A Grounded Theory of Parents Experiences of Incredible Years Parent Management Training within Whirinaki, a Child and Adolescent Mental Health Service

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Abstract

This thesis presents an exploration of parent's experiences of Incredible Years Parent Management Training within Whirinaki, Child and Adolescent Mental Health Service, Counties Manukau District Health Board. Nine participants were interviewed and selected based on their attendance at over 50% of the sessions of Incredible Years Parent Management Training groups offered over the course of one year. They had children with symptomology of Attention-Deficit Hyperactivity Disorder and/or Oppositional Defiant Disorder. The sample included both mothers and fathers representing various family compositions.

Using grounded theory methodology, a theory was developed which has created an understanding of the processes involved as parents seek to attribute meaning to their child's behaviour. It is anticipated that the findings which emerged from this study will enhance treatment outcomes for parents and create innovation in exploring how systemic strategies could be applied within a Child and Adolescent Mental Health Service framework, to incorporate more efficient service delivery and most importantly further meet the needs of parents and families.

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PART 1

INTRODUCTION AND LITERATURE REVIEW

Chapter 1

Introduction

Whirinaki, CAMHS

Whirinaki (formerly Campbell Lodge) is a community Child and Adolescent Mental Health Service ("CAMHS") with a multidisciplinary team of approximately 76 clinical staff. Whirinaki provides assessment and treatment for children and adolescents up to the age of 18, with emotional, mental health and behavioural problems within the Counties Manukau District Health Board ("CMDHB") region. Many of these children and adolescents exhibit disruptive and challenging behavior within a variety of settings. They also place increased caretaking demands on their parents (Kendall, 1999). To assist families, Whirinaki is concerned with actual functioning of the child or adolescent, rather than a reliance on a formal DSM IV diagnosis, although formal diagnosis is often provided. Whirinaki offers Incredible Years Parent Management Training ("IYrs PMT") as a psychosocial treatment option for many of these parents with younger school aged children. IYrs PMT is an evidence-based programme, which is part of a series which also includes child and teacher components. The series is designed to help reduce children's aggression, behaviour problems and increase social competence at home and school.

Referrals of Children with Disruptive Behaviour Symptomology

Research indicates that disruptive child behaviours which include aggression, oppositional behaviour and non-compliance, are the most common problems for which parents seek professional mental health intervention (Kazdin, Bass, Ayers, & Rodgers, 1990; Lundahl, Risser & Lovejoy, 2006). Whirinaki, CAMHS is no exception. Parents referred to IYrs PMT within this setting report considerable difficulties in managing their child's disruptive behaviour. Consequently, this can lead to conflict and predominantly negative interactions between parents and their children. Referred parents have expressed a willingness to learn new strategies to help understand their child's behavior and to have more positive interactions and experiences within their family. Parents referred to IYrs PMT have children who display symptomology of disorders such as Attention-Deficit Hyperactivity Disorder ("ADHD") and/or Oppositional Defiant Disorder ("ODD"). A formal mental health diagnosis is not necessarily required for parents to attend. This study will focus on the parents of these children.

History of IYrs PMT within New Zealand

IYrs PMT was developed in the United States by Carolyn Webster-Stratton over 25 years ago and is now being incorporated within the New Zealand ("NZ") context. IYrs PMT is being implemented into CAMHS and Non Governmental Organizations ("NGO's"). IYrs PMT had initially been introduced at Tauranga CAMHS in 2002 where it was offered for solo mothers of children diagnosed with ADHD. Community networking resulted in the establishment of the

Incredible Years Guardian Group Tauranga, which has focused on issues for practitioners facilitating the programme. This group is now commonly referred to as the Guardian Group and is a recognised organisation in its own right (Hamilton, 2005).

IYrs PMT Inter-Sectorial Collaboration & Delivery within New Zealand

The Werry Centre (an organization which promotes child and adolescent mental health workforce development); has a parent management training project which aims to facilitate inter-sectorial collaboration to provide training and supervision in evidence based parent management training (Werry Centre for Child and Adolescent Mental Health, n.d). Professionals from many disciplines and various agencies are being trained in IYrs PMT all over NZ and are also now being encouraged to obtain accreditation and mentor status. In April 2008, the Werry Centre released a Maori Hui Report on "Maori Experiences of Delivering the Incredible Years Parenting Programme" (Cargo, 2008) and made some key recommendations regarding the adaptability of IYrs PMT for Maori. This type of investigation is pertinent to CAMHS where a growing proportion of Whirinaki clients are Maori and improved Maori models of practice are required for psychosocial interventions such as IYrs PMT to be more culturally appropriate and relevant.

In 2008, it was also announced that the Ministry of Education had adopted the programme, and would be targeting parents of young children identified with challenging behavior (Collins, 2008). The Ministry of Education also released a fourteen minute information DVD about IYrs PMT featuring NZ group leaders and parents who had attended the programme, which advocated the positive benefits for families. Otago University has also started clinical trials to investigate effectiveness of IYrs PMT within NZ and preliminary data is consistent with the view that IYrs PMT is an effective and culturally appropriate programme (Fergusson, Stanley & Horwood, 2009). The Advisory Group on Conduct Disorders has recently released a report on the prevention, treatment and management of conduct disorders in children and young people. IYrs PMT is an intervention recommended in this report (Advisory Group on Conduct Disorders, 2009).

In summary, IYrs PMT is rapidly gaining momentum and recognition within NZ and hundreds of professionals have now been trained to deliver IYrs PMT. Others are furthering their training by achieving accreditation, peer and mentoring status. As professionals become more familiar with the programme, and refine their skills at delivering this intervention, they are also raising important questions and issues which will assist NZ to develop a solid research base of its own.

IYrs PMT within Whirinaki, CAMHS

Whirinaki initially launched a couple of pilot groups of IYrs PMT (basic programme) in late 2005. From the beginning of 2006, the groups at Whirinaki gained momentum and the first evening group commenced. The evening groups were developed from an identified need to have both parents attend and provide more flexibility to families. Since this time, a number of clinicians

have received formal training in IYrs PMT. In 2007, six groups were held during the year of thirteen weeks duration, with an estimate of approximately 60 parents completing the programme. In 2008, only two evening groups were delivered as the management of IYrs PMT was transferred to the Whirinaki Child team. Whilst only 2 groups were held, retention rates had improved with reduced attrition compared to the previous year. There were also a greater number of couples attending and there appeared to be a more even balance between solo parents and couples. Child team clinicians felt that some of these findings could be attributed to the introduction of IYrs PMT information evenings a week or two prior to the course being held. Parents who attended this information evening were automatically guaranteed a place on the course. It was a forum where an overview was provided, where questions were answered and potential barriers addressed to ensure parents were fully informed. In 2009, two evening groups were held and one day group. There were 7 clinicians involved during 2009 in the delivery with varying experience. Regular supervision occurred between these clinicians which incorporated delivery of the programme and maintenance of programme fidelity. This type of practice is supported by the Werry Centre PMT project. Child team clinicians have become more reflective regarding the processes involved for IYrs PMT. Unfortunately, there are long waiting periods for parents to attend due to the limited number of groups delivered, and this often results in parents losing interest when it finally becomes time to attend. In 2010 there has been the introduction of advanced IYrs PMT to Whirinaki as well as an overwhelming increase in referrals of parents to attend the programme. This has resulted in greater demand to meet capacity for parents of children with behavioural difficulties.

IYrs PMT and the Local Context of Counties Manukau

The demographics of Counties Manukau reflect a population base with alarming statistics of antisocial youth behaviour, poverty and other risk factors. The delivery of evidence based programmes such as IYrs PMT to families of younger children are vital, not just for the emotional wellbeing of the child and family, but to the community of Counties Manukau. Whirinaki CAMHS is rapidly growing to accommodate the needs of its client base. Research of interventions that are delivered within this setting are required to improve service delivery, outcomes for families and for the future prospects of the community as it grows older.

Chapter 2

Attention-Deficit Hyperactivity Disorder and Oppositional Defiant Disorder

Introduction to ADHD & ODD

In NZ, consistent with North American trends, ADHD and ODD are among the most common diagnoses given to children and for which parents seek assistance from CAMHS services. IYrs PMT has a high percentage of parents participating in this programme who have children with these diagnoses as well as symptomology of these disorders. Some of these children also exhibit co-morbidities such as Autism Spectrum Disorders ("ASD") and ADHD, ADHD & ODD or ADHD and encopresis. In the scope of this literature review, ADHD and ODD are the disorders that are the focus of this study. However, applicable co-morbid conditions will also be briefly discussed. Whilst not all parents included in this study had children with a formal diagnosis of ADHD or ODD, most did exhibit symptomology of these disorders.

The literature review on ADHD and ODD will include common behavioural characteristics, DSM diagnostic criteria, prevalence, history of the disorders, etiologies and co-morbidities. ADHD, ODD and Conduct Disorder ("CD") do all feature commonly together in research literature and whilst they are defined separately in terms of diagnostic categories, there are parallels in terms of etiological, epidemiological and treatment factors. CD will not be a specific focus, as parents in this study did not have children diagnosed with this disorder, mainly due to the younger age of the children in the study. This is not to rule out that some children may go on to develop conduct disorder at a later age.

ADHD Behavioural Characteristics

ADHD is one of the most commonly diagnosed behavioral disorders of childhood which is characterized by symptoms of hyperactivity, inattention and impulsivity. ADHD is a chronic condition, which adversely affects many areas of child psychosocial functioning over multiple domains including academic, social and emotional adjustment (Barkley, 2006). Common features of the disorder include social immaturity, learning difficulties, clumsiness, non-compliance, and short term memory impairment (Green & Chee, 1994). Children with ADHD typically struggle with inhibiting undesirable behaviours that aren't in keeping with particular societal expectations or norms. These can include failing to remain seated, excessive chattiness, being noisy, interrupting and distracting others and fidgeting (Barkley, 1997; Harrison & Sofronoff, 2002). Onset is typically during the preschool years and it is most commonly diagnosed when children reach middle childhood at about age 7 years (Barkley, 2006).

ADHD DSM-IV Definition

The current 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (APA, 2000) specifies three subtypes of ADHD. These include predominantly inattentive, predominantly hyperactive/impulsive, or combined. All of these subtypes need to have persisted over the past 6 months for the symptoms to be classified to a degree that is maladaptive and inconsistent with the child's developmental level. Impairment also needs to be present in two or more settings, and there must be clear evidence of clinically significant impairment in social or academic functioning. The 'inattentive' diagnostic criteria include 9 symptoms of inattention with 6 of the symptoms needing to be evidenced in the child's behaviour. The 'hyperactive-impulsive' criteria also include 9 symptoms (6 of hyperactivity and 3 of impulsivity) and require 6 or more of hyperactive and/or impulsive symptoms. For this subtype, the symptoms that caused impairment need to have been present prior to 7 years. Finally, the 'combined type' requires both criteria of inattentive and hyperactivity-impulsivity to be met (APA, 2000).

ADHD Prevalence

NZ prevalence rates for ADHD are estimated to be approximately 5% of school aged children with rates for boys three times higher than for girls (Ministry of Health, 2001), although unofficially this is probably much higher, as NZ follows international trends with growing statistics of children who are being treated for disruptive behaviour disorders. Up to 8% of children in the United States are affected by ADHD, with similar numbers being reported in other countries (Buttross, 2007).

ODD Behavioural Characteristics

Children with ODD can be persistently stubborn and resistant to directions. They often create conflict with others as they are unwilling to compromise. They will often argue in retaliation to requests, persistently test limits and fail to accept blame for misdemeanours. Children with ODD express aggression often in neutral situations and have difficulty interpreting social cues from peers. They experience difficulty problem solving and often expect to be rewarded for their aggressive responses (APA, 2000).

ODD DSM-IV Definition

ODD is characterized by core symptoms of oppositionality, vindictiveness, hostility and aggression. ODD falls under the classification of Disruptive Behaviour Disorders (also referred to as 'externalizing disorders') which also includes 'Disruptive Behaviour Not Otherwise Specified' (NOS) and 'Conduct Disorder'. The diagnostic criteria of ODD emphasizes a negativistic, hostile, and defiant behaviour lasting at least 6 months, during which four or more symptoms must be met, from a pool of eight. A symptom is met only if the behaviour occurs more frequently than is typically observed in individuals of comparable age and developmental level. The disturbance in behaviour must also cause significant impairment in social and academic functioning (APA, 2000).

ODD Prevalence

ODD has a wide ranging prevalence rate between 1-16% depending on varying criteria and assessment methods (Loeber, Burke, Lahey, Winters & Zera, 2000). It is difficult to discern specific prevalence due to the overlap of ODD with other disorders i.e CD. There is no current accurate data on the prevalence in the preschool age range although it is well documented that ODD occurs mostly in the lower socioeconomic groups (Steiner et al; 2007). The prevalence of ODD in NZ is not known, however it is highly likely that it is less diagnosed than ADHD, particularly with younger school age children and is more commonly diagnosed following a diagnosis of ADHD.

Co-morbid ADHD & ODD Prevalence

A substantial proportion of children with ADHD develop oppositional behaviours that qualify for a co-morbid diagnosis of ODD with estimates of approximately 55% of children with ADHD also developing ODD (Barkely, 2006). Again, prevalence estimates in New Zealand are difficult to predict. However, it is highly likely that more children are being diagnosed with co-morbid ADHD and ODD following trends in the United States.

Chapter 3

History & Etiology ADHD & ODD

History of ADHD

The definitions of ADHD, and subsequent assessment and treatment, have been evolving since around the middle of the 19th Century. The first clinical description of hyperactive behaviour in children was theorized by Still in 1902 (Still, 1902 cited in Barkley, 2006). Still presented a paper to the Royal College of Physicians in London describing the behaviours of children he had seen in clinical practice with inattention, excessive motor activity and 'poor inhibitory volition'. Theorists such as Still posited at the time that children who lacked behavioural attention had a defect in the moral control of behaviour (Barkley, 2006). A further article was published by Still describing these children and encompassed other behavioural issues such as discipline problems, defiance, dishonesty and lawlessness. These latter behaviours are now separately defined as ODD and CD, which sometimes exist co-morbidly with ADHD (Buttross, 2007; Rafalovich, 2004).

An encephalitis epidemic in North America during 1917-1918 resulted in children exhibiting behavioural and cognitive characteristics of what we also now refer to as ADHD. At the time, this disorder became known as 'Post-Encephalitic Behaviour Disorder'. Brain disease and causal pathways of brain injury and its manifestation in children's behaviour then became more widely researched. Conceptualizations of a clinical disorder resulting from brain damage i.e minimal brain damage' was gradually superceded by the term 'minimal brain dysfunction' in the 1950s-1960s (Houghton, Carroll, Taylor & O'Donoghue, 2006). An evolving understanding was now more focused on the dysfunction of the central nervous system as opposed to damage specific to the brain.

Investigators then shifted their focus to the behavioural symptom of hyperactivity. The first edition of the DSM (1968) introduced the definition 'hyperkinetic disorder of childhood' to describe core symptoms of inattention and hyperactivity (Ross & Ross, 1982). In the 1970s the defining feature of hyperactivity or hyperkinesis was broadened to include impulsivity, short attention span, low frustration tolerance, distractibility and aggressiveness (Barkley, 2006; Ross & Ross, 1982). Later, by 1980 the DSM-III represented a paradigm shift as it began to emphasize inattention as a significant component of the disorder, defined as attention deficit disorder. This definition also incorporated developmental variability in the presentation of the disorder at different ages and also introduced a residual type of ADHD if the remaining symptoms continued to cause significant levels of impairment (Spencer, Biederman & Mick, 2007).

The revised edition moved back towards more emphasis on hyperactivity, with ADD without hyperactivity reclassified into the minor category of Undifferentiated ADD. The current version of the DSM (DSM IV) uses the term Attention-Deficit-Hyperactivity-Disorder. The DSM IV text revision further defines 3 subtypes under this classification predominantly inattentive, predominantly hyperactive-impulsive, and combined type (APA, 2000).

History of ODD

ODD first appeared in the DSM III (American Psychiatric Association, 1980), but its inclusion as a category had been suggested by the Group for the Advancement of Psychiatry back in 1966 (Steiner et al; 2007). DSM III-R further encouraged clinicians to distinguish between ODD and CD. Prior to DSM IV, further extensive field trials provided the rationale for more specific but minor modifications (Steiner et al; 2007).

Since this time the diagnostic categorization of ODD has met with much controversy and debate due to its overlap with CD and the search for empirical support has not met with uniformity. Empirical evidence of the diagnostic categories has been questioned. The proposal of integrating CD and ODD into a single, alternative disruptive behaviour syndrome with 3 levels of severity, and recasting ODD and CD as a developmental disorder has been posited by Lahey, Loeber, Quay, Frick & Grimm,1992). Their rationale was that children and adolescents who had developed CD had retained the symptoms of ODD that emerged at earlier stages.

Etiology-ADHD

Most research conducted into the etiology of ADHD reveals predominantly genetic, biochemical and environmental factors. Most of the experts agree that there are multiple causal pathways which reflect genes and environment interacting in a multitude of ways to produce the behavioural characteristics of the disorder. Research suggests that the most common pathway to developing ADHD is one in which children are born with a genetic susceptibility or congenitally acquired predisposition to ADHD (Barkley, 2006; Biederman, 1998; Ross & Ross, 1982).

A developmental psychopathology framework has been formulated by some researchers to provide predictions of how ADHD characteristics develop over time, and how multiple risk and protective factors, including biology and family environment, transact to impact this development (Hinshaw, 1994; Kazdin & Kagan, 1994; Rutter & Stroufe, 2000). This model allows for the possibility that across children and across time, various influences weigh differently in the development of the disorder. For some children, the development of ADHD may be more biologically determined due to biological risk factors, whilst subsequent contributions from the family or other environmental factors will have a lesser role.

Genetics-ADHD

Twin, family and adoption studies report a substantial genetic component in the etiology of ADHD (Biederman et al; 1987; Pffifner et al; 1999). Siblings of children with ADHD have been shown to have 2-3 times the risk of having ADHD compared to siblings of normal controls (Barkley, 2006). Concordance for ADHD is higher in full siblings than in half siblings and higher in monozygotic twins than in dizygotic twins. There are also reports of increased risk of ADHD in the parents of children with ADHD and these parents are at risk of other psychiatric problems as well (Biederman et al; 1995). Various genes have been associated with ADHD but molecular genetic studies have produced conflicting results. The model of familial transmission is still unclear and further research is required on delineating genetically homogenous subtypes (Faraone & Doyle, 2000).

Biochemical-ADHD

The psychological deficits of those with ADHD have been extensively studied through various scientific methods and have been linked to several specific brain regions. These include the frontal lobe, its connections to the basal ganglia, and their relationship to the central aspects of the cerebellum (Barkley, 2006). The majority of these studies have found that those with ADHD have less brain electrical activity and less reactivity to stimulation in one or more of these regions. Advances in neuro-imaging of groups of children with ADHD also demonstrate relatively smaller areas of grey brain matter and less metabolic activity of the brain matter than controls (Barkley, 2006). Neurotransmitters have also been implicated in ADHD. Most evidence relates to a selective deficiency in the availability of both dopamine and norepinephrine, although this evidence cannot be considered conclusive (Barkley, 2006). More recently a meta-analysis of studies of ADHD and magnetic resonance imaging was conducted by Soliva-Vila & Vilarroya-Oliver (2009) and found that the findings supported the involvement of the right fronto-striatal circuit in the neurobiology of ADHD.

