിക്കുന്നുവെന്ന് തോന്നുക. — 0 1 2
35. സ്വയം തരംതാണ വനാണെന്നോ ഗുണമേന്മ ഇല്ലാത്തവനാണെന്നോ തോന്നുക. — 0 1 2
36. ഒരുപാട് മനപ്രയാസമുണ്ടാവുക. — 0 1 2
    എളുപത്തിൽ അപകടത്തിൽ പെടാനുള്ള സാദ്ധ്യത.
37. പലവിധ കലഹങ്ങളിൽ പെടുക. — 0 1 2
38. ഒരു പാട് പരിഹാസ്യത്തിന് വിധേയമാവുക. — 0 1 2
39. പ്രശ്നക്കാരായ കുട്ടികൾക്കൊപ്പം ചേർന്ന് നടക്കുക. — 0 1 2
40. ഇല്ലാത്ത കാര്യങ്ങളെ കുറിച്ച് പലതും കേൾക്കുക. — 0 1 2
    (വിവരിക്കുക).....
41. ആവേശഭരിതനാവുക. വേണ്ടത്ര ചിന്തിക്കാതെ എന്തെങ്കിലും ചെയ്യുക. — 0 1 2
42. തനിച്ചിരിക്കാൻ ഇഷ്ടപ്പെടുന്നു. — 0 1 2
43. കള്ളം പറയുക മറ്റുള്ളവരെ ചതിക്കുക. — 0 1 2
44. നഖം കടിക്കുക. — 0 1 2
45. വികാര വിവശനാവുക. ലോല മനസ്കനാവുക. പ്രക്ഷുബ്ധമായിരിക്കുക. — 0 1 2
46. പരിഭ്രമം പ്രകടിപ്പിക്കുന്ന ചലനങ്ങൾ — 0 1 2
    (വിവരിക്കുക).....
47. പേടിസ്വപ്നങ്ങൾ — 0 1 2
48. മറ്റ് കുട്ടികൾ ഇഷ്ടപ്പെടാതിരിക്കുക. — 0 1 2
49. മലബന്ധം അനുഭവപ്പെടുക. — 0 1 2
    വയറ് കല്ല് പോലെയായിരിക്കുക.
50. വളരെ കൂടുതൽ ഭയമോ ഉൽകണ്ഠയോ പ്രകടിപ്പിക്കുക. — 0 1 2
51. തലകറക്കം അനുഭവപ്പെടുക. — 0 1 2
52. കൂടുതൽ കുറ്റബോധം തോന്നുക. — 0 1 2
53. ആവശ്യത്തിലധികം പ്രതികരിക്കുക. — 0 1 2
54. കൂടുതൽ പരിക്ഷീണത അനുഭവപ്പെടുക. — 0 1 2
55. അമിതഭാരം — 0 1 2
56. വ്യക്തമായ രോഗകാരണങ്ങളില്ലാതെ പ്രകടമാവുന്ന ശാരീരിക പ്രശ്നങ്ങൾ. — 0 1 2
)വേദനകൾ — 0 1 2
)തലവേദന — 0 1 2
)മനപിരട്ടൽ - അസുഖം തോന്നുക — 0 1 2
)കണ്ണിനു പ്രയാസങ്ങൾ — 0 1 2
    (വിവരിക്കുക).....