Environmental/Social Factors-ADHD

Family environment remains an important consideration in the development, manifestation and outcome of the disorder (Lange et al; 2005). Evidence suggests that parents of children with ADHD are often found to have their own mental health problems, including depression, anxiety and substance abuse (Biederman et al; 1995). Conflict within families of children with ADHD is frequently noted, (Lin, Huang & Hung, 2009; Webster-Stratton & Spitzer, 1996) marital discord & separation (Wymbs et al; 2008), and familial psychosocial problems particularly expressed emotion (Webster-Stratton, 2007). Parents have also shown to be more insular and exhibit lower self esteem than other parents of children without such difficulties (Wahler & Dumas, 1984). Patterns of family interaction and family influence are thought to be a consequence of ADHD. Consequently, parenting attributes are also thought to shape, maintain or exacerbate the ADHD symptoms (Barkley, 2006; Miller, 1995).

Other Etiologic Factors-ADHD

Other biologic factors proposed as contributors to ADHD include food additives, lead contamination, cigarette and alcohol exposure, maternal smoking during pregnancy and low birth rate. Some of these factors have been popularized i.e food additives and lead contamination and studies dispute their role in the etiology of ADHD (Barabasz & Barabasz, 1996; Barkley, 2006). More recent literature has cited maternal smoking and alcohol exposure during pregnancy, low birth rate, and psychosocial adversity as additional independent risk factors for ADHD (Spencer et al; 2007; Mick, Biederman, Prince, Fisher & Faraone, 2002; Biederman et al; 1995). Pregnancy and delivery complications have also been cited as contributing to a predisposition toward ADHD (Beydoun & Saftlas, 2008; Sauver et al; 2004).

Etiology-ODD

There have been no separate systematic investigations in the origin of ODD, data lies within the body of literature on CD. The current and most prevalent opinions are that ODD also originates within a bio-psycho-social constellation of an individual. In this context there is an interrelationship between risk and protective factors. Identifying primary risk factors and developmental pathways to disruptive behaviour disorders ("DBD") are complex, and convincing causal linkages remain elusive (Burke, Loeber and Birmmaher, 2002).

Genetics-ODD

Evidence for genetic influence on ODD has been found although further research is required before more specific conclusions can be drawn. Twin studies have indicated genetic correlations across gender in liability for ODD and CD (Eaves et al; 2000). Associations have also been found, by using child and parent self reports, between familial negativity and adolescent antisocial behaviour, although a modest effect for non-shared familial environment has also been found (Pike; McGuire, Hetherington, Reiss & Plomin, 1996). Other evidence suggests various associations between genetic factors and aggression versus environmental factors and nonaggressive delinquency (Edelbrock, Rende, Plomin & Thompson,1995); and between early criminal behaviour, primarily environment versus adult criminal behaviour (Lyons et al; 1995).

An intergenerational transmission of ODD has been found in families which includes parents and siblings of both genders (Farrington, Jolliffe, Loeber, Stouthamer-Loeber & Kalb, 2001; Lahey et al; 1997). In boys with co-morbid ADHD and DBD, paternal externalizing disorder is strongly associated with co-morbid CD and more moderately associated with co-morbid ODD (Pfiffner et al; 1999). In girls, mother and daughter antisocial behaviour are linked, with stronger influence coming from parental psychological distress than parenting behaviours (Kaplan & Liu, 1999). Associations between parental depression have been found in relation to onset and persistence of DBD in offspring (Loeber, Green, Keenan & Lahey,1995; Weissman, Warner, Wickramaratne, Moreau & Olson, 1997).

Neurological Factors-ODD

Research is still evolving in relation to the examination of brain functioning and its relationship to DBD's such as ODD. Neuro-developmental pathways to aggression have been studied. Sugden, Kile and Hendren (2006) developed a model which helps establish a relationship between symptom domains (impulsivity, affective instability, anxious/hyper-arousal, cognitive disorganisation, and predatory aggression) and brain structure and function. The model is designed to focus on symptom domains and brain circuits which may help plan a more strategic intervention which is able to be more specific in the origins of the aggressive behaviour.

Psychological & Environmental Factors-ODD

Psychological theories of attachment and learning theory influence the psychological factors implicated in the development of ODD. Attachment theory has been used by some theorists to help explain the similarities between behaviour of children with insecure attachment (particularly anxious-avoidant) and DBD's. It is hypothesized that oppositional behaviour is a special signal to an unresponsive parent (Lyons-Ruth, 2008). It has also been hypothesized that children with co-morbid ADHD, ODD, and CD have multiple individual and environmental risk factors first apparent in infancy and potentially leading to adverse personality formation in adulthood (Rutter, 1999). Social learning theory has also been applied to suggest that the negativistic characteristics of ODD are learned attitudes reflecting the effects of negative reinforcement techniques used by parents and other authority figures (Bandura, 1969,1978; Webster-Stratton & Handcock, 1999).

Environmental factors such as poverty, lack of structure, community violence and gang affiliation have all been posited as contributing to the likelihood of an ODD diagnosis. Also implicated are family characteristics and social processes including coercive parenting styles, lack of parental supervision, lack of positive parental involvement, inconsistent discipline and child abuse (Burke et al; 2002). These factors will be further reviewed in the risk and protective factors section.

Attachment Theory and Disruptive Behaviour Symptomology

Controversy regarding ADHD suggests mis-diagnosis and over-diagnosis. It has been argued that diagnosis meets the needs of the parents more than it does of the child. Alternative theories of conceptualizing problem behaviours in children have been proposed which are embedded in attachment theory. The behaviours might resemble ADHD or other disruptive and aggressive behaviours in children but can be explained within the context of parental attachment patterns (Erdman, 1998).

Attachment theory was originally developed by John Bowlby & Mary Ainsworth (Bowlby, 1979). The basic premise is that attachment behaviours are part of a drive-behavioural system organised around specific attachment figures. Infants attempt to establish a secure base with a primary caregiver, usually the mother, from whom they later develop appropriate exploratory

behaviours. The response by the attachment figure as they interact with the infant either positively or negatively become encoded in the child's mind and is referred to as the internal working model. Inter-generational transmission of attachments have been proposed, where attachment patterns may be a learned response passed down from one's family of origin, which explains the recursive nature of parent child interactions (Bowlby, 1979; Byng-Hall, 1995,1998, 2008; Byng-Hall & Stevenson-Hinde,1991; Main, Kaplan & Cassidy, 1985).

Byng-Hall (1995) described four ways that insecurities in one's relationship can spoil the security of another relationship:

1) Turning to an appropriate attachment figure (i.e divorced parent turning to a child for comfort)
2) Competition for an attachment figure (i.e jealous child who clings to a parent because they cannot tolerate the parents relationship with other family members)
3) Defensive response to attachment cues (i.e a parent who failed to acquire a model from their parents to tolerate normal attachments
4) Anticipation that the past may be repeated (a child who refused attachment to avoid the painful consequences of anticipating the repetition of a previous traumatic loss

Further, parental depression is identified as a significant risk factor for insecure attachment. Parental responses to children are impaired by interferences from external variables; children react in disorganised, detached, and disruptive ways. The circular nature of these interactions then reinforces a pattern of coercive exchange between parent and child and solidifies a detached and insecure parent-child relationship (Erdman, 1998).

Insecure-attached children develop strategies to allow themselves to explore the environment in spite of their caregiver's unavailability and unresponsiveness. They alert their caregivers to fearful situations by using anger and negative affect which gives the child a false sense of power. The demanding and helpless behaviours from the child, who is actually powerless, encourage negative involvement from the attachment figure, which only increases the child's feelings of anxiety and vulnerability (Crittenden,1992; Moretti, Holland & Peterson, 1994).

ADHD/ODD Co-morbidty

There is a robust association between ADHD and ODD. Co-morbid ADHD and ODD is associated with poor prognosis with children tending to be more aggressive, having more extreme problem behaviours; rejection by peers and underachieving more significantly in education (Barkley, 2006). A large proportion of children with co-morbid ADHD & ODD will subsequently develop conduct disorder (Barkley, 2006).

There are various theories articulating how a biologically based neurological disorder such as ADHD can develop to include ODD, which encompasses specific responses which are often learned (Danforth, 2007). The stepping stone model (Lynam, 1996) claims that children with

ADHD may not listen to instructions or follow instructions and consequently they respond quickly and carelessly or do not complete a task. They then respond with impulsive behaviour such as rudeness. A failure of rule-governed behaviour is another theory which relates to how children with hyperactive behaviour often fail to use self speech or private speech to regulate their own behaviour (Barkley, 2006). This deficiency is more problematic in co-morbid ADHD/ODD where the child does not generate or follow rules that guide their behaviour toward future goals and therefore the rules need to be generated by others. Coercion explains how the chronic intensity of ADHD behaviour results in parents giving in earlier when their children protest and is more common with ADHD children than typical children. Fewer positive responses and attention is given to appropriate behaviour. This behaviour is more pronounced in families of children with co-morbid ADHD/ODD (Seipp & Johnson, 2005).

Children with ADHD and ODD have worse verbal and visuo-spatial skills that are associated with a lower full scale and verbal IQ, higher performance than verbal IQ, decreased verbal fluency and a poorer academic level of achievement. Studies of families have shown that this group of children has significantly more first-degree relatives with ODD symptoms, antisocial behaviours and alcohol abuse or dependence disorders. Symptom levels of inattention and impulsiveness have been reported as increased in children with ADHD and ODD. Longer term outcomes are also worse in this group of children with rates of committed offences, rates of drug and alcohol abuse or dependence disorders, levels of antisocial personality disorder and unemployment being increased (Barkley, 2006).

Co-morbid ADHD & Encopresis

Encopresis is an involuntary excretion of stool. It occurs in approximately 1-3% of children (Fishman, Rappaport, Schonwald & Nurko, 2003). Anal retentive behaviour occurs when the child has an extensive period of withholding stool. Boys are three times more likely to have this condition. Many children with encopresis have co-morbidities. Evidence suggest that children with encopresis and ADHD, and encopresis and child-parent relational problems, are less responsive to treatment (involving laxatives, psychosocial intervention and bio-feedback training) than children with encopresis alone (Van Everdingen-Faasen, Gerritsen, Mulder, Fliers & Groeneweg, 2008).

Co-Morbid ADHD/ODD and Mood Disorders

Mood disorders and ADHD co-occur in 20-30% of children and adolescents diagnosed in both epidemiological and clinical studies. Depressed children have been found to display what Beck, Rush, Shaw and Emery (1979) have referred to as the negative cognitive triad, a unique set of cognitions characterized by a negative view of the self, the world and the future. Depressed children have been found to be more likely to attribute negative events to internal, stable and global causes and positive events to external, unstable and specific causes, thus endorsing a particular style for explaining events in their lives that is reflective of negative expectations and

the inability to positively affect outcomes. Research demonstrates that ADHD children show a tendency to positively distort their perceptions of events, more often attributing positive events to internal factors and negative events to external factors. Depressive disorders in childhood and adolescence are associated with self destructive and life threatening behaviours (Kovacs, Goldston & Gatsonis, 1993).

Research suggests that children with ODD have substantial co-morbidity with anxiety and depression and that the degree may vary over time in particular groups of children. Boys and girls have been found to have different patterns of ODD co-morbidity with either anxiety or depression, as well as ages of onset of ODD although more large studies are required. Children with ODD early in life have been identified as a subgroup at increased risk for anxiety and affective disorders (Boylan, Vaillancourt, Boyle & Szatmari, 2007).

Disruptive Behaviour Symptomology and Suicidal Ideation

Suicide in 10-14 year olds in NZ occurs at a similar rate to the U.S and is higher than Australia, England or Wales (Kypri, Chalmers, Langley & Wright, 2000). Suicide in this period of life is repeatedly identified as a growing problem in NZ. Young children who have disruptive behaviours (which include ADHD, ODD & CD) are vulnerable to suicide. Suicide in younger children is harder to predict because young children exhibit fewer warning signs (Beautrais, 2001). Suicide in NZ among children and adolescents under the age of 15 years is described as rare, but the rate has been increasing, consistent with a worldwide trend. Beautrais (2001) has examined 15 year old and younger suicide deaths over a ten year period (1989-1998) in NZ. Beautrais (2001) found that suicide risk increased with age, the majority were aged 14 years (57.4 %) or 13 years (26.2%). Most were boys (72.1%) and Maori (57.4%). Hanging was found to be the most predominant method (78.4%); most suicides occurred when children were not living in intact biological families (67.2%) or had a family history of suicide (10%). A minority had a documented history of prior suicide attempts (13.1%) or mental health problems (23%). Twenty three percent of children had made threats of suicide within the year prior to their death. A majority of deaths appeared to have been precipitated by relatively minor family arguments or disciplinary events. These had occurred within the context of actual, anticipated disruptions and transitions in family living arrangements, school circumstances, or family problems.

Various risk factors confound to highlight that children most at risk of suicidality include those who have made previous suicide attempts, where there is presence of psychiatric disorders and psychopathology, a preoccupation with death, and family history of psychopathology and suicidal behaviour (Pfeffer, Jiang & Kakuma, 2000). Environmental, contextual and demographic factors also play a role in childhood suicidality. Children with affective disorders, disruptive/conduct disorders, and schizophrenia, as well as symptoms of psychotic or delusional thinking, are more likely to display suicidal behaviour than children without these disorders (Gould et al, 1998). The severity of a particular disorder likely influences a child's level of risk. Co-morbid psychiatric disorders are also a red flag; young children with conduct disorders and

concomitant depression are at high risk of suicidal behaviour. A negative home environment, including poverty, poor family cohesion, divorce, witnessing or experiencing family violence, experiencing multiple transitions in the living environment and a history of maltreatment; are all linked to suicidal behaviour. High levels of aggressive behaviour in relatives is common. Negative situations at school can increase the risk of suicidal thoughts and behaviours for children who are coping with negative peer pressure, peer problems, poor performance, and loneliness (Tishler, Staats-Reiss & Rhodes, 2007).

Children are often described as clinically different from suicidal adolescents or adults. Historically, there has been an assumption that young children are not capable of either contemplating or performing suicidal acts. However there is a growing body of evidence to suggest that they do plan, attempt and successfully commit suicide. The essential quality of suicide is the intent to cause self injury or death regardless of the cognitive ability to understand finality, lethality or outcomes. The immature cognitive functioning of children makes them vulnerable at times of stress to the (egocentric) view that their families will be better off without them. Children in problematic families with impaired child-rearing practices and little support; are often exposed to multiple and severe stressors. The child may respond to stress poorly, impulsively, and in extreme cases with suicidal behaviour. Children who are suicidal tend to think about and dream more about death, fear death more and worry more about death than similar children who do not exhibit suicidality (Tishler et al; 2007; Thompson et al; 2005).

Suicidal motivators have been reported which include self punishment, escape from an unbearable life situation, attempting to regain control, acting out the covert or overt desire of the parent to be rid of the child, seeking retaliation or revenge against real or perceived wrongs, avoidance of punishment/abuse, and seeking a better, happier, more comfortable place. Research suggests that younger children tend to use less complex and more easily available strategies. These methods include hanging, self immolation (setting oneself on fire), jumping from a high place or down stairs, stepping in front of a moving vehicle, intentional drowning, stabbing, cutting, banging head with deadly intent, strangling, suffocating, and medication overdose. Frequently these attempts look like accidental occurrences upon initial treatment (Tishler et al; 2007).

ADHD & Aspergers Syndrome

Children with Aspergers Syndrome display impairment in social interaction, restricted repetitive and stereotyped patterns of behaviour interests and activities, but display no impairment in language or cognitive ability (APA, 2000). Social deficits are therefore a primary symptom of Aspergers Syndrome. However, children with ADHD also exhibit behavioural difficulties with social interaction although it is unclear whether their problems arise from substrates similar to those with Autism Spectrum Disorders. Common to both ASD and ADHD groups is difficulty managing novel and/or complex stimuli, difficulty regulating attention and emotion and problems

with organisation and executive functioning (Fine, Semrud-Clikeman, Butcher & Walkowiak, 2008).

Attentional symptoms are often found in children with ASD and many have diagnoses of both ADHD & ASD. Co-morbidity of ADHD & ASD is high, with estimates to be between 49% and 78% (Fine et al; 2008). It is suggested that children with ASD have poor social behaviours related to deficits in social perception, while similarily poor social behaviours in children with ADHD are performance related and associated with inattention and impulsivity (Semrud-Clikeman, 2007).

Chapter 4

Assessment & Treatment

Introduction to Assessment & Treatment

This chapter explores the assessment and treatment of ADHD & ODD in NZ. Assessment recommendations and protocols will be highlighted. The effectiveness of medication and psychosocial treatments will be discussed as stand alone treatments as well as their effectiveness when used simultaneously. Parental beliefs regarding these treatments will also be explored as parental attributions regarding treatment are important considerations of clinical intervention.

Assessment of ADHD/ODD in NZ

Assessment of ADHD and ODD in NZ is generally consistent with the American Academy of Child and Adolescent Psychiatry ('AACAP') practice parameters for ADHD and ODD, in which assessment interviews involving the parent and child, behavioural rating scales, observation and medical evaluation are all techniques used to elicit information regarding the child's behaviour (Dunnachie, 2007; Ministry of Health, 2001; Dulcan et al, 1997; Anon, 2007, Steiner et al; 2007). G.Ps suspecting ADHD in patients will refer the child to a specialist services i.e CAMHS or alternatively the family may access a paediatrician privately and fund personally. Alternatively, requests for assessments are made predominantly from the education sector such as Group Special Education, or schools. In CAMHS services within New Zealand, assessments occur in the context of a multi-disciplinary team and various professionals are involved in collating and collecting this information. Formal diagnosis is made by paediatricians or psychiatrists in conjunction with other multi-disciplinary staff.

Clinicians are particularly cautious in making formal diagnoses of younger children as there are future ramifications for the child and family. Often clinicians will target interventions around specific presenting issues in order to alleviate or improve symptoms in the child. A developmental framework is also taken into consideration, as children develop, various symptoms emerge or disperse. Symptoms can be precursors to other disorders or co-morbidities later in childhood.

Accessibility to Services and Help Seeking

The behaviour of parents seeking help for their children with disruptive behaviour has also been explored within the literature. Learned helplessness theory was initially developed by Seligman (1975) in research with animals and relates to conditions where a person can feel completely powerless to change their circumstances for the better (Abramson, Seligman & Teasdale; 1978; Maier & Seligman, 1976. Learned helplessness has been posited as a coping mechanism which people employ to survive difficult circumstances and has been previously applied to

explain why parents may immerse themselves in help seeking behaviour (Webster-Stratton & Spitzer, 1996). Therefore, when parents seek assistance from CAMHS services it is plausible that they may suffer from learned helplessness. The ability for families to advocate and empower themselves when accessing services has also been explored within the literature (Singh et al; 1995; Singh et al; 1997; Wahler & Dumas; 1984). Disempowerment and the inability to advocate for oneself can result in less accessibility, engagement and satisfaction with services.