)ചൂടുപൊങ്ങൽ മറ്റ് ത്വക്ക് രോഗങ്ങൾ 0 1 2
)വയറ് വേദന മാംസപേശികൾ കോച്ചിവലിക്കുക. 0 1 2
)ഛർദ്ദി 0 1 2
)മറ്റുള്ളവ വിവരിക്കുക..... 0 1 2
57. മറ്റുള്ളവരെ ശാരീരികമായി ആക്രമിക്കുക. 0 1 2
58. മൂക്കോ തൊലിയോ ശരീരത്തിന്റെ മറ്റുള്ളഭാഗങ്ങളോ ചൊറിയുക. 0 1 2
(വിവരിക്കുക)
59. പരസ്യമായി സ്വന്തം ലൈഗികവയവം കൊണ്ട് കളിക്കുക. 0 1 2
60. കൂടുതൽ സമയം സ്വന്തം ലൈഗീകവയവം കൊണ്ട് കളിക്കുക. 0 1 2
61. സ്കൂളിലെ വളരെ മോശമായ പ്രകടനം. 0 1 2
62. ഇണങ്ങിപ്പോകുന്നതിൽ വളരെ മോശമായ അവസ്ഥ. 0 1 2
63. തന്നെക്കാൾ പ്രായം കൂടുതലുള്ളവരോട് കൂട്ട് ചേരാൻ താല്പര്യം 0 1 2
64. തന്നെക്കാൾ പ്രയം കുറഞ്ഞ കുട്ടികളോട് കൂടികളിക്കാൻ ഇഷ്ടം. 0 1 2
65. സംസാരിക്കാൻ വിസമ്മതിക്കുന്നു. 0 1 2
66. ചിലകാര്യങ്ങൾ ആവർത്തിച്ചു കൊണ്ടേയിരിക്കുന്നു. 0 1 2
(വിവരിക്കുക).....
67. വീട്ടിൽ നിന്നും ഓടിപ്പോകുന്നു. 0 1 2
68. ഒരുപാട് ശബ്ദമുണ്ടാക്കുന്നു. 0 1 2
69. രഹസ്യമായി സാധനങ്ങൾ സ്വന്തമാക്കിവെക്കുക. 0 1 2
70. യഥാർത്ഥത്തിൽ ഇല്ലാത്ത കാര്യങ്ങൾ കാണുക. 0 1 2
(വിവരിക്കുക).....
71. ആത്മബോധം ഉണ്ടാകുന്നു. 0 1 2
72. സാധനങ്ങൾ തീവെച്ചു കത്തിക്കുന്നു. 0 1 2
73. ലൈഗീക പ്രശ്നങ്ങൾ 0 1 2
(വിവരിക്കുക).....
74. കോമാളി വേഷം കെട്ടുക. 0 1 2
75. നാണം കുണുങ്ങിയോ ഭീരുവോ ആയിക്കാണുക. 0 1 2
76. മറ്റുകുട്ടികളെക്കാൾ കുറച്ചു ഉറങ്ങുന്നു. 0 1 2
77. മറ്റുകുട്ടികളെക്കാൾ രാത്രിയിലോ/പകലോ കൂടുതലായി ഉറങ്ങുക. 0 1 2
(വിവരിക്കുക).....
78. വിസർജ്യം കൊണ്ട് വൃത്തികേടാക്കി കളിക്കുക. 0 1 2
79. സംസാരത്തകരാറ് 0 1 2
(വിവരിക്കുക).....
80. ശൂന്യഭാവത്തിൽ തുറിച്ച് നോക്കുക. 0 1 2
81. വീട്ടിൽനിന്നും കളവ് നടത്തുക. 0 1 2
82. വീടിന് പുറത്ത് കളവ് നടത്തുക. 0 1 2
83. അവനോ/അവൾക്കോ ആവശ്യമില്ലാത്ത വസ്തുക്കൾ ശേഖരിച്ച് വെക്കുക. 0 1 2
(വിവരിക്കുക).....