There are various potential barriers for parents to seek assistance from CAMHS and other relevant health services; particularly for minority cultures and lower socio-economic families (Hiebert-Murphy et al; 2008; McKernan-Mckay, McCadam & Gonzales, 2005). Further, parents have reported dissatisfaction about the response they receive from clinicians when they do seek assistance for their children (Reijneveld, de Meer, Wiefferink & Crone; 2008) which indicates a need for further research to explore accessibility for families to assessment procedures. The process of assessment is required to occur within the context of a parent-professional partnership in which clinicians are required to establish a strong working alliance with families and empower families by enhancing their capacity to meet their own needs.
Whilst parent-professional partnerships are recognized in international literature (Hiebert-Murphy, Trute & Wright, 2008); clinicians within NZ CAMHS services have a legislative commitment to uphold principles of the Treaty of Waitangi in their services to families. This incorporates partnership, participation and protection obligations to Maori.

Psychopharmacology

Methylphenidate (Rubifen, Ritalin, Concerta) is a central nervous system stimulant which is the most commonly used medication for ADHD in New Zealand. Methylphenidate is funded by the pharmaceutical company Pharmac. Rubifen is usually trialled initially. Ritalin is able to be funded if Rubifen is proven not as effective, as is Concerta, a longer acting slow release form of methylphenidate. Dexamphetamine is another accepted treatment but is not as commonly used in NZ.

Stimulants for ADHD work by increasing both blood flow and the levels of dopamine in the brain, particularly the frontal lobes where the brain's effective functions take place. They are also effective in enhancing the inhibitory systems of the brain by enhancing serotonin and norepinepherine levels, ADHD Information Library; n.d).

The effectiveness of medication is well documented as a treatment for ADHD (Chronis, Jones & Raggi, 2006; MTA Cooperative Group, 1999). Medication is reported to be the treatment of choice for school aged children and in the Multimodal Treatment of ADHD study, medication was superior in reducing ADHD symptoms when compared to an intensive psychosocial intervention and a community care control group (MTA Cooperative Group, 1999).

Research has demonstrated that stimulant medication often improves short term academic and behavioural outcomes for children with ADHD, yet extensive research efforts during the past 20 years has not demonstrated the sufficiency of these medications in improving later social, psychiatric, academic and legal outcomes in adolescence and childhood (Barkley, 2006; Cantwell,1996; Hechtman, 1996).

Stimulant medication does not relieve some ADHD related symptoms (Hoza et al; 2005) and research indicates that it appears ineffective in reducing behavioural symptoms in up to 30% of cases (Spencer, et al; 1996). There is widespread reservation from parents against first line medication regimes. Stimulant medication for co-morbid ADHD can have reduced benefit. Some children have to be withdrawn from pharmacotherapy because of intolerable side effects. Medication, however, is still often intended as the primary choice particularly in severe cases or if psychosocial interventions are not sufficient (Ministry of Health, 2001; Taylor, Schmidt, Pepler & Hodgins, 1998).

There are currently no formal registered medications for the treatment of disruptive behaviour disorders (which includes ODD) as research on the effects of medication for these disorders are preliminary. Mixed results are reported with varying conclusions drawn on the effectiveness of medication in treating disruptive behaviour disorders. Children with disruptive behaviours are described as a population difficult to treat. On balance, there is consistent evidence to support the use of methylphenidate in children with co-morbid ADHD and ODD/CD, (Wolpert et al; 2006) although further investigations are required to determine the efficacy of stimulants in treating ADHD with co-morbid conduct disorder. It appears that a combination of these disorders is physiologically distinct from either diagnosis on their own and therefore requires a more specific research base (Banaschewski et al; 2003). There have also been some positive outcomes reported for lithium and risperidone particularly in the reduction of aggressive symptoms (Wolpert et al; 2006) However, there is a general caution in the use of these medications due to potential adverse effects such as an increase in nausea and vomiting for the use of lithium. Risperidone has been linked to significant drowsiness, vomiting, weight gain and extrapyramidal symptoms of parkinsonism (Ipser & Stein, 2007; Dunnachie, 2007).

Short term and longer term response rates to psycho-stimulant medication are no different between children with ADHD alone and ADHD and ODD/CD (Ollendick et al; 2008). Taken together, these findings suggest that there are important clinical implications in recognising and treating this co-morbidity of ADHD. Future directions include the determination of specific medication combined with psychological treatments for this group of children along with monitoring for effectiveness in both the short and the longer term.

Psychosocial Approaches

Psychosocial approaches used to treat ADHD have had a long history and there is evidence from controlled trials which demonstrates their potential to reduce ADHD symptoms (Pelham, Wheeler & Chronis, 1998). Most trials however have produced minimal effects on the core symptoms and that is why psychosocial approaches are currently not recommended as stand alone, front-line treatments for ADHD (Dulcan et al; 1997; Evans, Schultz & Sadler, 2008). Psychosocial approaches are considered an important component in a multimodal treatment strategy that helps address a broad range of behavioural and emotional problems.

Standard psychosocial approaches use techniques based upon generic theories of behaviour management arising from operant and social learning theory. Parents or teachers are taught ways to manage behaviour through rule setting and effective management of contingencies. These treatments, however, don't address the underlying dysfunctions of ADHD or the socio-developmental processes that play a role in promoting psychological development in the domains of attention, impulse control and self organization during early childhood (Crandell and Hobson, 1999; Sonuga-Barke, 2006).

The most convincing evidence for psychosocial treatment remains parent training in combination with behavioural therapy with the child (Dunnachie, 2007). Cognitive behavioural strategies of self instruction and social skills training remain unproven in their effectiveness (Vance & Luk, 2000; Abikoff, 1991).

Other treatments, often considered as alternatives include dietary supplements. There is no strong evidence for dietary modification/exclusion diets, although research does suggest a relationship between the intake of artificial colours or preservatives on the symptoms of ADHD and hyperactivity (Newmark, 2009). It is also suggested that children with ADHD have low levels of omega fatty acids compared with non ADHD children and therefore some studies have looked at omega-3 fatty acid supplementation (Richardson, 2006). Generally these have reported positive effects. Micro-nutrients have also been studied, including zinc, iron and magnesium deficiencies although further research is required to provide more conclusive results (Newmark, 2009).

Parental Beliefs about Medication and Psychosocial Treatment

Johnston, Hommersen and Seipp (2007) found that mothers of children with ADHD have rated behavioural parent training as a more acceptable treatment for children with ADHD than stimulant medication. This is consistent with findings of previous research focusing on both parents of children with ADHD (Liu, Robin, Brenner & Eastman, 1991) and also with non problem children (Wilson & Jennings, 1996). Further, in the study by Johnston et al; (2007) it was found that co-morbidity of ADHD and ODD did not influence these ratings. Reluctance of parents to place their children on stimulants, as well as the scarcity of information regarding the

long term effects of stimulants, has been described as making the development and testing of non-pharmacological treatments for children with ADHD (particularly younger children) a major public health priority (Sonuga-Barke, 2006).

Singh (2003) has also used treatment as one of the measures of fathers' perspectives of ADHD, categorizing two dimensions of 'reluctant believers' and 'tolerant believers'. Several factors were relevant to fathers' perspectives: resistance to a medical framework for understanding their son's behaviours, identification with the son's symptomatic behaviours; and resistance to drug treatment with stimulants. Further, Singh (2003) postulates that these factors help to explain father's absences from clinical evaluations and treatment of their son's behaviours.

Chapter 5

Parent Management Training

Introduction to PMT

This chapter introduces the psychosocial treatment of parent management training ("PMT"), featuring early historical influences of its development, the predominant evidence based PMT programmes and its main features. The effectiveness of PMT will be discussed, which will include which characteristics of PMT programmes and its participants are more conducive to improved outcomes. As the literature has focused predominantly on outcomes for mothers, there will be an exploration of some of the findings for fathers. The limitations of PMT research will be highlighted, concluding with the predominant components of structured group environments within PMT.

Historical Influences of PMT

PMT (also known as 'parent training' or more specifically 'behavioural parent training') formally began in the 1960s. It emerged in a context of change in psychotherapy, dissatisfaction with many existing treatments, and research demonstrating the important influence the family has and contributes to a child's behaviour. Historical influences on the development of parent management training include B.F Skinner who developed operant conditioning (Skinner, 1950); Gerald Patterson who extended the application of operant conditioning principles to alter child behaviour (Patterson, Jones, Whittier & Wright; 1965); Albert Bandura who developed social learning theory (Bandura,1969,1978; Bandura, Ross & Ross, 1963; Bandura, Blanchard & Ritter, 1969) and the study of the contribution of family interaction to children's aggressive and antisocial behaviour i.e models of family therapy contributed by Minuchin and Haley (Briesmeister & Schaefer, 2007; Haley,1971; Kazdin, 2005 & Minuchin, 1965).

Training parents to effect behaviour changes has been described as one of the most significant achievements within the field of child therapy (Graziano, 1977). PMT has now evolved into an empirically based and widely applied intervention. PMT is used in a variety of situations, tailored to meet a range of specific problem behaviours, within an individualized or group setting and over various contexts or treatment settings i.e community or mental health services (Briesmeister & Schaefer, 2007).

PMT Variations

PMT has become one of the most investigated psychotherapies for children and adolescents and is a popular psychosocial treatment option due to its established evidence base. There have been a variety of PMT developed and researched. Validated programmes (proven to be effective for children with disruptive behaviour and conduct problems) and which can be purchased, include IYrs PMT (Webster-Stratton, 2000), Triple P-Positive Parenting Programme

(Bor, Sanders & Markie-Dadds, 2002) and programmes developed by the Oregon Social Learning Centre (DeGarmo, Patterson & Forgatch, 2004). Features of PMT differ according to theoretical orientation, amount of intervention; mode of delivery i.e group, therapeutic components provided, and targeted recipients such as parent only or with the child receiving therapy.

PMT Components

Kazdin (2005) distinguishes PMT by four inter-related components:

a) A conceptual view about how to change social, emotional, and behavioural problems
b) A set of principles and techniques that follow from that conceptual view
c) Development of specific skills in the parents through practice, role play, and other active methods of training and
d) Integration of assessment and evaluation in treatment and treatment decision-making

PMT has been defined as being at the very core of the intervention process for childhood disruptive behaviour disorders such as ADHD, ODD and conduct disorder. Within this process, the parent-child relationship is fundamental. In PMT, the goal is to enhance the parent-child relationship which has deteriorated as parents struggle to manage their child's behaviour. The parents, their parenting and management kills therefore become a central focus in the intervention and therapeutic paradigm (Kazdin, 2005).

PMT must also acknowledge the age and developmental level of the children who are the targets of the intervention (Briemeister & Schaefer, 2007). To enable parents to modify their child's behaviour successfully i.e enhance compliance and reduce inappropriate behaviours, parents need to understand realistic expectations relevant to the parameters of their child's developmental level.

Effectiveness of PMT

PMT has a strong evidence base as a robust and successful treatment for children with disruptive behaviour disorders. There have been several meta-analytic studies which have examined the relationship between features of PMT and outcomes (Chronis, Chacko, Fabiano, Wymbs & Pelham; 2004; Johnston & Mash, 2001; Kane, Wood & Barlow; 2007; Lundahl et al; 2006). The effectiveness of PMT can vary according to the interplay between characteristics of participants attending and the features of parent training programmes, which are indicative of why some families are more responsive to treatment and others do not perform as well (Grimshaw & McGuire, 1998). These are often defined as risk factors or protective factors (Webster-Stratton & Handcock, 1998).

Characteristics of PMT Interventions

Webster-Stratton & Handcock (1998) argues that it is the characteristics of PMT interventions, not of the client, that determine the success of PMT with low income parents. Families are often

more responsive to parent training which is community based and when parents are involved in planning, recruitment, co-leading groups and setting priorities for programme content. Further, parents who reported a successful experience with a parent programme were more interested in broadening the focus to other family issues that they saw as needs for themselves. Successful programmes will involve parents in determining priorities for the content, but also need to be accessible and realistic given the practical constraints of parents living on a benefit or the working poor. Providing child care, transportation, food, evening groups as well as daytime groups are all components that will help access and retention. The training programme also needs to be responsive to a variety of learning styles; utilizing performance based training methods such as videotape modelling (now DVD), role playing and home assignments. Programme content needs to be relevant and sensitive to individual parent needs and family circumstances. The group format enhances support networks both within the family and within the community, ultimately leading to greater parent empowerment. Webster-Stratton & Handcock (1998) argue that these elements of an intervention lead to a higher level of parental engagement, and this involvement will result in parents gaining the knowledge, control, and competence they need to effectively cope with the stresses of parenting under conditions of poverty.

Characteristics of Participants

Family adversity is a characteristic that has the ability to disrupt parent training processes regarding how a parent acquires new knowledge and puts this into practice at home i.e a parent who has difficulty reading. It is well documented that adversity such as low socio-economic status, sole parenting, and being a beneficiary is associated with poorer outcomes (Webster-Stratton, 2007). If a parent has a younger child, then they are more likely to respond to the child management skills that their parents are taught in PMT (Bor & Sanders, 2004; Bor et al; 2002). This is attributed to younger children's greater reliance on parents for fulfilment of basic needs. If a PMT intervention is mindful of these factors and seeks to address them as much as they can, then improvements in children's behaviour should still be observed.

Sustainable Treatment Effects

The lack of sustainable treatment effects of PMT dominates the literature and is a focus for future refinement and research (Reid, Webster-Stratton & Hammond, 2003; Anderson, Vostanis & O'Reilly, 2005). Often significant improvements of child behaviour and family relationships are unsustainable longer term. Many studies have focused on up to 6-12 month follow up. At 2-3 year follow up additional difficulties and poor treatment response have been observed and this could be attributed to various external and developmental factors (Anderson et al; 2005).

PMT & Fathers

A noticeable absence of research validating efficacy of PMT for fathers has been observed and has been longstanding (Amato & Rivera,1999; Barclay, 1977; Coplin & Houts, 1991; Fabiano,

2007; Fabiano et al; 2009; Fischer, 1990; Horton, 1984; Tiano & McNeil, 2005). Fathers are also more broadly absent from research, clinical settings, parent support groups and educational meetings related to ADHD. Singh (2003) estimates only about 8% of studies since 1990 regarding ADHD included fathers, whilst Fabiano (2007) in a systematic review of behavioural parent training of 37 studies, found that 87% did not include information on father-related outcomes. These statistics are concerning as fathers are now more involved in care-giving. They also make an important contribution to their children's wellbeing and development, more specifically the development of emotional regulation, social cognition and focused attention which contribute to the enhancement of appropriate peer relationships. Fathers contribute uniquely to their child's academic achievement and academic sense of competence. Research has found that when fathers do attend PMT with their spouses, there is evidence of reduced maternal attrition and improved maintenance of treatment gains (Bagner & Eyberg, 2003; Patterson, Mockford & Stewart-Brown, 2005; Strain, Young & Horowitz,1981 & Webster-Stratton,1984).

Whilst the lack of research on father involvement in PMT can be strongly linked to the lack of father involvement in the actual groups that are delivered, there are also other variables operating which can account for the scarcity of research. Fathers are far less likely to attend PMT than mothers and fathers are much more likely to drop out. Some fathers may be more uncomfortable in PMT groups when the majority of participants are mothers. Singh (2003) in a qualitative study of father's perspectives on ADHD, theorises that the reason for the gender bias included in studies may be attributed to three factors; resistance to a medical framework for understanding their son's behaviours, identification with the son's symptomatic behaviours, and resistance to drug treatment with stimulants. These factors could help to explain the absence of fathers from clinical evaluations of their son's behaviours.

Engagement and retention of fathers in PMT has been explored. Helfenbaum-Kun & Ortiz (2007) found that initial interest and attendance was strong, but dropout became a major problem with 70% of fathers attending fewer than half of the sessions. More recently, Fabiano et al (2009) has reported enhanced engagement and satisfaction for fathers in behavioural parent training when incorporating a soccer game with their children, therefore integrating sports skills training with a focus on parent-child interactions and parenting strategies. This suggests that sports settings may also be an effective setting for teaching parenting strategies.

Research has also focused on the involvement of fathers in the lives of their children with ADHD. Arnold, O'Leary & Edwards (1997) looked at variables on the relation between father involvement and self reported parenting practices of couples who have children with ADHD. They found that father involvement was associated with fathers' use of more effective discipline when fathers had no ADHD symptoms and reported more love for their wives, but was associated with fathers' use of less effective discipline when fathers reported having ADHD

symptoms, when they reported less love for their wives, and when they identified highly with traditional roles. Salem, Zimmerman & Notaro (1998) found numerous positive sequelae for African-American adolescents whose fathers were closely involved in their lives. Paternal involvement predicted higher rates of self-esteem, lower rates of depression and anxiety and slightly lower levels of delinquent behaviours. It is also noted that fathers positively involved with their children have children with fewer mother-reported behavioural problems. Not only has parent training and father involvement been explored across cultural groups but other fathering roles including step fathers. Efficacy of parent training with stepfathers (using the Oregon model of PMT) has produced medium effect sizes at 6 and12 months, with parenting effects diminishing at 24 months (De Garmo & Forgatch, 2007).

Researchers have also commented on the lack of extensive investigations into parenting stress for fathers and that the scope of the findings needed to be broadened (Fischer, 1990). Baker (1994) did conduct a study comparing parenting stress between mothers and fathers and found little difference between maternal and paternal reports of parenting stress in such families and that other variables which included child behaviour, socioeconomic status, and years married contributed more to parenting stress than did parent gender. More recent findings by Treacy,Tripp & Baird (2005) also indicate that there is no significant difference in parenting stress between mothers and fathers of children with ADHD, but found that fathers have a significantly smaller social support network compared to mothers. Podolski & Nigg (2001) found that for fathers of children with ADHD, parenting role distress was associated uniquely with child oppositional or aggressive behaviors in contrast to mothers which related to child inattention and oppositional-conduct problems.

Fathers of children with ADHD have also been reported as more verbose in their parenting style, using physical discipline more often than fathers of children without ADHD (Treacy et al; 2005; Mash & Johnston, 1990).

More recently Lundahl, Tollefson, Risser, & Lovejoy (2008) completed a meta-analysis investigating whether involving fathers in parent training enhances outcomes and if mothers and fathers benefit equally from parent training. They found that studies that included fathers, compared with those that did not, reported significantly more positive changes in children's behaviour and desirable parenting practices, but not in perceptions towards parenting. Compared with mothers, fathers reported fewer desirable gains from PMT. They recommend that future research will further illuminate the role that fathers play in PMT and how PMT might be adapted to better meet their needs. Their data suggests that fathers should not be excluded from PMT and should be recruited to participate.

Mahalik & Morrison (2006) theorize that fathers' involvement with their children can be enhanced by identifying and changing restrictive masculine schemas that interfere with men's

parenting roles. Involved fathering is also connected to various wellbeing issues for children, spouses or partners and fathers themselves. Further, they suggest that certain traditional constructions of masculinity are likely to restrict men's involvement in fathering roles. Restrictive masculine schemas constrain men to only certain ways of acting, thinking or feeling and tend to be resistant to change in the face of experiences that suggest they are not accurate understandings of reality (Mahalik & Morrison, 2006).