84. അസാധാരണമായ പെരുമാറ്റം 0 1 2
85. അസാധാരണമായ ആശയങ്ങൾ 0 1 2
(വിവരിക്കുക).....
86. ദുർവാശിയുള്ള, അപ്രസന്നനായ, എളുപ്പത്തിൽ കോപിതനാവുന്ന. 0 1 2
87. വികാരപ്രകടനങ്ങളിലോ ഭാവങ്ങളിലോ പ്രത്യക്ഷമാവുന്ന പെട്ടെന്നുള്ള മാറ്റം 0 1 2
88. മുഷിഞ്ഞിരിക്കുക. 0 1 2
89. സംശയാലുവായിരിക്കുക. 0 1 2
90. അനാവശ്യമായി സത്യം ചെയ്യുക. 0 1 2
അശ്ലീലഭാഷ ഉപയോഗിക്കുക.
91. സ്വയം കൊല്ലുമെന്നതിനെ കുറിച്ച് ഒരുപാട് സംസാരിക്കുക. 0 1 2
92. ഉറക്കത്തിൽ സംസാരിക്കുക/നടക്കുക. 0 1 2
(വിവരിക്കുക).....
93. വളരെ കൂടുതൽ സംസാരിക്കുക. 0 1 2
94. കളിവാക്ക് പറഞ്ഞ് പരിഹസിക്കുക. 0 1 2
95. ദുശ്ശാഠ്യം പിടിക്കുക. ക്ഷിപ്രകോപിയാവുക. 0 1 2
96. ലൈഗീക കാര്യങ്ങളെ കുറിച്ച് കൂടുതൽ ചിന്തിക്കുക. 0 1 2
97. ആളുകളെ ഭീഷണിപ്പെടുത്തുക. 0 1 2
98. പെരുവിരൽ ഊമ്പുക. 0 1 2
99. വൃത്തി, വെടിപ്പ് എന്നിവയ്ക്ക് അമിതപ്രാധാന്യം നൽകുക. 0 1 2
100. അശാന്തമായ ഉറക്കം 0 1 2
(വിവരിക്കുക).....
101. സ്കൂളിൽ പോവാതെ ഒഴിഞ്ഞുമാറുക/ഒളിച്ചോടുക. 0 1 2
102. ഊർജ്ജസ്വലത ഇല്ലാതിരിക്കുക. തിരുന്മേഷവാനായ, വളരെ സാവധാനത്തിൽ ചിരിക്കുക. 0 1 2
103. അസന്തുഷ്ടി, ദുഖം, വിഷാദം തുടങ്ങിയവ പ്രകടിപ്പിക്കുക. 0 1 2
104. അസാധാരണമായ വിധത്തിൽ ശബ്ദമുണ്ടാക്കുക. 0 1 2
105. മദ്യമോ മയക്കുമരുന്നോ ഉപയോഗിക്കുക. 0 1 2
(വിവരിക്കുക).....
106. വിധ്വംസന ശീലം 0 1 2
107. പകൽ സമയങ്ങളിൽ അറിയാതെ മൂത്രമൊഴിച്ച് വസ്ത്രങ്ങളും ശരീരവും നനയ്ക്കുക. 0 1 2
108. രാത്രിയിൽ ഉറക്കത്തിൽ കിടക്കയിൽ മൂത്രമൊഴിക്കുക. 0 1 2
109. പിറുപിറുക്കുക, നീണ്ട സ്വരത്തിൽ കരയുക. 0 1 2
110. എതിർ ലിംഗത്തിൽ പെട്ടവരാവാൻ കൊതിക്കുക. 0 1 2
111. ഉൾവലിയുക, മറ്റുള്ളവരുമായി ചേർന്ന് പോകാൻ കഴിയാതിരിക്കുക. 0 1 2
112. സദാസമയവും ഉൽകണ്ഠാകുലരാവുക. 0 1 2
113. മുകളിൽ പറയാത്ത എന്തെങ്കിലും പ്രശ്നങ്ങൾ താങ്കളുടെ കുട്ടികൾക്കുണ്ടെങ്കിൽ അത് വിശദമായി എഴുതുക. 0 1 2
.....
.....
.....

APPENDIX -IV

Mother---------- Father ----------

THERAPY ATTITUDE INVENTORY*

(Please circle the response for each question which best expresses how you honestly feel)

I. Regarding techniques of disciplining, I feel I have learned

1. nothing 2. very little 3. a few new techniques 4. several useful techniques 5. very many useful techniques

II. Regarding techniques for teaching my child new skills, I feel I have learned

1. nothing 2. very little 3. a few new techniques 4. several useful techniques 5. very many useful techniques

III. Regarding the relationship between myself and my child, I feel we get along

1. much worse than before 2. somewhat worse than before 3. the same as before 4. somewhat better than before 5. very much better than before

IV. Regarding my confidence in my ability to discipline my child, I feel

1. much less confident 2. somewhat less confident 3. the same 4. somewhat more confident 5. much more confident

V. The major behavior problems that my child presented at home before the program started at this time

1. considerably worse 2. somewhat worse 3. the same 4. somewhat improved 5. greatly improved

VI. I feel that my child's compliance to my commands or requests is at this time

1. considerably worse 2. somewhat worse 3. the same 4. somewhat improved 5. greatly improved