In early work theorizing restrictive masculine schemas, David & Brannon (1976) described four injunctions of traditional masculinity (1) no sissy stuff (2) the big wheel (3) the sturdy oak and (4) give 'em hell. These injunctions are associated, respectively, with messages to men that they should avoid anything that might be remotely feminine (e.g expression of feelings, experiencing vulnerability, being nurturing); they should strive to defeat others and achieve status by climbing to the top; they should never show weakness, have the ability to endure difficulties without relying on others for help; and they should actively seek out adventure and risk; even responding with violence, if necessary.

The work of Levant and colleagues (Levant, Hirsch, Celentano & Cozza,1992 & Levant,1996) elaborated on these restrictive masculine schemas to define seven masculine ideologies. In their model, traditional socialization can shape men to 'avoid all things feminine, restrict their emotional life, act tough and aggressive, be self-reliant, emphasize achieving status above all else, be non-relational and objectifying in their attitudes toward sexuality and fear and hate homosexuals'.

Gender role stress has also been explored in relation to restrictive masculine schema as when a restrictive schema is challenged this will inflict gender role stress (Gilbert, 1992; Pleck, 1995). Mahalik, Locke, Theodore, Cournoyer and Lloyd (2001) have explored masculine social intimacy and self esteem in relation to historical and societal context whilst Law, Campbell & Dolan (1999) have provided a more specific exploration of masculinity within Aotearoa as gender role stress varies according to cultural context and place in history.

Restrictive masculine schemas have not been fully explored regarding how they might contribute to fathers' experiences of PMT. The resistance of fathers to seeking help and other elements of resistance encountered in PMT (i.e relating to the group experience) could be linked to restrictive masculine schemas and warrant further research.

Limitations of Current Research on PMT

There is still relatively little known about the relationship between parent training characteristics and outcomes for parents and their children, although this is an area of increasing interest. Systematic investigation of the clinical efficacy of PMT has been limited often due to variations in research design and factors that moderate the role of PMT for ADHD. Diagnoses of

disruptive behaviour disorders and symptomology i.e hyperactivity are also difficult to compare across studies. Most research has examined short term outcomes and has not evaluated generalization over time or across settings. Another limitation is that much of the research is conducted in university-based or medical school settings, not in traditional clinic-based or CAMHS services. Lower socio-economic families, single parents and fathers are not adequately represented.

Most PMT target families who have children with behavioural problems or they are generic health promotion programmes for the whole population. The few programmes that specifically address parent education and support for parents with a mental illness have not yet provided evidence that they produce long-term benefits. There are limited programmes for women with mental illness and even fewer programmes for women with mental illness who have children. To meet the need of parents with mental illness encompassing parent training that caters to children with ADHD and disruptive behaviour is an even further challenge (Craig, 2004).

PMT & Early Intervention

Research has demonstrated that the efficacy of psychosocial intervention for parents of children with ADHD appears stronger for pre-school children (Sonuga-Barke et al; 2002; Bor et al; 2002) and weaker for school aged children. Research indicates that intervening prior to transition to school and prior to the child's behaviour becoming associated with antisocial tendency and school failure, provides the best opportunity of altering the developmental course of ADHD (Daley, 2006; Brotman, Gouley, Chesir-Teran, Dennis & Klein; 2005)

Therapeutic Processes within Structured Groups

The work of Drum and Knott (1977) originally explored the positive attributes that structured groups make for promoting the group participant's growth and development. Their rationale has stood the test of time. Structured groups have a systematic structure for goal attainment which is viewed as non-threatening as they encompass structured exercises which encourage people to try out new behaviours. They also allow for both peer and professional feedback relating to a specific skill. Structured groups represent an economical use of treatment time and encourage change and growth by providing a mechanism of active problem-solving. Group participants invest in practicing a skill, clarifying an issue and structuring a resolution. Structured groups assist participants to become aware of the frequent occurrence of the type of problem situation they are attempting to resolve. They reduce the stigma associated with seeking help because they focus on common developmental needs and enable boundaries between the leader and participants, therefore creating a sense of psychological safety for group members.

Yalom (2005) outlines eleven primary factors in contributing to the group therapeutic experience which include (1) instillation of hope; (2) universality; (3) imparting information; (4) altruism; (5) The corrective recapitulation of the primary family group; (6) development of socializing

techniques; (7) imitative behaviour; (8) interpersonal Learning; (9) group cohesiveness; (10) catharsis and (11) existential factors.

Cultural considerations have also been explored as an important component in group process (Tsui & Shultz, 1988) as well as the comparisons of therapeutic factors in groups and individual treatment processes (Holmes & Kivlighan, 2000).

IYrs PMT incorporates many of the characteristics contained within a structured group format by providing clear focus and direction for group participants alongside providing some of the health promoting conditions that are characteristic of group therapeutic experience. Corey & Corey (2006) theorize groups as encompassing domains of cognitive, affective and behavioural and that all of these domains need to be included for a therapeutic approach of group work to be complete. IYrs PMT places emphasis on behavioural and cognitive domains and less so on the affective, supporting Webster-Stratton & Sptizer (1996) that IYrs PMT is not group therapy but does encompass therapeutic process.

Chapter 6

Incredible Years

Incredible Years Overview

This chapter will introduce the Incredible Years Training Series which comprises separate modules for parents, teachers and children. More specific focus will be applied to IYrs PMT in an examination of the effectiveness and efficacy of the programme. As this study focuses on IYrs PMT within a community setting, exploration of the literature in relation to community samples will also be highlighted. Finally, the cultural considerations applicable for Maori will be summarised which is a developing area of research within NZ.

Incredible Years Training Series

The Incredible Years Group-Based Series incorporates separate structured group programmes or modules for parents, teachers and children. The series is designed to prevent, reduce and treat conduct problems as well as increasing social competence in children. Each of the programmes has been empirically validated in randomized control-group studies for use with children with conduct problems. The fidelity of the series is maintained by detailed treatment manuals, with specific principles and the promotion of training in specific skills required of group leaders such as collaboration and problem solving processes. Within each session, group leaders are required to emphasize key therapeutic principles which encompass goals, issues and various circumstances for each group participant. This enables the content to be personally adapted to the context of a particular family or classroom. Vignettes are common to each programme and feature realistic scenarios which are potentially encountered by parents, teachers or children. The vignettes provide a focus for group discussion in which effective and ineffective responses are demonstrated and explored (Webster-Stratton, 2000, 2006, 2007, 2009).

For children diagnosed with conduct problems, developmental and other emotional problems or stressful life circumstances, it is recommended that the child dinosaur small group treatment group be offered in conjunction with the parent programme. Research indicates that these programmes when offered together have the strongest long term follow up results (Webster-Stratton, Reid & Hammond, 2004)

IYrs Parent Management Training Programme

IYrs PMT has been described as intricate as it encompasses a number of variations (Kazdin, 2005). For parents of children with diagnosed ODD or conduct problems, the BASIC Parent Programmes (early childhood or school-age versions) and the ADVANCE Parent Programmes 5 to 7 are recommended. They take 20-24 weeks to complete in their entirety (Webster-Stratton, 2007).

The objectives of IYrs PMT are designed to strengthen parent-child relationships and bonding, promote effective limit setting, non-punitive discipline, encourage systematic behaviour plans and to strengthen parents' interpersonal skills and supportive networks (Webster-Stratton, 2007). In the BASIC programmes (early childhood and school age) a framework of a pyramid is used to help guide parents to use certain concepts more often (such as play and praise) and others less often (such as time out). Key concepts are introduced in each weekly 2 hour session, vignettes form the basis of discussion, role plays are incorporated to help practice the strategies, and homework is assigned to establish the practices at home. The following week, parents discuss their experiences of applying the strategies and concepts with their own children. Parents are encouraged to collaborate and problem solve.

Teacher Training Programme

The teacher programme is taught in 4 day long sessions. Teachers of children involved in treatment are invited to attend the training. The Teacher Training component enables teachers to be trained in classroom management skills which include such components as encouraging and motivating students, strengthening social competence, reducing inappropriate behaviour and how to teach social skills, anger management and problem solving in the classroom (Webster-Stratton, 2000). The vignettes feature teachers managing common and difficult situations which can be experienced in the classroom and stimulate discussion and problem solving within the teacher group. The teachers are seen as the experts, encouraged by the facilitator to use each other as resources for solving difficult problems, making changes in the classroom and developing individual behaviour plans for the target child. Outside of the training days, clinic therapists observe the target child in the classroom, meet with teachers individually to develop behaviour plans, transition plans and facilitate meetings with the parents, teachers, and other school personnel.

The Child Programme

The child programme, referred to as 'Dina Dinosaurs Social Skills and Problem Solving Curriculum' teaches groups of children friendship skills, appropriate conflict management strategies, successful classroom behaviours and empathy skills. This programme incorporates cognitive strategies to cope with negative attributions and situations which can incite anger. There are two versions, one to be used for small groups of children with conduct problems, or in a classroom setting. Vignettes are used to stimulate the children's discussions, problem solving and prompt role playing which promotes confidence in the skills being acquired. The programme is 22 weeks duration and can be administered concurrently with the basic parenting module of Incredible Years (Kazdin, 2005).

Incredible Years Effectiveness & Efficacy

Incredible Years has been continually researched since its development in the 1980s and therefore has acquired a sound research base. The effectiveness of IYrs PMT has been evidenced in many randomized control evaluations by Webster-Stratton and colleagues

(Webster-Stratton, Reid & Hammond, 2004; Reid, Webster-Stratton & Baydar, 2004) and replicated by many independent investigators internationally (Jones, Daley, Hutchings, Bywater & Eames, 2007). Its effectiveness has also been examined and proven in various community investigations (Gardner, Burton & Klimes, 2006; Stern, Alaggia, Watson & Morton, 2008). Effectiveness and efficacy studies of the PMT component have also encompassed the teacher and child programmes (Webster-Stratton, Reid & Hammond, 2001). Comparisons of IYrs PMT have also been made with other treatment options (Taylor et al; 1998) or parent programmes. The broad research base demonstrates a number of findings. Investigators have reported increases in parental positive affect which includes praise and a reduction in criticism and negative commands. Increases in the use of effective limit setting by parents, parental self confidence and monitoring of children are evident. Family dynamics and relationships are known to improve due to positive family communication and problem solving. Parents have reported a reduction in depression. Conduct problems in children's interactions with parents are noted to reduce and interactions become more positive. Children consequently show an increase in compliance to parental commands.

Effectiveness within Community Settings

IYrs PMT has been shown to be effective in community settings and in various populations, by reducing key risk factors for the development of conduct problems in children. The research of Webster-Stratton has been replicated in various real world community settings (Hutchings et al; 2007; Jones et al; 2007; Axberg, Hansson & Broberg, 2007; Gardner et al, 2006). Stern et al; (2008) examined group leaders' adherence to the IYrs PMT and found that protocol and collaborative group processes were implemented with a high degree of adherence with the three exceptions of role plays, videotape modelling dosage, and buddy calls. Community based research of IYrs PMT is also now focusing on early intervention for pre-school children which has been found to be very valuable for many pre-school children exhibiting early symptoms of ADHD (Jones et al; 2007).

Incredible Years Parent Management Training in NZ

Preliminary data on the efficacy of the Incredible Years Basic Parent Programme in NZ has been recently reported (Fergusson et al; 2009) and is consistent with international evidence that it is an effective and culturally appropriate programme. This research is the largest study in New Zealand to date, which includes 214 parents, attending 29 courses, and is based on data obtained from the Ministry of Education, Special Education throughout New Zealand. Lees (Lees & Ronan, 2008) has completed a multi baseline study of 4 solo mothers attending IYrs PMT with a CAMHS service in Tauranga and reported improvements in teacher and parent reports of child behaviour, including targeted family functioning problems; increased parental confidence; reduced stress and depression levels for most parent participants; and reports of better parent-child relationships. Hamilton (2005) has also completed a study on the IYrs PMT in Tauranga which focused on practitioners' perspectives, processes and prospects. Stanley &

Stanley (2005) also report that applying IYrs PMT in a NZ context (Tauranga) is also a practical response to high caseloads. It can also promote collegial support and establish solid professional and parental partnerships.

Cultural Considerations of Incredible Years for Maori

Webster-Stratton (2007) maintains that IYrs PMT is a generic culturally sensitive evidence-based programme as this provides cost effectiveness and flexibility in the delivery of the programme. This allows IYrs PMT to be implemented with heterogenous cultural groups. However, Webster-Stratton cautions against any cultural adaptions to IYrs PMT as this may potentially compromise the fidelity of the programme.

A Maori IYrs PMT consultation hui was held in January 2008. A report was completed of Maori experiences of delivering IY's PMT (Cargo, 2008). This report examined some of the arguments and debate regarding adaption of IYrs PMT when delivering to Tangata Whenua. Considerations and obligations of the Treaty of Waitangi within Government legislation maintain that Maori are entitled to a choice of access to both the full range of mainstream services and Kaupapa Maori services. Maori are entitled to choose whether they would like to attend an indigenous programme or a culturally adapted mainstream programme. The report highlighted the necessity for further evaluation of IYrs PMT and its adaptability for Maori; recommendations for Maori development of their own resources, their processes and Maori models of mental health incorporated i.e (Te Whare Tapa Wha) including videos which reflect their own cultural parenting practices; and that Maori practitioners of IYrs PMT create a system of support and supervision to develop culturally appropriate responses to IYs PMT (Cargo, 2008).

Further research regarding the delivery of IYrs PMT for Maori, (Manawanui Marae Based Group Evaluation (2009) has found an 80% retention rate of a group delivery and that this was a significant indicator of the engagement of participants. Three key determinants of retention included appropriate facilitators, a marae-based delivery and cultural adaption, as well as aspects of the programme itself. This evaluation highlighted essential cultural principles of IYrs PMT delivery for Maori as well as recommendations for future considerations.

Chapter 7

Risk/Protective Factors & Local Context

Introduction to Risk and Protective Factors

This chapter will highlight the main risk factors for children in developing disruptive behaviour. Discussion of protective factors will briefly summarise how they can be enhanced where possible to maintain better outcomes for children and families in coping with disruptive behaviour. Counties Manukau is the local context for this study and therefore this chapter will also focus on the demographics of the local area and how IYrs PMT relates to this context. Risk factors and how they apply within this context will be examined, along with some of the alarming statistics representative of the region.

There are a number of inter-related factors which are cited as contributing to the risk for children in developing disruptive behaviour/conduct problems and which also influence their response to treatments such as PMT. The risk increases exponentially with the child's exposure to each additional risk factor. These risk factors include parental coercive behaviour, marital discord, family violence, parenting stress, parent demographics (low income, educational level, single parental status), negative schooling experience, lack of support, parent psychopathology, criminal activity within the family, substance abuse, and parents who are disengaged from their child's school experiences (Webster-Stratton, 1998). Many of the risk factors for ADHD and ODD cannot be easily resolved. These include genetic predisposition, adverse family history, low socio-economic status and single parent status. However, other risk factors are amenable to intervention programmes, which include marital conflict, parent mood states and parenting practices (Bor & Sanders, 2004).

Parental Coercive Behaviour

Parental coercive behaviour (i.e. hitting, shouting and scolding) has been identified as one of the most influential risk factors for future psychopathology, including the development of antisocial behaviour (Segal, 2001). There are links between reports of unfair and harsh discipline in childhood and adult outcomes such as depression and alcohol problems (Holmes & Robins, 1987). Interventions which target parent functioning have shown strong relationships between changes in parenting discipline and changes in antisocial behaviour. The factors contributing to why some parents have coercive parenting have also been investigated, particularly parental mental states such as anger (Peterson, Ewigman & Vandiver, 1994), maternal depressive symptoms (Campbell, 2002), low levels of coping (McKee,Harvey, Danforth, Ulaszek & Friedman, 2004) and parental attributions about child behaviour (Johnston & Freeman, 1997; Joiner & Wagner; 1994). Further, Bandura (2001) argues that task specific self-efficacy (parental beliefs about their capacity to manage their children's behaviour in

specific contexts or times) is more predictive of performance than global self-efficacy. Therefore, the identification of specific demands that parents find difficult has the potential to more effectively target areas in which parents require assistance (Bor & Sanders, 2004).

Various models have been developed to describe parental coercive behaviour including the early childhood coercion model (Scaramella & Leve, 2004) and the work of Patterson regarding coercive processes (Patterson,1982; 1986,1996).

Parental Psychiatric Disorders

Associations have been found between parental psychiatric disorders/psychopathology and ADHD. These associations also apply to disruptive behaviour disorders. Nigg & Hinshaw (1998) found that boys with ADHD were more likely than control boys without psychiatric disorders to have mothers with a past year history of major depressive disorder or anxiety. It is also well documented that parental Major Depressive Disorder also confers risk in the offspring for disruptive behaviour disorders (Hirshfield-Becker et al; 2008). Elevated rates of disruptive behaviour disorders in the offspring of parents with major depressive disorders appear to be in part due to the presence of disruptive behaviour disorder in the parents. Some research has indicated that mothers of children with ADHD tend to have higher depression scores than their husbands or the mothers of children without ADHD. Mother's depression has also been linked to family functioning and to child behaviour whereas father's depression linked primarily to family functioning (Cunningham, Benness & Siegel;1988).

High levels of maternal ADHD symptoms have also been found to limit the improvement shown by pre-school children with ADHD after a parent training programme (Sonuga-Barke et al; 2002). This seems to highlight that treatment of parental ADHD may be a prerequisite for the success of psychosocial interventions for childhood ADHD.

Parent Demographics

Parents who exhibit lower levels of educational achievement, lower skilled or paid employment, and who have fewer resources available to them in terms of support, encounter more difficulties coping with children with disruptive behaviour. They have been found to be less likely to respond to treatment. Family characteristics such as demographic attributes, stressful family circumstances, and the severity of children's behaviour problems has been found to be unrelated to attendance at treatment i.e parent groups but related to quality of participation and that quality of participation is a consistent predictor of treatment response (Nix, Bierman & McMahon, 2009). In general, parents who experience more challenges in their lives (such as less education and lower skill employment) have been reported to be less likely to show high quality participation in parent management training (Nix et al; 2009; Dumas, Nissley-Tsiopinis & Moreland, 2007).

Academic Achievement/Learning difficulties

Children with ADHD/ODD show significant academic under achievement, poor academic performance, and educational problems (Loe & Feldman, 2007). They also show significant decreases in estimated full-scale IQ compared with controls but score on average within the normal range (Biederman et al; 1996). Children with ADHD are 4-5 times more likely to need more special education services than children without ADHD (LeFever, Villers, Morrow & Vaughn III, 2002). They are more likely to be suspended, expelled or required to repeat a school year than controls. Longitudinal studies have shown academic under-achievement and poor educational outcomes to be persistent with symptoms being commonly reported between 3-6 years (Mariani & Barkley, 1997; DuPaul, McGoey, Eckert & VanBrakle, 2001). Pharmacology treatment and behaviour management have been found to be associated with reduction of the core symptoms of ADHD and increased academic productivity, but not with improved standardized test scores or ultimate educational attainment (Loe & Feldman, 2007). Further research is a necessity to understand how educational professionals and other related disciplines can provide an appropriate environment and foundation for children with ADHD to achieve better and have improved outcomes in later life.