VII. Regarding the progress my child has made in his/her general behavior, I am

1. very dissatisfied 2. somewhat dissatisfied 3. neutral 4. somewhat satisfied 5. very satisfied

VIII. To what degree has the treatment program helped with other general personal or family problems not directly related to your child in the program

1. hindered much more than helped 2. hindered slightly 3. neither helped nor hindered 4. helped somewhat 5. helped very much

IX. I feel the type of program that was used to help me improve the behaviors of my child was

1. very poor 2. poor 3. adequate 4. good 5. very good

X. My general feeling about the program I participate in, is

1. I disliked it very much 2. I disliked it somewhat 3. I feel neutral 4. I liked it somewhat 5. I liked it very much

APPENDIX - V

FACTOR LOADINGS OF ITEMS ON CHILD BEHAVIOR CHECK LIST

(Boys Aged 6-11)

Internalizing Scales

I. Schizoid or Anxious

40. Hears things	50. Anxious
70. Sees things	47. Nightmares
29. Fears	59. Plays with sex parts in public
30. Fears school	75. Shy, timid
11. Clings to adults	

II. Depressed

35. Feels worthless	14. Cries much
52. Feels guilty	50. Anxious
53. Needs to be perfect	71. Self-conscious
32. Feels unloved	33. Feels persecuted
112. Worrying	88. Sulks
103. Sad	45. Nervous
104. Fears own impulses	89. Suspicious
105. Suicidal talk	18. Harms self
12. Lonely	

III. Uncommunicative

65. Won't talk	80. Stares blankly
69. Secretive	71. Self-conscious
75. Shy, timid	13. Confused
103. Sad	86. Stubborn

IV. Obsessive-Compulsive

85. Strange ideas	46. Twitches
100. Can't sleep	83. Hoarding
76. Sleeps little	66. Compulsions
84. Strange behavior	54. Overtired
9. Obsessions	13. Confused
92. Walks, talks in sleep	93. Excess talk
80. Stares blankly	47. Nightmares
17. Day dreams	50. Anxious

V. Somatic Complaints

56f. Stomach problems	49. Constipation
56b. Headaches	51. Dizziness
56c. Nausea	77. Sleeps much
56a. Pains	54. Overtired
56g. Vomits	

Mixed Scale

VI. Social Withdrawal
- 48. Unliked
- 25. Poor peer relations
- 111. Withdrawn
- 42. Likes to be alone
- 38. Is teased
- 64. Prefers young kids
- 34. Feels persecuted
- 102. Slow moving

Externalizing Scales

VII. Hyperactive
- 8. Can't concentrate
- 1. Acts too young
- 61. Poor school work
- 62. Clumsy
- 13. Confused
- 17. Daydreams
- 41. Impulsive
- 64. Prefers young kids
- 10. Hyperactive
- 79. Speech problem
- 20. Destroys own things

IX. Delinquent
- 82. Steals outside home
- 81. Steals at home
- 21. Destroys others' things
- 106. Vandalism
- 72. Sets fires
- 101. Truant
- 67. Runs away
- 39. Bad friends
- 43. Lies, cheats
- 20. Destroys own things
- 90. Swears
- 23. Disobedient at school

VIII. Aggressive
- 3. Argues
- 22. Disobedient at home
- 95. Temper
- 86. Stubborn
- 37. Fighting
- 16. Cruel to others
- 97. Threatens people
- 94. Teases
- 74. Shows off
- 104. Loud
- 23. Disobeys at school
- 57. Attacks people
- 68. Screams
- 90. Swearing
- 25. Poor peer relations
- 88. Sulks
- 7. Brags
- 43. Lies, cheats
- 27. Jealous
- 87. Moody
- 19. Demands attention
- 93. Excess talk
- 48. Unliked

FACTOR LOADINGS OF ITEMS ON CHILD BEHAVIOR CHECK LIST

(Boys Aged 12-16)

Internalizing Scales

I. Somatic Complaints

- 56c. Nausea
- 56a. Pains
- 56f. Stomach problems
- 56b. Headache
- 54. Overtired
- 51. Dizziness
- 56g. Vomits
- 56e. Rashes
- 56d. Eye problem
- 102. Slow moving
- 36. Accident prone
- 49. Constipated
- 112. Worrying
- 50. Anxious
- 80. Stares blankly

II. Schizoid

- 52. Feels guilty
- 31. Fears own impulses
- 99. Too neat
- 5. Acts like opposite sex
- 40. Hears things
- 51. Dizziness
- 32. Needs to be perfect
- 30. Fears school
- 11. Clings to adults
- 112. Worrying

III.. Uncommunicative

- 69. Secretive
- 75. Shy, timid
- 65. Won't talk
- 111. Withdrawn
- 42. Likes to be alone
- 103. Sad
- 71. Self-conscious
- 80. Stares blankly
- 102. Slow moving
- 88. Sulks
- 89. Suspicious
- 86. Stubborn
- 87. Moody
- 112. Worrying
- 13. Confused

IV. Immature

- 14. Cries much
- 109. Whining
- 11. Clings to adults
- 64. Prefers young kids
- 108. Wets bed
- 19. Demands attention
- 1. Acts too young

V. Obsessive-Compulsive

- 9. Obsessions
- 66. Compulsions
- 85. Strange ideas
- 83. Hoarding
- 84. Strange behavior
- 31. Fears on impulses
- 17. Day dreams
- 7. Brags
- 104. Loud

VI. Depressed Withdrawal

48. Unliked
25. Poor peer relations
38. Is teased
35. Feels worthless
64. Prefers younger kids
34. Feels persecuted
111. Withdrawn

12. Lonely
1. Acts too young
21. Destroys others things
33. Feels unloved
62. Clumsy
37. Fights
20. Destroys own things

Externalizing Scales

VII. Delinquent

82. Steals outside home
81. Steals at home
39. Bad friends
106. Vandalism
43. Lies, cheats
101. Truant
72. Sets fires

21. Destroys others things
105. Alcohol, drugs
23. Disobeys at school
67. Runs away
20. Destroys own things
61. Poor school work

VIII. Aggressive

97. Threatens people
95. Temper
16. Cruel
22. Disobeys at home
90. Swearing
68. Screams
3. Argues
57. Attacks people
86. Stubborn
94. Teases
104. Loud

27. Jealous
87. Moody
10. Hyperactive
41. Impulsive
37. Fights
88. Sulks
19. Demands attention
45. Nervous
89. Suspicious
93. Excess talk
34. Feels persecuted

IX. Hyperactive

8. Can't concentrate
10. Hyperactive
61. Poor school work
44. Bites nail
45. Nervous

23. Disobeys at school
1. Acts too young
62. Clumsy
41. Impulsive
74. Shows off

FACTOR LOADINGS OF ITEMS ON CHILD BEHAVIOR CHECK LIST

(Girls Aged 6-11)

Internalizing Scales

I. Depressed

112. Worrying
35. Feels worthless
50. Anxious
52. Feels guilty
31. Fears own impulses
103. Sad
33. Fears unloved
34. Feels persecuted
12. Lonely
30. Fears school
32. Need to be perfect.
71. Self-conscious
45. Nervous
11. Clings to adults
111. Withdrawn
38. Is teased
75. Shy, timid
88. Sulks

II. Social Withdrawal

111. Withdrawn
42. Likes to be alone
69. Secretive
102. Slow moving
65. Won't talk
103. Sad
88. Sulks
75. Shy, timid
13. Confused
87. Moody
80. Stares blankly

III. Somatic complaints

56c. Nausea
56a. Pains
56f. Stomach problems
56b. Headaches
56g. Vomits
51. Dizziness
56c. Rashes
56d. Eye problems
92. Walks, talks in sleep
47. Nightmares
2. Allergy
54. Overtired
77. Sleeps much

IV. Schizoid-Obsessive

70. Sees things
40. Hears thing
84. Strange behavior
85. Strange ideas
9. Obsessions
18. Harms self
67. Runs away
100. Can't sleep
76. Sleep little
91. Suicidal talk
66. Compulsions