Family violence/criminal activity

Traumatic events can interrupt normal processes of attention and arousal in both adults and children (as in post traumatic stress disorder). It is possible that for children expressing symptoms of ADHD, extreme stressors could serve as a catalyst (Becker & McCloskey, 2002). However, despite the literature which has explored environment aspects of the expression of ADHD, there has been little research which has focused on family violence and its effects on ADHD. Preliminary evidence is varied. It has been found that exposure to family conflict at an early age gives rise to ADHD in children (Glod & Teicher,1996); that family violence is related to attention and conduct problems in girls only, but these girls were not necessarily at risk for later delinquency, and that family violence fails to account for attentional problems or delinquency in boys (Becker & McCloskey, 2002).

There are links between ADHD and antisocial behaviour with the likelihood that between 20-30% of boys with ADHD exhibit delinquent behaviour as adults (Weiss & Hechtman, 1993). Later research has been more cautious regarding the existence of co-morbidities such as conduct disorder in the interplay of developing antisocial behaviour. The findings of Herpertz et al; 2001 supported a high persistence of antisocial behaviour from childhood to adulthood in boys, but found no evidence that ADHD itself is associated with a predisposition to antisocial behaviour.

Parenting Stress

Parenting stress has been associated with ADHD (Anastopoulos, Guevremont, Shelton & Dupaul, 1992; Mash & Johnston, 1990) and disruptive child behaviour; (Eyberg, Boggs, & Rodriguez, 1992) suggesting that stress adversely affects parental functioning and contributes

to increased child behaviour problems (Baker, 1994; Mash & Johnston, 1983). Parenting stress has been found to directly and indirectly affect parenting behaviour, while multiple role-related stress indirectly affects parenting behaviour. Further, that social support can buffer the relationship between parenting stress and parenting behaviour, and between parenting symptomology and parenting behaviour (Rodgers, 1998).

Psychological distress in parents of children with ADHD has been significantly associated with a combination of variables which include parent and child demographics, severity of child behaviour disturbance, low knowledge of ADHD, causal and controllability attributions internal to the child & lower perceived parental control (Harrison & Sofronoff, 2002). This complexity of variables indicates that interventions for ADHD aimed solely at child behaviour, are unlikely to alter long term outcomes.

Parental cognitions contribute to psychological distress as parents of children with ADHD often view themselves as less skillful and derive lower parenting satisfaction. Deficits in knowledge and coping skills regarding ADHD also predisposes parents to high levels of parenting stress than parents of children without ADHD (Mash & Johnston, 1983). Other research further expands on parental cognitions and cites that the types of attributions parents make about the cause of their child behaviour can partially explain the emotional and behavioural response of the parent toward the child and that these attributions are predictive of the quality of the parent-child relationship and the child's development in general (Bugental, Blue & Cruzcosa;1989; Dix, Ruble, Grusec & Nixon, 1986).

Marital Discord

Marital discord and a lack of effective social support have also been linked to elevated parenting stress among the parents of children with ADHD (Fischer,1990; Johnston & Mash, 2001). Baker (1994) compared stress between mothers and fathers of children with ADHD and found that fathers of children with ADHD experience levels of parenting stress similar to those experienced by mothers, although mothers may be somewhat more likely to perceive child characteristics as more stressful. Baker (1994) also found that parenting stress decreased as number of years married increased, which suggests that there may be stress buffering effects associated with a longer term marital relationship. However, not all children with disruptive behaviour come from families with problem marriages. Discord between parents of children with ADHD or disruptive behaviour disorders is common however parents generally report less marital satisfaction, fight more frequently and use fewer positive and more negative verbalizations than do parents of children without behaviour disorders (Barkley, Fischer, Edelbrock & Smallish, 1990). Wymbs et al; (2008) found that youths diagnosed with ADHD in childhood had parents who were more likely to divorce and had a shorter latency to divorce compared with parents of children without ADHD. Factors which impacted included maternal and paternal education level, paternal antisocial behaviour, child age, race and conduct

problems which uniquely predicted the timing of the divorce between the parents. The research emphasized how parent-child variables interact to exacerbate marital discord.

Marital conflict has been consistently linked to adverse health and mental health outcomes for both children and their parents. Although the causal mechanisms responsible for the association between marital conflict and child adjustment are not fully understood, marital conflict may reduce the sense of safety and security children derive from home environments with less conflict, disrupt parent child relationships, contribute to inconsistent discipline practices, decrease parental monitoring of potentially risky child and adolescent behaviour, or more directly model aggressive social interactions (Cunningham, 2007). It has also been suggested that parenting may provide a mediating mechanism via which marital relationships may contribute to poor outcome for children with ADHD. Conflict about discipline may result in inconsistent child management strategies, deteriorating child-parent relationships and a resulting increase in non-compliance and oppositional behaviour (Cunningham, 2007).

A negative conflict management style has been found to have direct links with children's conduct problems (Webster-Stratton & Handcock, 1999). The linkage between negative marital conflict management and children's interactions with parents and peers is reported to be mediated by both mothers' and fathers' critical parenting and emotional response, therefore supporting the indirect as well as the direct model of negative family interactions. Remarriage is also a risk variable for negative child outcomes because it is associated with disruptive parenting practices, the presumed mediators of developing externalizing and internalizing problems for children in stepfamilies (DeGarmo & Forgatch, 2007).

Alcohol

Studies strongly support the assumption that the deviant child behaviours characteristic of disorders such as ADHD, ODD and CD, represent major chronic interpersonal stressors for parents of ADHD children and are associated with increased parental alcohol consumption (Pelham & Lang, 1999). Alcohol consumption has been reported to be higher in families of children with ADHD than without ADHD and even higher for mothers than fathers in parents of children with ADHD (Cunningham et al; 1988).

In the last 10 years researchers have begun to explore the causal mechanisms operating that contribute to an elevated risk for alcohol-related problems for children with behaviour disorders and their parents. The most salient variable identified has been parenting stress (Pelham & Lang, 1999). Parental alcohol problems have been described as a vicious cycle (Pelham & Lang, 1999). Parental alcohol problems have been cited as contributing to a child's current and future psychopathology, and in turn a child's behaviour problems may intensify parental drinking, which in turn may exacerbate the child's pathology. Most research has explored the influences exerted by child behaviour on parental behaviour but some research has examined

the influences of parental alcohol consumption on child behaviour (Lang, Pelham, Atkeson & Murphy; 1999)

ADHD has also been shown to predict pathological alcohol involvement. Offspring characteristics may moderate the life stress pathway to alcoholism and indicate that ADHD may serve to facilitate the transmission of pathological alcohol use from parent to child (Marshal, Molina, Pelham & Cheong, 2007).

Protective Factors

The overall aim is to reverse risk factors by building up protective factors which may help buffer some of the adverse accompanying stressors (Webster-Stratton, 1998). Protective factors can include family cohesion, family social support, positive school involvement and family moral-religious orientation. The goal of most agencies working with children with disruptive behaviour difficulties is to enhance children's wellbeing and potential. This is achieved by implementing various services and treatments with the potential of empowering families to be in the position to cater for their own children's emotional wellbeing. Factors such as high self-esteem, good coping skills, school achievement, involvement in extra-curricular activities, positive relationships with parents, peers and adults and parents' involvement with their child protects against adverse outcomes (Buchanan, Flouri & Brinke, 2002).

There has been debate over whether risk and protection are merely two ends of a continuum. However, recent research by Prevatt (2003) who further elaborated the work of Rutter (1987); identifies that they are conceptually distinct, with risk factors being associated with negative outcomes, and protective factors associated with positive outcomes. Interventions may target the cessation of negative outcomes and focus on reducing risk factors. As a second step, interventions that target more adaptive behaviours (such as social skills or leadership) would focus on increasing protective factors.

Counties Manukau Demographics

IYrs PMT is an intervention which has the potential to deliver a number of benefits to the local population of Counties Manukau. The demographics reflect a captive audience where children and young people make up a third of the Counties Manukau population. The region reflects a cultural diversity with a representation of over 165 ethnic groups. CMDHB has the highest population of Maori children aged 0-14 (an estimated 28,400 in 2007); Pacific children 0-14 (an estimated 33,400) and the second highest number of Asian children (16,700) of District Health Boards within NZ. It is therefore a necessity that parenting programmes within the Counties Manukau region are relevant to the diversity of cultural needs of its population. IYrs PMT has been empirically validated as having the mechanism to achieve cultural sensitivity and relevance and therefore it has potential to be able to meet the needs of the ethnic diversity within the CMDHB region (Craig, Jackson & Yeo Han, 2007; Craig & Jackson, 2006).

Risk Factors for Children within Counties Manukau

Counties Manukau has significant social deprivation and poverty and is the most disadvantaged region within NZ as it has the highest number of people who are living in areas which are relatively deprived of decile nine and ten (Wang & Jackson; 2008). This number is nearly double the next highest DHB. There are large disparities between groups with Maori, Pacific Island and children from low income families experiencing poorer health outcomes than the overall child population. They are also exposed to greater environmental risk factors. It is therefore pertinent that a child and adolescent mental health service caters to the demographics and environmental characteristics of the region. The Ministry of Health's Child Health Strategy (Child Health Advisory Committee,1998) states that achieving good child health is vital for later adult health, as both the risk factors for many adult diseases and the opportunities for preventing these diseases arise in childhood. Poor child health and development also has an adverse impact on broader social outcomes including sexual and reproductive health, mental health, violence, crime and unemployment.

While NZ prepares for an aging population, Counties Manukau is still experiencing a growing youth population. Whirinaki, CAMHS is also struggling to meet this demand. The demographics pose both opportunities and challenges for the families and communities of Counties Manukau. There have been a number of initiatives to improve the economic and social wellbeing of children and young people and their families and communities that support them in Counties Manukau (Saville-Smith, Warren, Ronan & Salter, 2005) and it is most apparent that a united response from various agencies is required to find solutions (Auckland Youth Support Network, 2006). Delivering psychosocial interventions such as IYrs PMT within the region is only part of an overall strategy for improving the needs of children, youth and families and fighting back against the appalling statistics.

Summary

This literature review has provided an overview of ADHD and ODD which includes diagnostic criteria, prevalence, etiology, epidemiology, assessment and treatment. Co-morbidity of ADHD and ODD is common with other child psychiatric disorders and there are often overlaps in symptomology amongst disorders which can make diagnosis and treatment difficult. Despite, the vast array of research on ADHD (and to a lesser extent ODD) there are still significant gaps in understanding about these disorders. There are varying risk factors for children and families who are diagnosed with ADHD or ODD and associated co-morbidities. It is evident that Whirinaki, CAMHS follows recommendations from international research regarding assessment and treatment of children with mental health concerns with the recognition that evidence-based treatments provide the best possible outcomes for children and families. Parent management training has become an increasingly established treatment option within child mental health clinics internationally as well as in NZ. IYrs PMT has a well established evidence base and is now being researched within the NZ setting. Gaps in the literature exist regarding the

involvement of fathers in parenting and parent management training as well as the cultural relevance of IYrs PMT within NZ. It is most apparent that the local context of Counties Manukau reflects a population at risk for ADHD and disruptive behaviour disorders due to a young population base with alarming statistics and demographics. It is imperative that Whirinaki, CAMHS, other governmental organisations and non-governmental organisations adapt their service delivery to meet the growing need for addressing disruptive behaviour in children.

PART TWO

METHODOLOGY

Chapter 8

Grounded Theory

Introduction to Grounded Theory

This section commences with a rationale for using Grounded theory methodology within this study. Theoretical and paradigmatic underpinnings of grounded theory methodology will be introduced. The grounded theory approach located within the constructivist paradigm has been applied within this study and the processes of data analysis will incorporate the more recent works of Charmaz (2006) and Corbin & Strauss (2008). Grounded theory will be outlined with an explanation of data methods and tools incorporated into this approach. Finally the section will conclude by examining criteria by which grounded theory research can be evaluated.

Rationale of Grounded Theory

The study incorporates grounded theory into the field of inquiry as it involves experiences of parents incorporating the existence of multiple realities. The data reflects mutual constructions as the researcher enters the world of the parents. An interpretive portrayal of their world is provided with the aim being to learn the parent's implicit meanings attached to the parents' experiences and build up a conceptual analysis of these. The constructivist approach takes these implicit meanings, experiential views and grounded theory analyses as constructions of reality. Social and social psychological processes are explored within grounded theory and it provides the mechanism from which to define and explore meanings which are created for parents. The data is located within contexts such as the context of the specific interview, IYrs PMT, the parent's life and the contextual aspects of setting, culture, society and historical moment.

Grounded Theory was selected as the research method for this study as it captures a topic which has been well researched in overseas settings, but is relatively new to the NZ context. Whilst we have some knowledge about how IYrs PMT is viewed in quantitative studies (regarding effectiveness and efficacy in clinical samples) and that it is culturally relevant to various cultural groups in many countries; quantitative research does have its limitations. Quantitative research does not provide us with insight into an individual's experience and how their own meanings are created as they interact with other parents within the group context of IYrs PMT. This study also does not focus solely on the experience of attending IYrs PMT as the nature of an individual's interactions with varying people make it a complex inter-relationship of actions in which people create meanings of various constructs. A major feature of IYrs PMT is that of collaboration. By using a grounded theory approach we are attempting to not impose expert strategies of quantification but are seeking to understand participant's meanings and understandings by collaborating in a way that potentially improve factors, conditions that are in our control. This in turn helps create a sense of empowerment for families.

Underlying Assumptions

The use of grounded theory within this study incorporates a constructivist framework and is informed by the theory of symbolic interactionism. The constructivist research paradigm assumes that there are multiple, equally valid realities which co-exist and which are constructed by the individual (Ponterotto, 2005). The constructivist ontology is relativist as an individual's reality is formed as they interpret their world through a pre-constructed system of ideas, theories, values and attitudes. The emphasis of inquiry is therefore focused on uncovering subjective experiences of participants and meanings they ascribe to their experiences. Inquiry is viewed as a process in which the findings are a culmination of both the participants and researcher's meaning systems interacting, therefore rejecting the concept of objectivity (Kidd, 2002). Symbolic interactionism proposes that people construct selves, society and reality through interaction. This is achieved by processes where individuals are active, creative and reflective, which results in the creation and mediation of meanings (Charmaz, 2006).

Grounded Theory was originally developed by Glaser and Strauss (1967) and has further evolved since this time. Contemporary thought now incorporates postmodernist and post-constructivist paradigms to grounded theory methodology (Clarke, 2005; Charmaz, 2006). The classic view of grounded theory has been described as post-positivist as it assumes that a reality does exist but can only be approximately known, and an objectivist epistemology with a detached observer seeking an objective view (Chamberlain, 1999). The more recent developments in grounded theory (Corbin & Strauss, 2008; Charmaz, 2006) have predominantly diverged from this view and are located within a constructivist paradigm of inquiry. Within this constructivist paradigm, grounded theory practice is accepted as interpretive, knowledge having been 'created' rather than found, and to be provisional as it is historically and contextually located (Chamberlain,1999).

Although there are variations to the grounded theory approach, the procedures that are consistent throughout include simultaneous data collection and analysis, searching for emergent themes through prior data analysis, locating basic social processes within the data, the construction of initial abstract categories that explain and synthesize these processes, sampling to refine the categories through comparative processes and integration of categories into a theoretical framework that establishes causes, conditions and consequences of the studied processes (Charmaz, 2003).

Data Methods and Tools

Grounded Theory is a methodology developed for the purpose of generating theory from data (Charmaz, 2003). It can be portrayed as a 'journey' in which a researcher develops a theory about a phenomenon, moving beyond a purely descriptive account to the abstract. The definition of 'grounded' applies to how this theory must arise from the data and not from pre-determined hypotheses or formulations (Chamberlain, 1999). The methods of grounded theory

(of which there a few variations), all consist of guidelines which enable the researcher to examine social and social psychological processes, to direct data collection, to manage data analysis and to develop and abstract a theoretical framework that explains the studied process (Charmaz, 2003).

Analysis of the data begins with coding which forms the framework of further analysis of data. Coding requires a researcher to closely examine data and to advance from actual description through to conceptualization of description. Coding comprises two steps of initial or open coding which compels the researcher to make decisions about the data; followed by selective or focused coding which helps to arrange, amalgamate and conceptualize larger amounts of data. Coding enables categories to be formed which allow properties in the data to be upheld. Coding includes line by line coding, using active terms to define what is happening in the data and follows leads in the initial coding through further data gathering. As the grounded theorist defines processes, more data is gathered about the processes. This can be achieved by continuing to conduct interviews, obtaining new kinds of data from participants or including another type of participant (Charmaz, 2003, Charmaz, 2006).

Axial coding specifies the properties and dimensions of categories. Its purpose is to sort, synthesize and organize large amounts of data and reassemble them in new ways to provide coherence to the emerging analysis. Strauss and Corbin (1998) apply a set of scientific terms to make links between categories visible such as grouping participant statements into components of an organizing scheme. These include conditions, actions/interactions and consequences.

The purpose of memo writing is to link coding to the first draft of the analysis, and move analysis forward. Memos enable a researcher to think critically about the data and further elaborate on processes which have been defined in focused coding (Corbin & Strauss, 2008; Charmaz, 2006). Conceptual categories can then begin to emerge. The properties of each category are further defined; and examples of interview excerpts incorporated to ensure the analysis is reflective of researcher interpretations as well as participants' narratives (Charmaz, 2006.

Theoretical sampling is a process where relevant data is sought to elaborate and refine categories to develop the emerging theory. The properties of a category are defined by discriminating conditions and relationships to other categories by using comparative methods. It is a non linear process and involves movement back and forth between category and data raising the conceptual level of the categories. The grounded theorist will keep seeking data to check a category, until it is saturated and where no new information emerges (Charmaz, 2006). Theoretical sorting then provides the logic for organizing analysis and enables theoretical links to be created and refined, prompting comparisons between categories. Diagrams can reflect

visual representations of categories and their relationships, they are often considered as an intrinsic part of grounded theory methods (Charmaz, 2003).

Evaluation

There have been various recommendations made regarding what constitutes good practice in evaluating grounded theory research, generated predominantly by Glaser (1978, 1992); Strauss & Corbin (1990;1998) and Guba & Lincoln (1994). Debate has ensued over post-positivist and constructivist underpinnings and it is apparent that not all studies that label themselves as grounded theory can meet all the criteria for evaluation. Discussion of the evaluation of grounded theory research will therefore emphasize a constructivist paradigm which underpins this study.

Corbin & Strauss, 2008) recommend ten general criteria as guidelines to use when evaluating the quality of research findings. These have been drawn from multiple sources and are similar to those proposed by other qualitative researchers.

1) The findings fit with the experience of both the professionals for whom the research was intended and the participants who took part in the study.
2) The findings are applicable and useful.
3) The findings are organised around concepts.
4) Contextualization of concepts (where findings are understood with contexts).
5) There is a logical flow of ideas.
6) There is depth of substance within the findings.
7) Variation has been built into the findings and captures the complexity of human life.
8) The findings are presented in a creative and innovative manner.
9) Sensitivity is demonstrated to the participants and the data.
10) There should be evidence or discussion of memos in the final report (p.305-307).

Charmaz (2006) suggests that criteria for evaluating grounded theory studies should include credibility, originality, resonance and usefulness. Charmaz argues that a strong combination of originality and credibility increases resonance, usefulness, and the subsequent value of the contribution.

Credibility relates to:

- If the research achieved intimate familiarity with the setting or topic.
- The data being sufficient to merit the claims.
- Systematic comparisons between observations and between categories.
- Whether the categories cover a wide range of empirical observations.
- Strong logical links between gathered data and analysis.
- If the researcher has provided enough evidence for the claims to allow the reader to form an independent assessment, and agree with the claims (p.182).

Originality focuses on whether the study had:

- Categories that were fresh and offered new insights.
- An analysis which provided a new conceptual rendering of the data.
- Social and theoretical significance of the work.
- Challenged, extended or refined current ideas, concepts and practices (p.182).

Resonance applied to how:

- The categories portray the fullness of the studied experience.
- Have revealed both luminal and unstable taken-for-granted meanings.
- Drawn links between larger collectivities or institutions and individual lives when the data so indicate.
- Whether the grounded theory makes sense to the participants or people who share their circumstances and offer them deeper insights about their lives and world (p.182-183).

Usefulness reflects whether:

- Analysis offers interpretations that people can use in their everyday worlds.
- Analytic categories suggest any generic processes and explained generic processes for tacit implications.
- The research sparks further research in other substantive areas.
- How the work contributes to knowledge and contributes to making a better world (p.183).

Additional criteria for evaluation has recommended adequate record keeping to enable a comprehensive audit of the study and its findings (Sandelowski, 1986; Henwood & Pidgeon,1992).

Finally, the role the researcher plays in the research process should also be acknowledged. The rigor of grounded theory can be enhanced by incorporating reflexivity and relationality. Reflexivity addresses the influence of investigator-participant interactions on the research process, and relationality addresses power and trust relationships between participants and researchers. Reflexivity and relationality both have the potential to increase the validity of the findings in grounded theory studies (Hall & Callery, 2001).

Summary

This chapter provided a rationale for the utilization of grounded theory. Grounded theory enables the exploration of the worlds of parents who have attended IYrs PMT. This is achieved by seeking to learn the implicit meanings of their experiences, and creating a conceptual analysis which is based within contexts of their social worlds.

Grounded theory within the constructivist paradigm is informed by symbolic interactionism.

The constructivist research paradigm assumes that there are multiple, equally valid realities which co-exist and which are constructed by the individual. Symbolic Interactionism proposes that people construct selves, society and reality through interaction and is informed by action and the consequences of action.

Grounded theory provides a guiding framework for analysis. It is described as a non-linear process incorporating various techniques to interpret large amounts of data. Data analysis commences through initial coding, focused coding and axial coding. Data is explicated and closely examined to understand what is occurring within the data. It is then reassembled and redefined in new ways; categories become more conceptual as the process continues. Memos are used to move the analysis forward, interpretations of research and participants are supported and balanced by including interview excerpts. Theoretical Sampling is applied to search for data to further elaborate and refine categories to develop the emerging theory. Once no new data emerges, theoretical saturation has occurred. Theoretical Sorting is applied to enable relationships to be examined and comparisons to be made. This is often conducted within a visual form such as a diagram.

Various guidelines have been introduced by theorists for recommending a broad range of criteria to evaluate grounded theory. There is no universal agreement. Recent overviews by Strauss & Corbin (2008) and Charmaz (2006) are among the most current comprehensive guidelines which are based on examination of the literature of various sources within this field.

Chapter 9

The Research Method

Procedure

Parents participating in this study initially had their child referred to Whirinaki, CAMHS, Counties Manukau District Health Board due to difficulties experienced with their child's behaviour. They became consumers of the service as a result of a referral from their child's GP, school, or other professional. Parents completed an initial assessment with their child's clinicians. They were then advised about IYrs PMT by their child's clinician as a recommended psychosocial treatment option if appropriate. Clinicians completed an internal referral form to IYrs PMT and in consultation with the parents, discussed their primary goals in attending the group. Parents were then required to wait until the commencement of the next group (day or evening) and attend either a day or evening group.

Sample Selection

Potential participants were identified through administration records of IYrs PMT course attendance during 2007. The inclusion criteria for their involvement in the study was the requirement to have attended at least 50% of the IYrs PMT programme during 2007 and have a child aged between 5-12 years at the time of the parent's participation in the programme. Potential participants were excluded if they had recently experienced a major trauma within their family i.e death, or if their family circumstances had seriously deteriorated since participating in IYrs PMT. In these instances, it was felt that any questioning was likely to be too intrusive and impact negatively on the participants.

Whirinaki, CAMHS Delivery of IYrs PMT

Overall, approximately 6 day and evening groups were held during 2007. The programmes ran over 12 consecutive weeks (excluding school holidays) for a duration of 2 hours each and were held at the East Tamaki premises of Whirinaki in a large conference room. The size of the groups varied, the size of the evening groups was usually larger, up to a maximum of approximately 20 parents. Participants attending included solo parents and couples. Meals were provided to the programme participants on their arrival for the evening groups, and refreshments for day groups. No childcare assistance was provided by Whirinaki. Groups were each run by two multi-disciplinary CAMHS clinicians. These included clinical psychologists, social workers, a family therapist and a nurse. Only one group leader was male. At least one of the facilitators for each group had attended the Basic Facilitator Training for Incredible Years, which is delivered through The Werry Centre (for Child and Adolescent Workforce Development). As facilitators, the clinicians were required to have clinical supervision. Participants of the groups were also required to sign consents to be videotaped at times in order to assist the facilitators for ongoing supervision and training purposes.

IYrs PMT Content

The IYrs PMT delivered by Whirinaki, consisted of the basic parenting training, recommended for children aged 3-7 years. This has a training manual and established protocol for delivery. The programme commenced with an introduction to the philosophy of the programme, an overview of the content, goal setting and an explanation of the parenting pyramid. The programme content included: importance of parental attention and special time, effective praise and encouragement, using tangible reward programmes to teach your child new behaviours, reducing inappropriate behaviour i.e clear limit setting, ignoring misbehaviour, time out, logical consequences and problem- solving with children and special problems.

Each session included a review of the previous session and home activities, an introduction/teaching session of the new topic, video-vignettes demonstrating examples of parents and children interacting (relevant to the topic being covered), group discussion of the vignettes and the opportunity to perform role plays to practice some of the demonstrated strategies. Each week, parents were asked to read the relevant chapter of the book (Webster-Stratton, 2006) at home and were provided with handouts on exercises to practice. Some of these exercises included daily measures of child behaviour and measures of family functioning. Parents were also encouraged to partake in a 'buddy system' where they made supportive phone calls to another parent in the programme during the week.

Treatment Materials

Equipment and materials required to deliver the training programme include a complete set of DVD's for the Incredible years Basic Parent Training, facilitator manuals, weekly reading and handout material, DVD recorder, television, mobile whiteboard and markers, large butcher paper (for brainstorming), folders for each participant, toys for role plays, lollies/chocolates and stickers as incentives for participants.

Data Collection

For the present study, the principal investigator liaised with the clinicians about the study and they were provided with an information sheet. If the potential participant met the study criteria, the clinician was asked to make the initial contact where possible with the potential participant to inform them of the study and enquire if they were interested in receiving an information sheet. If interested, they were posted out an information sheet (Appendix A) and asked to make contact with the principal investigator. The principal investigator made a follow up phone call to potential participants who had not responded to enquire if they were interested. No further contact was made with disinterested parties following this phone call.

Participants were invited to a semi-structured interview either at Whirinaki, or at their home. They were interviewed by the principal investigator. Prior to the interview commencing, they

were asked to complete a short participant profile form (Appendix B) have any further questions regarding the study explained, and to sign a participant consent form (Appendix C).

The participant profile form was designed to gather some general details about the composition of the family i.e which other family members live with their child, their age and their relationship to the child, if anyone else lives in the home, and whether their child lives part of the time with another family member e.g shared care arrangements. Participants were also asked about the nature of their child's difficulties with disruptive behaviour and whether they attended IYrs PMT alone, with a spouse/partner or support person. A copy of this brief questionnaire is presented in Appendix B.

Participants were required to attend one interview only of approximately 11/2 hours duration. Following the interview and transcription of the audiotape, participants were given the opportunity to read their transcript for reflection and feedback. Participants were then required to sign a release of tape transcript to the principal investigator (Appendix E)

Participants

A total of nine parents participated in the study. These included three fathers and six mothers. The sample included 2 couples i.e both parents were interviewed, four participants who were solo parents, with the remaining participant being married, with the husband unavailable for interview. Two participants were Maori, 1 was English and the remainder were NZ European.

Participants 1 and 2: Brian and Rebecca

Lisa (11) is a current client of Whirinaki. Lisa's disruptive behaviour difficulties were diagnosed as Attention Deficit Hyperactivity Disorder (ADHD) and Aspergers Syndrome. According to her mother, she also displays undiagnosed compulsive and oppositional tendencies. Lisa lives with her blended family. Her family comprises of mother Rebecca, Stepfather Brian, half-sibling Stephanie (5) and two adopted siblings Leroy (1) and Glory (2) The family are NZ European and the two adopted children are of Pacific Island descent. Lisa sees her father for fortnightly access. Both Brian and Rebecca attended Incredible Years together. Lisa and her family receive support funded through the High and Complex Needs Contract.

Participant 3: Linda

Steven (10) is a former client of Whirinaki. Steven's difficulties include controlling, uncooperative and bullying behaviour. He does not have a formal diagnosis. Steven lives with his mother Linda, older sister Jennifer and younger sister Kelly. Steven has weekend visits with his father 1-2 times a month, but more recently this has become somewhat irregular. Linda separated from her husband just prior to attending Incredible Years. She attended Incredible Years on her own. Linda has Bipolar Mood Disorder and attends a weekly bipolar support group. Linda has been thinking about sending Steven to boarding school.

Participant 4 and 5: Sally & Tony

Billy (7) lives with his parents Sally and Tony and younger sister Chloe. Billy has no formal diagnosis. His behaviour has symptoms of ADHD such as lack of concentration, hyperactivity and non compliance. He also has a very low self image. He initially displayed a failure to relate to his peer group which has improved, but he still displays behavioural issues which his parents find difficult. He is described as never doing what he is told straight away to the extent where it will endanger himself in an emergency. Sally is a nurse and Tony is self employed. Sally and Tony attended Incredible Years together. Sally is NZ European and Tony is English.

Participant 6: Mere

Samuel (6) has a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) and has a mild learning disability. He is a former client of Whirinaki. He has problems with establishing friendships and issues with anger. Samuel lives with his mother Mere and Grandparents and is an only child. Samuel has no contact with his father. Mere is a nurse. The family are Maori. Mere attended Incredible Years alone.

Participant 7: Naomi

Conner (8) has a diagnosis of Attention Deficit Disorder (ADD) and Encopresis and difficulties with auditory processing. He is a former client of Whirinaki. He lives with his parents Naomi and Ian and younger brother Matthew. Naomi has depression. Ian has Aspergers Syndrome. Ian attended Incredible Years a term prior to Naomi. Naomi has suggested to Ian that he attend Incredible Years again. The family are NZ European.

Participant 8: Hone

Isaac (10) has been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD). Most of his difficulties were displayed at school and with his mother. He now lives with his father Hone. He has access with his mother on the weekend. Isaac went to live with his father following his attendance at Incredible Years. Isaac's mother also hopes to attend Incredible Years. Hone queries Isaac's diagnosis of ADHD. Isaac's mother is NZ European and his father is Maori.

Participant 9: Sharon

Luke (6) has been diagnosed with ADHD and Encopresis. He is a former client of Whirinaki. He lives with his mother Sharon. He does not have any contact with his father. Sharon attended Incredible Years alone. Luke has also attended the Pakuranga Health Camp and his mother Sharon also attended parenting courses through the Health Camp. The family are NZ European.

Ethical Considerations

Prior to beginning the present study, consent was sought and obtained from the Northern X Regional Ethics Committee of the New Zealand Health and Disability Ethics Committee. Consent was also sought and obtained from the Counties Manukau District Health Board Maori

Research Review Committee and the Counties Manukau District Health Board Clinical Research Board. The research was carried out within the MUHEC code of ethical conduct for research, teaching and evaluation involving human participants and the NZ Psychological Society code of ethics (in particular section of wellbeing of human research participants).

All participants received a Participant Information Sheet (Appendix A) and signed the Participant Consent Form (Appendix C).

Cultural Considerations

Cultural advice and consultation was provided by the Maori cultural advisor at Whirinaki and approval gained through the Counties Manukau District Health Board (CMDHB) Maori Research Review Committee to explore how the research process could best serve the needs of Maori participants in a culturally appropriate manner consistent with Treaty of Waitangi principles of partnership, participation and protection. Programme attendance records indicate that approximately 6 potential participants from a pool of 60 (10%) identify as Maori. As the principal investigator is not Maori, potential Maori participants were contacted by their clinician, and if the clinician was not Maori, a process of cultural consultation occurred regarding who was the most appropriate staff member to make the initial contact with the potential participant. Potential participants were provided with the option of having a Maori interviewer during the interview and or completing the interview in their native tongue.

Data Analysis

Qualitative interviews were conducted to explore a field of inquiry, open ended questions allowed for an in-depth exploration of an aspect of life for which the researcher had some insight. This is due to involvement as a group leader of IYrs PMT and experience as a clinician working with parents of children with disruptive behaviour. Interview questions were drafted regarding avenues of possible exploration. Any ideas or issues that emerged from the interview were further pursued within the interview; therefore the interview schedule was developed as a guide only. The narratives provided in response to the interview questions (see Appendix B) were audio-taped and transcribed verbatim. Other possible questions were applied within the next interview to gain more focused data.

Analysis of the interview transcripts was performed using the grounded theory paradigm outlined by Charmaz, 2006 which is informed by the work of Strauss & Corbin (1990) and Glaser (1992). Coding was applied to the transcripts, where data was categorized with a short name that simultaneously summarized and accounted for each piece of data. These codes enabled the selection, separation and sorting of data to begin an "analytic accounting" (Charmaz, 2006). Various phases of grounded theory coding were applied to the data which included initial coding, focused coding and axial coding.

Firstly, initial coding was applied. Fragments of data were analysed. This included naming words, lines, segments or incidents. Initial codes were provisional in the sense that they opened up further analytic possibilities regarding the best possible fit for the data. The goal was to remain open to all possible theoretical directions in the reading of the data. Initial codes assisted in the separation of data into categories and enabled processes to be observed within the data. The initial data also incorporated in-vivo codes which related to the codes of participant's special terms i.e. "being americanized" and which served as special markers of participant's speech and meaning. Many of these in-vivo codes, such as analogies i.e. "war zone" were later incorporated in the descriptions of categories to help categorize the theory within parents' use of analogy and expression.

Focused coding was applied to help synthesize and explain larger segments of data using the most significant and/or frequent earlier codes to sift through large amounts of data. The focused coding was non-linear. Decisions were made regarding which initial codes made the most analytic sense to categorize the data, frequent revisiting was required of previous coding to more clearly discern the meanings within the data. Through the comparison of data to data, the focused code was developed. Data was then compared to these codes which helped to further refine them.

Axial Coding helped specify the properties and dimensions of each category by relating categories to subcategories. Relationships between categories were defined to provide a framework reflecting processes that parents experienced. Axial coding enabled the development of a diagram representing an analytical framework of processes and concepts.

Memo writing was incorporated to analyze initial ideas about codes and prompted further data analysis. Memo writing enabled further development using comparisons of the data, codes and categories which enabled concepts to be articulated.

Theoretical sampling, saturation and sorting was applied to develop the emerging theory. This involved further elaboration and refinement of the categories which constituted the theory. Properties of each category were developed to the extent that no new properties emerged. The categories were then saturated with data and then sorted and integrated into the emerging theory. Saturation was achieved when no new data provided theoretical insights or revealed any new properties of the core categories. A diagram representing a framework was created to enable the data to be more easily sorted into the categories.

Part Three

Results and Discussion

Chapter 10

Results

A diagrammatic representation was created to reflect the grounded theory of parent's experiences of IYrs PMT within Whirinaki, CAMHS. This is divided into five themes and reflects an analogy of a war zone to describe the processes. Parents frequently reflected the analogy of a war zone in their discourse (refer to Appendix F). The first theme comprises emotional and social processes of lived experience and reflects the world of the parents prior to their help seeking behaviour at Whirinaki. The second theme represents the interaction with Whirinaki clinicians prior to IYrs PMT. The third theme is where parents attended the group and interact with other parents and group leaders within the group environment. The fourth theme represents the new meanings and actions for parents which evolve from IYrs PMT. Finally the last theme relates to preservation where parents attempt to retain their learning and gains from attending IYrs PMT. The themes represent a fluid process. The parents may need to re-enter the processes again and this is represented by the arrows at the bottom of the diagram.

The results section is divided into five chapters. Excerpts from the parents' transcripts are provided to support the themes, concepts and categories which emerged from the data.

Emotional and Social Processes of Lived Experience

"ENTRAPMENT"

- Judgement
- Cycles of Parenting
- Planning Escape

"UNDER SIEGE"

- Child as Boss
- Psychosocial Stressors "life is hard"

"COMBAT"

- Conflictual Relationships
- Being Naughty
- Expression of Symptomology
- Parental Response "Losing my Rag"

"BATTLE FATIGUE"

- Parental Mental Health & Emotional Response

"ENTRAPMENT"

Judgement

Parents perceived that judgement by others is encountered and in turn, judged themselves regarding their parenting. There was also the realization that perceiving judgement from others at times was based on their own thoughts, not necessarily the actions or behaviours of others.

> *"I think some of it was just in my head, that I was thinking that people were judging me but other times".....* (Sharon).

Parents experienced blame and the burden of responsibility about their child's behaviour. Self judgement, by perceiving one's own parenting to be at fault can be precipitated by parents comparing their child's behaviour to that of other children. This includes children within their family i.e siblings, the child's cousin, other extended family and friends.

> *"Like you couldn't help but think Oh my God, I'm such a useless bad mother, because you see how he's acting and then you might go to another friend's place whose got a*

lovely well behaved child and you're thinking 'yay' kind of thing what am I missing" (Mere).

Judgement perceived by others toward the parent can then be passed through to the child. Judgement made by the parent about their child's behaviour occurs particularly when parents believe that their child's behaviour is within the parameters of the child's ability to control it.

Judgement occurs when people have limited knowledge about the area in question. Assumptions are made that a child's behaviour is solely related to parenting skills. Parents in the study were struggling for the recognition that there was something else wrong with their child, but often encountered judgement in their search for meaning. Judgement from others and disputing one's own explanation that something may be wrong, or just adopting a "wait and see" approach can lead to inaction by accepting another's judgement over their own.

"They did refer us when he was a toddler- he was referred to special education but that didn't turn into anything and he was pretty bad at pre-school age as well- nothing much happened there, they sort of closed the books and thought it'll all get sorted when he starts school –school will sort him out but it didn't" (Sharon).

Perceived judgement by others about their child can be a source of embarrassment for parents who need to be constantly on guard or alert when their child is out in public. It was evident that other parents had become accustomed to outbursts or attempting to manage difficult behaviours in situations that were potentially embarrassing as it was something that frequently occurred.

"I had to think ok, there could be outbursts, there could be this- there could be that" (Brian).