Externalizing Scales

V. Hyperactive
- 8. Can't concentrate
- 1. Acts too young
- 61. Poor school work
- 17. Daydreams
- 62. Clumsy
- 64. Prefers young kids
- 41. Impulsive
- 13. Confused
- 10. Hyperactive
- 80. Stares blankly
- 38. Is teased
- 48. Unliked
- 79. Speech problem
- 23. Disobeys at school

VI. Sex Problems
- 96. Sex preoccupations
- 73. Sex problems
- 63. Prefers older kids
- 52. Feels guilty
- 60. Plays with sex parts too much
- 93. Excess talk

VII. Delinquent
- 81. Steals at home
- 82. Steals outside home
- 43. Lies, cheats
- 39. Bad friends
- 67. Runs away
- 90. Swears

VIII. Aggressive
- 95. Temper
- 3. Argues
- 22. Disobeys at home
- 86. Stubborn
- 68. Screams
- 104. Loud
- 16. Cruel to others
- 37. Fights
- 94. Teases
- 87. Moody
- 97. Threatens people
- 25. Poor peer relations
- 19. Demands attention
- 27. Jealous
- 88. Sulks
- 74. Shows off
- 41. Impulsive
- 93. Excess talk
- 23. Disobeys at school
- 33. Feels unloved
- 109. Whining
- 48. Unliked
- 7. Brags
- 14. Cries much
- 21. Destroys others things

IX. Cruel
- 5. Acts like opposite sex
- 16. Cruel to others
- 15. Cruel to animals
- 21. Destroys other's things
- 57. Attacks people
- 37. Fights
- 20. Destroys own things

FACTOR LOADINGS OF ITEMS ON CHILD BEHAVIOR CHECK LIST

(Girls Aged 12-16)

Internalizing Scales

I. Anxious obsessive

50. Anxious
52. Feels guilty
112. Worrying
14. Cries much
35. Feels worthless
32. Needs to be perfect
31. Fears own impulses
12. Lonely
71. Self-conscious
9. Obsessions
47. Nightmares
27. Jealous
45. Nervous
34. Feels persecuted
100. Can't sleep
29. Fears
76. Sleeps little
33. Feels unloved
30. Fears school

II. Somatic Complaints

56c. Nausea
56f. Stomach problems
56a. Pains
56b. Headaches
51. Dizziness
56g. Vomits
56d. Eye problems
30. Fears school

III. Schizoid

40. Hears things
80. Stares blankly
85. Strange ideas
17. Daydreams
84. Strange behavior
96. Sex preoccupations
70. See things
47. Nightmares
29. Fears

IV. Depressed Withdrawal

111. Withdrawn
103. Sad
69. Secretive
42. Likes to be alone
75. Shy, timid
102. Slow moving
65. Won't talk
88. Sulks
86. Stubborn
71. Self-conscious
77. Sleeps much
80. Stares blankly
54. Overtired

Mixed Scales

V. Immature-Hyperactive

1. Acts too young
64. Prefers young kids
62. Clumsy
8. Can't concentrate
38. Is teased
58. Picking
25. Poor peer relations
13. Confused
83. Hoarding
10. Hyperactive
11. Clings to adults
48. Unliked
80. Stares blankly
17. Daydreams
98. Thumbsucking

Externalizing Scales

VI. Delinquent

39. Bad friends
43. Lies, cheats
101. Truant
61. Poor schoolwork
105. Alcohol, drugs
23. Disobeys at school
67. Runs away
41. Impulsive
81. Steals at home
82. Steals outside home
90. Swears
8. Can't concentrate
22. Disobeys at home
69. Secretive
63. Prefers older kids
26. Lacks guilt the

VII. Aggressive

95. Temper
194. Loud
86. Stubborn
68. Screams
94. Teases
97. Threatens people
3. Argues
19. Demands attention
16. Cruel to others
22. Disobeys at home
74. Shows off
93. Excess talk
87. Moody
88. Sulks
37. Fights
7. Brags
57. Attacks people
27. Jealous
34. Feels persecuted
90. Swears
89. Suspicious
33. Feels unloved

VIII. Cruel

21. Destroys other things
15. Cruel to animals
57. Attacks people
20. Destroys own things
16. Cruel to others
37. Fights
81. Steals at home
97. Threatens people
48. unliked
25. Poor peer relations
106. Vandalism
34. Feels persecuted