Judgement from schools was experienced. In some situations the parent felt that the child was actually stigmatized within the school environment and this impacted on the child's self esteem, their ability to relate to peers as well as their learning. In response, parents can make judgements or assumptions about the school environment, contributing to a negative cycle.

"My ex-girlfriend, she's got a lot of friends that live out that way-and they all go to the same school, and they seem to have similar problems with that school-they are very picky, you know- it's like if they find a certain child they don't like, then I reckon they just pick on them you know what I mean? And so I'm not really happy with that school" (Hone).

Prior to attending IYrs PMT, parents often felt disempowered about advocating for their child and often had negative encounters and experiences within school settings. Two parents had children with co-morbid ADHD and encopresis prior to IYrs PMT. Liaising with schools regarding such a sensitive topic was difficult for parents. However, there were parents who acknowledged the difficulties from the school's perspective; that they were out of their depth in terms of their level of expertise and managing encopresis.

> *"I think we tried to sort it on a school level, his behaviour in class was pretty bad and as well as his soiling, but it wasn't enough, they couldn't do enough, their hands were relatively tied"'* (Sharon).

Cycles of Parenting & Entrenched Behaviour Patterns

The difficulty in coping and managing disruptive behaviour had been ongoing and continues. The analogy of a roller coaster reflects the "ups and downs". Extreme downs are more prevalent for parents of children with disruptive behaviour. The end of the difficulties that are faced appear unforeseeable, or will end when the child is living independently and will learn through their own mistakes as an adult. Parents can express resignation or feel a sense of helplessness that many symptoms will not disappear, that there is "no cure" and that there will be imminent risks or difficulties in adolescence and beyond.

> *"He is the way he is and he's going to be that way for a long time"* (Naomi).

Behavioural patterns are recognised as forming from an early age, how these are learned, entrenched and therefore difficult to change. Parents also reflected on the influence of patterns of parenting learned by their parents and through the generations.

> *"It's very hard to change the rut that you get yourselves in and especially since it's learnt from your parents and they've learnt it from their parents"* (Sharon).

Patterns of parenting are also influenced by contextual factors such as societal beliefs about parenting. The acceptability of discipline methods change over time and these are sometimes incongruent with one's one beliefs which have been guided by childhood experience and upbringing.

> *"My upbringing was different in that my mum was the disciplinarian and you know you didn't mess around you know...right up until she died, when I was in my 20s, you had to stay out of arm's reach if you weren't doing as you were told as you got one around the ear hole. I mean that we-, I don't think it was that bad um I mean with two boys like we were you she ruled with a rod and iron, you had to, yeah, but it's different now, supposedly"* (Tony).

Planning Escape

Parents are actively attempting to resolve their child's disruptive behaviour well before IYrs PMT and "planning an escape" in relation to a sense of entrapment which is felt. Researching by reading literature or attending other programmes was frequently reported to precede IYrs PMT as well as afterwards.

Mothers frequently express knowledge of current NZ literature regarding child behaviour and were avid readers of self-help books. Mothers attended parenting courses prior to IYrs PMT in various forms, which included programmes based at Children's Health Camps, Parent's Inc. or through the local church. Mothers referred to Celia Lashley's book on raising boys and books by Family Therapist Diane Levy and felt a special affinity to some of these authors.

> *"I've just finished reading Celia Lashley and it's not like I'm not trying to educate myself about the kids and behavioural things…. I probably just got as much out of Celia Lashley's book becauses she gone out into the schools with the boys and she's seen them and she sort of-she just sees what they're like and I've found I got a lot more- I felt like I had a lot more recognition……, you just identify with what she is saying of.. well God! -that is what we live like- that's it! thats it!, she's got it you know. If you haven't read that book you must do"* (Linda).

The purpose of reading books was due to the realization that strategies that parents were using weren't working, trying to put theories into practice from the latest books or programmes on child behaviour strategies, or out of personal and/or professional interest.

> *"I'm the sort of person who will buy the latest book and try and put things into practice"* (Sally).

Parents who were professionals (related to the health or social services sector) were interested in researching due to their own child's disruptive behaviour and relevance to studying or attending programmes relevant to their own professional development.

> *"Because I've already done a few courses anyway like in child protection and other things just due to when I did my counselling"* (Rebecca.)

> *"I did undergraduate courses on human growth and development so I've always been interested prior to having children on you know, the effects of their behaviour"* (Sally).

Mothers voiced their interest in being more avid readers than fathers, who were assumed by mothers to be more inclined to read on topics that they were interested in such as history or engineering. One mother commented that her husband was not interested in reading self-help

books on child behaviour and that she encountered difficulty when she would attempt to implement some new strategy as her husband hadn't read the material, and wasn't entirely "on board" with what was happening. This consequently resulted in frustration and inconsistencies of managing behaviour.

> *"I'm the sort of person that reads, well Tony reads a lot of books; but he reads a lot of history and engineering. He doesn't like- I give him books oh, this is a really good book about you know dealing with kids behaviour and stuff, he won't read it, he's not interested"* (Sally).

Parents reported attendance at other parenting programmes prior to IYrs PMT and were able to make comparisons of these with IYrs PMT.

> *"I did one when he went to the Pakuranga Health Camp. They had a 3 day course but it was all day-3 intensive days, I liked the fact that your one was little chunks and you could go away and take what you learnt that night and think about it, whereas I think I forgot more than what I actually learnt when it was all compressed; and it was all on- you know, you didn't have time to absorb. I mean their course was good too, don't get me wrong but it was relative to the fact that he was there at the same time. We were understanding what they were learning there so it was good in that respect. I like the fact that you had a short, was it 2 hours?, 2 hour chunk and you could go away and think about what you had just gone through that night and had reading material to refer to, um that was good"* (Sharon).

Television was another likely source for the search for answers.

> *"You know you watch all those programmes the nanny and stuff like that, the naughty seat and you know think about different things that might work, um which we used to watch together and discuss and the kids used to love watching those programmes"* (Sally).

There was identification for parents with components of other programmes which were helpful in the formation of alternative narratives, explanations, or analogies regarding their child's behaviour.

> *"Building Families for Life- it was at our local church and it was the same- I can't remember if it was 6 weeks or 4 weeks...it started off talking about different children's personalities and the strategies you would have to use with each type; and I remember identifying Matthew as I think, they used animals to describe their personalities, and Matthew was definitely a Lion type-leader, you know you always had the- I mean you*

feel like you're in a constant battle- I think there was Lion, Beaver, Golden Retriever....." (Naomi).

"UNDER SIEGE"

"Child as Boss"

"Child as boss" refers to indecision or dilemmas that parents face regarding decisions over parenting their child and knowing what to do. When the child was perceived by the parent as being the boss, or frequently trying to secure their position as the boss, this impacted on the parent-child relationship and the child's relationship with siblings. Prior to IYrs PMT, many parents felt that the child wanting to be boss was a deliberate and intentional behaviour.

When the child was perceived as being the boss, or always wanting to be the boss, the parent may feel "under siege" in terms of their response of battling to retrieve the "control" of their child's behaviour. The parent's focus on "control" and "controlling" their child can undermine the parent-child relationship. It assumes that the parent's desire is to hold power in the relationship over their child"; that they have lost this power or control and that once it is regained or retrieved then their child will respond. Clarity regarding how a child may be "controlling" the parent can be gained when the child is absent. There can be short respite or reprieve from being under siege at times when the child is visiting another parent or at school. The meaning of the child's intention to try and exert "control" over the parent can be explained by the parent as "learned behaviour", the behaviour may have been modelled by another parent. The parent may realize that feeling under siege and aspirations to resume control "over their child" may never be achieved until the child matures and leaves home.

"I'm coming quite convinced that it's a controlling thing that he's doing over me like his Dad has always has done. You don't really see that until you get outside the marriage, you don't see that and I think rather than it being the mental thing with Steven, it is mental but it's how he is mentally controlling me because he's just had two days off school and I noticed today I had to send him to school because he was just really doing my head in-it's that controlling thing-it's not until you get away from him, that you have a break that you can see them doing it to you" (Linda).

Psychosocial Stressors "life is hard"

There were various family compositions for parents who participated in the study and which affected how parents were able to participate in IYrs PMT. It was most apparent that parents had to juggle multiple roles and responsibilities within their lives. Psychosocial stressors which were present in parents dialogues included marital conflicts and dissolution, parental alcohol abuse, terminal illnesses and major health issues of grandparents, mental health issues of other family members within the household or external to the household, juggling work and parenting

responsibilities, lack of support, financial stressors and trying to lobby for services for their child i.e High and Complex Needs Funding, GSE involvement and teacher aide.

The effects of marital or relationship dissolution was particularly evident for some parents and creating greater stress when it had recently occurred as a period of adjustment to solo parenting was required. The lack of support from an ex partner or spouse following the break-up was paramount as a contributing factor why life had become much more difficult. There was reluctance by the parent to even mention their participation in IYrs PMT to their ex-partner for fear of being patronized. Acrimonious disputes regarding the break appeared to take up a considerable amount of emotional energy as parents pondered potential scenarios of what would have happened if their ex-partner or spouse had come.

> *"I think like I would have really loved my husband to come-but I know what he's-he's a workaholic, I just know what he's like.He would just say this is a load of mumbo jumbo ****. He wouldn't come, or he would come twice and go (snort) the whole time, the whole way through it and say this is not the real world-you know you, just- you're just talking this mumbo jumbo rubbish"* (Linda).

Limited contact or access exacerbated stress, particularly when this was not regular and there was limited phone contact with the children. The absence of fathers in the children's lives was acknowledged as a great loss by some mothers. There was an awareness that Dads play an important role in children's development which is different from mothers and provide that much needed male perspective.

> *"This age they need to be with their Dad's and I think well maybe thats what he needs, to spend-to get away from me trying to get him to do things to a womens point of view, because men do, you can see it, they think differently to how women do"* (Linda).

The effect of marital breakdown on the child's behaviour was also considered by parents.

> *"We had a separation-my husband and I and I wondered whether that was part of it but it's more just a behavioural thing"* (Linda).

For mothers who had been on their own for some time, or where there was no involvement from the father in the child's life, extended family/whanau appeared to have more influence for NZ European mothers who needed this support. Differences of opinion regarding their child and their behaviour with these family members exacerbated stress for these parents. They were in a difficult predicament to challenge family members particularly when they had more at stake, such as reliance on assistance with babysitting (i.e when they were attending IYrs PMT).

Parents encounter opposition from others during their attempts to learn and understand their child's behaviour. Significant others may dispute the parent's actions. Changing patterns of parenting can create uneasiness, or unsettle family members who are not "on board". Whilst those in the immediate household will be more aware of the parent's inclinations to read material or attend various courses; extended family members may not be quite as familiar with these existing behaviours and unprepared for change when it does occur. Extended family members may deny or dispute the parents concerns about their child. There will be narratives within the family to explain why the child is behaving the way they are.

> *"I've got older sisters and they never thought that there was anything wrong with him they just thought that he was being a boy…. he does spend some time with my Dad and Step-mum and they're a bit more understanding because I've got a stepbrother who has similar issues as well……..he's a lot higher up on the scale of how bad it is so they're a bit more understanding and they listen to what I say, never judged me or said there is nothing wrong with him or he's being a boy because I knew right from the start that there was more to it than just being a boy"* (Sharon).

There is a reluctance to confront or challenge the views of family and a tendency to avoid conflict.

> *"It's quite hard when half of your family doesn't believe what you are saying and the other half does and you want to-you don't want to cause any conflict within your family so you just don't say anything but yeah they did get to see some of his true colours when I went away for four days but they just put it down to him being a boy"* (Sharon).

Parents reported tensions within family and extended family regarding explanations for disruptive behaviour which were varying narratives about what was happening. It became apparent that parents attending IYrs PMT had to work hard to get family "on board" or to enhance their understanding. For some, this appeared too difficult, as they believed the programme would not receive any credibility in the eyes of various family members. For a Maori parent living with her son with her own parents, the mother acknowledged that her son's behaviour was stressful for her parents living within the household as he exhibited major outbursts and concerning behaviours.

Parents' struggles to secure resourcing or services for their child was acknowledged when children had various co-morbidities and complex behaviours that were difficult to understand and manage. Children often required extra services or learning supports to achieve within the school system. Parental stress was exacerbated by not knowing what services were available, where to seek help in finding this out, how to apply for assistance and often not being entitled to

certain supports. Stress was also exacerbated regarding disputed diagnoses and differences of opinion of the use of medication amongst parents.

Family members also demonstrate a lack of support by disputing the diagnoses of the child. This can create a dilemma for parents particularly when the child has contact or access with the parent who disputes the diagnosis and refuses to administer any medication.

> *"Without putting the birth father down, the birth father hasn't always accepted the diagnosis so to have someone go through it with her that knows that the child is definitely different you know"* (Brian).

"COMBAT"

Conflictual Relationships

The parents who attended IYrs PMT frequently reported various conflicts. This included conflict within child-parent interactions, between siblings, the parental relationship, with other family members (living within the home and outside the home). Conflict also occurred within the school environment and with peers.

Most often, the child with disruptive behaviour was targeted as the instigator of the various conflicts with siblings or influencing potentially hazardous situations.

> *"Like he had an episode with his sister playing with matches... and he set fire to something, luckily it was outside- and she got a burn to her face and he burnt his foot"* (Tony).

The parents described their child with disruptive behaviour as being competitive with siblings and also reflected on their own experiences of growing up with their own siblings. One Dad mentioned being covered in scars as a result of fights when growing up with his own brother, and doesn't want this for his kids, another parent reflected on her experiences with her siblings.

> *"I know you have family scraps, I grew up with two brothers and two sisters so I appreciate that there's always those little things, but it's like he's the biggest, he's the strongest he gets his way always and that's it and I-yeah I try to step in and stop it but I run out of ideas of things to do with him"* (Linda).

Conflict with siblings was also referred to as bullying behaviour and appeared to worry parents as they were concerned about the effects of their child's behaviour on siblings, fearing the long term consequences for the siblings and in essence wanting the siblings to "have a life".

*"I'm looking at boarding school so that I can have a break, Because I just want his sisters to have a life and I find-I've put it down, its bullying behaviour, it's controlling and it's uncooperative at home" (*Linda).

The difference in developmental or maturity levels of children was cited as a difficulty and catalyst for creating conflict with siblings such as when the child with ADHD who is struggling academically and a younger sibling catches up in terms of academic ability. Trying to resolve situations where the younger one "shows up" the older child i.e telling them how to do their homework and which reinforces to the child with ADHD their inadequacies, was difficult for parents to try to supervise. Parents reflected that prior to IYrs PMT they had concentrated on managing their child with disruptive behaviour at the expense of the other children who exhibited more compliant or positive behaviours. There was an oversight of the problematic behaviours of the sibling and the child with disruptive behaviour being seen as the instigator and always getting into trouble i.e "tell tale tit". This was also associated with the expression of guilt from the parents in that this was not the life they wanted for their children; that finding a balance was incredibly difficult and to treat all the children with equal attention when their needs are all so different.

Conflictual relationships relate to an inequality in the relationship, an uneven balance where parents present with parenting styles which are too authoritarian or too permissive.

"He*'s pro more authoritarian than I am, and so it's like I'll be a bit more permissive to try and counter that"* (Rebecca).

Being too authoritarian assumes that parents want to be in control and permissive assumes that they are not. The two extremes of permissiveness and authoritarian were not conducive to a positive and collaborative relationship with their child. However, following IYrs PMT parents worked to achieve this. "Control" implies too harsh a term when exploring the parent-child relationship prior to IYrs PMT; it can imply an individualistic approach. A father who identified as part Maori preferred to use the term "respect" to describe the close relationship he had with his son prior to IYrs PMT. The absence of sustained conflict within their relationship appeared to demonstrate that respect was an important mutual aspect of their relationship.

"Yeah, not so much control, um we just sort of had a bit of respect for each other you know what I mean aye, like I wasn't sort of authoritative, if he did something wrong I made sure I told him" (Hone*).*

Conflicts also arose when parents tried to implement strategies that had been recommended from sources such as television, (i.e "the nanny") and were not entirely cognizant of the process involved in a technique or the rationale behind it.

"You know we used time out quite a lot but it just didn't work with Billy we would shut him in his room and we had to lock in him there and he would smash on the door and try and smash the door down and it just wouldn't work" (Sally).

Being "naughty"

"Being naughty" is a construct that is applied to a state which assumes the child is deliberately intending to make life difficult for the parent. The child is viewed as having the capability to manipulate, defy and annoy parents. Explanations of the role of these behaviours are that they seek to serve the child's best interests in that they get to complete activities or tasks that they enjoy, or to avoid tasks that they don't enjoy. "Being naughty" or "naughtiness" is a generalized term which is not conducive to exploring alternative explanations of behaviour and can contribute to the parents' sense of entrapment or assumed roles within the family.

"Being naughty" disregards the child's stage of development and the perception is that the child has the emotional intelligence of an adult or a level of insight or intellect that is far beyond their cognitive ability. Games of strategy or manipulation by the child are assumed by the parent i.e that the child is "playing on it" or "wanting" or "loving" the conflict.

"I think that was one of the big things, it takes a while to dawn on you that it's not, they're not evil, they're not trying to wind you up even when they are- you know…it's not intentional" (Tony).

"Being naughty" is also a judgement made by the parent about their child. Prior to IYrs PMT parents' explanations about why their child may be "naughty" are externalized in the sense that the parent's role or responsibility in their maintenance is given less acknowledgement. Instead they can be posited in learned behaviours which are modelled from the "other parent" i.e the father who was controlling and the son is now controlling his mother; the parent who is too permissive, the birth father who also has the disorder. The meaning attributed to the child that was naughty was portrayed in the behaviours that parents described which included destructiveness, including damage to property.

"*How do you feel it when she starts destroying the property and there are holes in the wall? How do you separate that, cause you know, that's one of the things that I have huge trouble with, is separating the fact that her destructiveness is part of the disorder cos on the surface she looks like a normal kid so when she's destroying the property I almost take it, without intending to, but it becomes almost a personal fight"* (Brian).

Expression of Symptoms

There were a number of variables impacting for families with children with co-morbid diagnoses or other presenting difficulties which impacted on the child's behaviour and exacerbated the expression of the symptomology. Parent's discussion of the expression of symptoms of their child's behaviour included hyperactivity and described children who were constantly "on the go", which contributed to parent's exhaustion. Often the family experienced disrupted sleep patterns, particularly when the child was up late at night and the parent was quite exhausted and wanted to get to sleep. Bedtime was another battle and at the end of the day, this was the last thing that parents wanted to do.

> *"He's unsettled in the evenings as the days get longer and yeah, we've actually had quite a bad week where um he's been up during the night, he just keeps going and going, that's something that's difficult you know, to get him to go to bed"* (Naomi).

> *"If he has to come and break me out of bed to do it at the last minute, well that's ok for him but it's- it's that energy it takes for me to do it"* (Linda).

Impulsivity also meant that parents had to try to stay alert for sudden unexpected outbursts, hazardous situations, or be prepared to verbal onslaughts, insults, swearing and behaviours which would lead to retaliation by the parent and the use of coercive parenting strategies.

The lack of ability for the child to focus and pay attention to parent's commands or requests resulted in simple tasks becoming complicated ones for the parent to oversee and could result in the parent becoming inpatient and then prone to giving more commands to enable the child to comply such as the child getting ready for school in the morning.

Co-morbid ADHD and auditory processing difficulties resulted in instructions being difficult to process for the child.

> *"Any instruction bigger than a word you know it's like teeth, clean your teeth, get your bag, it's like there's no point saying get ready for school we're going in ten minutes I mean it's just not going to happen"* (Naomi).

There were children who presented with ADHD and encopresis. Parents described the interplay between the symptoms and attempts to manage the behaviours as very frustrating.

> *"The encopresis and it was very very frustrating um, it's worse than toilet training a toddler-it is* (Sharon).

The expression of ASD and ADHD were described as extremely difficult behaviours which were oppositional, destructive and violent. This included damage to personal property, humiliating public outbursts and difficulties in forming relationships (particularly for the stepfather within the study).

There were parents who had children with ADHD/symptoms of disruptive behaviour and who had self-harmed or deliberately hurt themselves. There were two families (three parents) who recalled self-harming behaviours that were very alarming and stressful to deal with where parents were still attempting to understand or explain the meaning of this behaviour.

> *"Billy was exhibiting some alarming behaviours to the point where he made a suicide attempt, whether it was a serious one or whether it was just trying to get attention or whatever it was- it was so alarming"* (Tony).

Negative self talk, expression of hatred and low self esteem were all symptoms that were evident with self harming behaviours.

> *"It could be something like he wasn't getting something from me that he wanted so he would go into um thinking that I hated him and I didn't want him and stuff like that and then he'd start whacking himself and saying I'm no good I'm stupid and stuff like that"* (Mere.)

Expression of symptomology within the school environment was longstanding for most parents. By the time the child was referred to Whirinaki, parents had encountered considerable difficulties for their child within the school setting. One of the issues encountered relates to the school and system being relatively out of their depth in trying to resolve the difficulties. Parents expressed dissatisfaction that even when difficulties were predicted or experienced early on there was limited action taken in circumstances. Consequently, by the time parents were engaged with Whirinaki, they had become somewhat disillusioned. Parents also postulated that the school experience with structures and routines resulted in the child feeling restricted and their ability to express themselves in a more rigid environment was not always conducive to their individual needs.

> *"I think it sort of manifested itself more when he started school and the separation from the parent and the new entrant teacher strict rules at school and you know just sort of the lack of - because he really really enjoyed Kindy and he always wanted to go back to Kindy once he had started school and um he wanted to play, like any boy, he didn't wanted to be restricted just sitting down in the classroom listening to things and doing what he's told, he just wanted to play"* (Sally).

Parental Response "losing my rag"

Parents reported difficulties in being unable to control their response to their child's behaviour or where events happened so suddenly there was no time to "think" or process what was happening and they quickly reacted. Parents recalled situations where they would get angry, yell, shout at their child, "lose their rag" or want to smack them. Resentment of their child also contributed to negative thoughts about their child and more intentional punitive behaviours to their child.

Parents reflected on "horrible interactions" with their child. A stepfather recalled difficulty in handling crisis situations and struggling to remember responses that have worked better in the past, and later gained a broader perspective of his stepdaughter's behaviour during the group context.

> *"Because when you are in the moment, it's almost like you've got blinkers on, but if you describe the moment to everyone, to other people that have similar experiences with ASD kids, right, they are almost like they are sitting back in the arena and they can see the entire thing, right, so they are getting the grandstand perspective, that is handy, because when you're in a situation it's very much almost like the gladiators in a coliseum, you're a combative yet you're a combatant in that situation, you don't have a chance to sit in and take in that whole thing"* (Brian).

Parents reported links between their mood, how they were feeling due to other stressors or events that had impacted on them and how they responded to their child.

> *"We very much got into a cycle of shouting at him to try and get him to do something"* (Sally.)

Parents can become frightened of their response and acknowledge that their reactions have escalated. This can result in a crisis in which the parent takes action and seeks help.

> *"It was literally one day when I nearly lost it that I said to myself that I've got to do something and get things sorted out"* (Sharon).

"BATTLE FATIGUE"

Parental Mental Health and Emotional Response

Bipolar Mood Disorder, Major Depression and Aspergers were conditions experienced by parents participating in the study. Parents were aware of a complex interplay of their own mental health with the concerns about their child's disruptive behaviour. Parents spoke of the

difficulty in predicting the times when they would feel better. Their own mental health as was their child's, was influenced by family relationships which featured periods of intense conflicts; or lulls where the situation may have improved. Mental health of family members was influenced by psychosocial stressors or variables that were not in their control, or outside their control. At times they were able to actively work on areas and improve conditions whilst at times there was an overwhelming inability to make any difference. Parents' temperaments and moods were perceived as influential for their child. There was recognition that children do learn emotional responses from their parents. Parents recognised that they model behaviours which their children learn.

> *"I am a bit of a moody bastard and I know that's why you know my son has obviously got a lot of that from me, you know he's learning it from me it's obvious you know but it's difficult" (*Tony).

Parents felt guilty in a variety of situations. The difficulty of conceiving children and feeling fortunate and blessed to have children was then met later with the guilt in realizing that they were not able to manage their child's behaviour as effectively as they desired.

> *"We tried for seven years to have children and went through IVF for 5 years and we were lucky to have children and then you feel guilty to cope with them as you're so incredibly lucky to have children in the first place so I think you know part of it as mother's guilt at not being able to handle the child that you were given"* (Sally).

Parents also felt guilty about the effect of their child's behaviour on other family members such as partners, siblings or extended family. Guilt was expressed that help or attendance at IYrs PMT wasn't accessed sooner when their child was younger. Parents also felt guilty that they could have contributed to the child's behaviour in some way i.e genetically, family circumstances or parental mental health issues.

Anger can be a response by a parent of not understanding why their child is behaving the way they are, and that they are deliberately doing it to annoy them. It can be a response of not knowing what to do. Therefore, a parent's anger toward their child is related to how parents make sense of why the behaviour is occurring and if they believe that the child is "being naughty" and that the behaviour is intentional, then their response is more likely to be anger.

> *"I had a lot of anger at him because I just didn't understand it and I just thought he was doing it to annoy me".* (Sharon).

Chapter 11

Clinical Work/Treatment

"ENGAGEMENT"

- Therapeutic Alliance
- Debriefing

"COLLABORATION"

- New possibilities
- Acceptance
- Introducing Incredible Years

"REFLECTION"

- Receptiveness
- Suitability

"FIRST AID"

- Co-existing Treatments

"ENGAGEMENT"

Therapeutic Alliance & Opportunities to Debrief

There were mixed experiences of having the opportunity to meet with the child's clinician. This included parents who had positive experiences, those who felt aspects were lacking, had minimal involvement with the child's clinician, or no contact at all.

Parents formed therapeutic alliances with their child's clinician and felt that they had the opportunity to "off-load" or debrief to clinicians. The opportunity to debrief about the history of their child's behaviour with the clinician enabled parents to help process their own emotions and journey up to this point due to the constant battle and various stressors that parents had encountered. In these situations, parents appreciated the opportunity to meet with the child's clinician individually, without the child. One parent had three sessions with the clinician prior to the clinician meeting the child. She developed a rapport with her clinician.

> *"I had my first appointment with Angela and I think it was a two hour appointment and I think I actually talked to her for three hours and went through a couple of boxes of tissues"* (Sharon).

Parents also expressed appreciation of contact from clinician to follow up progress. Even where things were progressing well, there was the opportunity for the clinician to provide positive affirmation to the parent, and acknowledge the parent's role in the child's progress. When parents contacted the child's clinicians during difficult periods, empathy, reassurance and encouragement could be provided, therefore enabling problem resolution within the therapeutic relationship. This resulted in the parent feeling empowered and supported.

> *"I know I had a bad day one day and I just rung her up and left a message and she called me back and I talked to her for half an hour and it seemed to somehow solve itself and I don't know, maybe I just needed to talk about it"* (Sharon).

When parents felt their concerns about their child were taken seriously, that assessment was thorough and adequate explanations provided or explored; they appeared more receptive to IYrs PMT as a possible treatment option.

> *"Mary was a sort of trainee, I can't remember what you call them, but a trainee psychologist who was our key worker and um she and another guy who was in charge of her did quite a few interviews with us and did quite a bit of testing of Billy……. Mary was very good and enthusiastic in working with him and so she was the one who suggested we do Incredible years"* (Sally).

"COLLABORATION"

<u>New Possibilities</u>

New possibilities were connected to coming to terms with having to ask for help. Parents perceived that there was a problem or difficulty which they hadn't resolved on their own or with their own resources. However, this didn't necessarily imply that it was entirely their parenting at fault.

Preparing for new possibilities relates to providing information and discussion of potential treatment options or avenues of further exploration. Parents contemplate the potential meaning of their child being diagnosed with a disorder, or not diagnosed with a disorder, which appeared to be a process which parents needed to work through. Sometimes children were diagnosed one to two years earlier prior to parents completing IYrs PMT. Time is often required for parents to become open to new possibilities at their own pace. For one parent, being open to new

possibilities was essential to understand the complexities of various difficulties that were being experienced within the family. It was not the child's diagnosis alone.

> *"We'd probably have known for about a year, we had seen a Paediatrician privately and we'd known for about a year that he'd had an ADD label but I mean it wasn't the ADD that brought us here"* (Naomi).

Parents can display a range of emotions related to their idealized views or aspirations of being a parent. There may be realization that their ideals cannot be aspired to and that they need to let go of particular ideologies or dreams for their child as the likelihood that the child can live up to these expectations are diminished. Similarly, ideals of "being the perfect parent' will not be achieved, reflective of their experiences of struggling with disruptive behaviour.

> *"I was trying to be this ultimate mother"* (Linda).

Preparing for new possibilities indicates that a period of contemplation is required for parent's to be able to adjust. This could be equated with cycles of grief i.e denial, anger, acceptance or hope. Emotions are acknowledged as central to realizing that this will help but being aware that there is "no cure" and the process will be ongoing. Having hope that things can improve is connected with the ability to escape from the sense of entrapment which is felt when dealing with their child's disruptive behaviour.

Acceptance

Parents' perception of having felt accepted by their child's clinician was central to the parent's ability to engage with their child's clinician. The necessity to feel accepted is driven by the judgement that parents have experienced about their child's behaviour and their parenting. Parents express self-deprecation, and display negative attributions about parenting which can bias their sense that they are being judged by others. There may be a tendency to misinterpret clinician's dialogue regarding parenting. It can be a difficult and sensitive topic for parents.

> *"I'd had my friend came along to sit with me at one of the meetings I had with her (clinician) and she could see what I was saying that I just felt that it was coming back that I was a bad parent. Well, not a bad parent-but you know that it was all in how I was parenting which I didn't feel quite was quite fair"* (Linda).

Acceptance of a CAMHS service being involved with the child and of the child's diagnosis is therefore a process. It is also dependent on whether psycho-education has been provided by the child's clinician and whether questions raised by the parent have been adequately addressed. Not all parents were involved in clinical work preceding IYrs PMT and explanations regarding diagnosis may not have been provided, particularly when parents are separated.

"When he was getting diagnosed with that ADHD I wanted to do everything that I could....to try and help him and me because I was stressing out so much, so yeah, I just wanted to learn a bit more about that sickness and that and I wanted to learn whether he did have it" (Hone).

Understandings and meanings of child behaviour therefore also exist within a cultural context, which is reflected in the acceptance and understanding of the child's diagnosis. Maori models of mental health i.e (Te Whare Tapa Wha) were absent in dialogues for this father. He was not the primary caregiver at the time his child was assessed, and was not directly involved in any clinical work. The language of "that ADHD" and "that sickness" reflects lack of acceptance and externalization of the terminology which is applied from a medical model, which can alienate parents particularly from indigenous or cultural minority groups.

Introducing Incredible Years

Parents recalled varying explanations of the overview of the IYrs PMT, and the rationale of why clinicians recommended it to them. These rationales were generally accepted by the parents (they had all attended the programme). For parents with difficult circumstances, on reflection, more preparation on the specifics of the programme and commitment required would have enhanced their experience and prevented misconceptions.

Parents were told that IY's PMT was a group where they would meet other parents who were parenting children with difficult behaviours and were clients of Whirinaki; that they would pick up other ideas and strategies for managing difficult behaviour; that it may not help for their child with extreme behaviours but would definitely help with their younger child; that it was a parenting skills class for children with ADHD (and because their child had ADHD the clinician thought it might be helpful to learn ways of dealing with more difficult behaviours);and that it would improve awareness of dealing with children's behaviours. One father recalled receiving written information.

"I had a whole lot of paperwork, describing you know what was sort of happening and everything and I was sort of quite interested so that's why I did it" (Hone).

"REFLECTION"

Receptiveness

Receptiveness of the parent to IYrs PMT is related to the clinical work that clinicians have completed with the parent. Recommendations to complete IYrs PMT without any foundation of a therapeutic relationship formed with the parent; may be at risk of being met with reluctance or

refusal, likely due to the judgement that parents report is being made about their parenting by the child's clinician, particularly in instances where parents have mental health issues.

> *"So I came along and um didn't seem to be-the therapist I was seeing-I didn't really feel like I was getting anywhere other than that it was my parenting that was at fault. So I thought well I'd try doing Incredible Years and see if that would help me with my parenting"* (Linda).

Receptiveness to attend IYrs PMT is also about timing for the parent with the parent realizing their own capabilities in being able to attend. Parents do not always attend following the first instance where the programme is recommended by the clinician. Parents demonstrate varying responses to being receptive to the programme, either requiring time to contemplate the programme, being involved with other interventions at the time which may be time consuming (i.e parenting programme at health camp) or having been on a waiting list to complete the programme and losing the momentum to want to attend at that particular time.

Participants are not always receptive at the time and may be reluctant to attend as they do not feel fully informed about what to expect. However, their reluctance can diminish as they become engaged in the programme. Realization that they are not the only one going through difficulties, that the discussion is open and honest and not "sugar coated" does attract parents to continue attending.

Suitability

The suitability of parents' attendance at IYrs PMT is contemplated by clinicians prior to referring parents to the programme. Any discussion with parents about the programme requires careful consideration. Parents reflected on the suitability of other parents attending and connected this to the effect for other group participants and some parents' unlikely chance of benefiting from the programme. There was an awareness that parents with too many psychosocial stressors or lack of support were not set up to do well on the programme as it would be just too hard.

> *"I mean for people who are obviously having trouble with their children, to ask them to spend twelve weeks, for that amount of time, is a huge ask..... and you could see that with some of the other people, that for obviously this was their second time at trying to do it -it's just logistically too difficult to spend twelve weeks away for that many hours and I don't know how many hours it is altogether but it's an enormous amount of time and if it was in an evening I mean where would you put your kids?"* (Tony).

Because of the long process of consolidation, parents need to be open to acknowledging the limitations and ineffectiveness of strategies or behaviours that were quite ingrained and to be prepared to address these. Having parents in the group who weren't ready to participate in the

programme, or who divulged too many personal issues created frustration for those genuinely attempting to make the most out of the experience. This created a tension that these people were wasting other's valuable time, whether it was clinicians leading the groups or parents attending them. It also detracts from positive experiences within the group as these group participants were often off track due to discussing more personal and intricate details in a group setting. They were also inclined to use the group more as a therapeutic one and potentially create embarrassment for others attending.

> *"It's definitely been a long process but very worthwhile um in doing it and I would recommend it to anybody who was open to making changes. I don't know if I would recommend it to anyone who quite wasn't there yet as it would just be a waste of other people's time as well as theirs cos I think you've really got to want to do something about it because I don't think it works if you're not open to it but it does if you've got to that point of being to say what I'm doing is not working and we're not getting anywhere and beating our heads against a brick wall and start doing something about it"* (Sharon).

> *"It would have been better-when I wasn't quite so exhausted from this um, going through a marriage breakup you know and all that sort of thing all at the same time"* (Linda).

First-Aid/Co-existing treatments

There are varying assessments and treatments that can complement outcomes for parents attending IYrs PMT or potentially hinder progress which is made. Medication (methylphenidate) was not always introduced as a first treatment option. Some children did not have a formal diagnosis and were not on medication. Some children were on medication but the dosage was not sufficient to have desired results and the dosage increased following incredible years. Parents observed more success at implementing strategies from IYrs PMT once children were on medication (for children with a formal diagnosis), experiencing less resistance by their child.

> *"My son Connor was- he had started the Rubefin in the small doses, he may have been on a 3 or 6 hour tablets a day at that point which means at that stage the school had the benefit of his behaviour and you know so it was pretty hard to manage his behaviour at that time and now that he's been on the Concerta since the end, like after we'd finished the course, at the end of last year I mean he's a different kid"* (Naomi).

Parents commented on other psychosocial interventions that were also offered at the time of IYrs PMT. This included a social skills programme developed by Whirinaki for children with ADHD and who encounter difficulties with peer relationships.

"At the same time he did the socialisation programme at Whirinaki and I think that helped him (Tony).

Chapter 15

Discussion

Grounded theory exists within the constructivist paradigm of inquiry. The knowledge the parents have shared was created through their interaction with others, in particular with their child, family/whanau, clinicians, group leaders and the researcher. The meaning created from that knowledge is socially located, culturally located and historically located. The concepts, categories and themes which emerged will be positioned within various psychological theories. These theories are socially, culturally and historically located as they apply to parents realities.

EMOTIONAL & SOCIAL PROCESSES OF LIVED EXPERIENCE

The meaning that parents attributed to their child's behaviour and to their parenting underpinned the emotional and social processes of their lived experience (Appendix F). Various concepts grounded in psychological theory may help to inform the meanings grounded within parent's dialogue. Many concepts including judgement, learned helplessness, coercion theory, attribution theory, low parenting self efficacy, low self esteem and negative cognitive distortions are concepts which have relevance to understanding parents' experiences. Parental, child and contextual factors also informed parental experience of their child's disruptive behaviour. In particular, the presence of co-morbid conditions within their children heightened the sense of disruption for parents.

Judgement

The concept of judgement incorporated the tendency of parents to make judgements about their own parenting abilities, their perceived judgements of others' perceptions of their parenting abilities, and making judgements of their child regarding causal factors for their behaviour. Judgement had the potential to make parents feel embarrassed and withdraw from others. In turn parents made judgements of others such as how the school were coping with their child's behaviour. A lack of knowledge appeared to have an influence on the judgement that occurred. It has been previously documented (Webster-Stratton & Spitzer, 1996) that parents of children with symptomology of disruptive behaviour and conduct problems have become sensitized to judgement due to the entrenched and cumulative effects of coping with their child's behaviours and the superficial views held by others such as professionals and lay people regarding the experience of parents.

Judgement appeared to accompany a negative cycle and not only occurred prior to parents seeking help, but was present in parents' cognitions and behaviours throughout their interactions with other professionals, through the group environment and following the group. Hiebert-Murphy et al; (2008) had also found that difficult interactions with professionals can

leave parents feeling unsupported, frustrated and invalidated. Many elements of judgement subsided following IYrs PMT strategies to promote improved relationships with others. The findings also reflect research by Webster-Stratton & Spitzer (1966) who argue that parents remain susceptible to judgement due to the evolving nature of their circumstances. They also experience the ongoing stigma of diagnoses such as ADHD.

Learned Helplessness

The difficulties parents experience when engaging in health services and in seeking assistance for their child has frequently been reported in previous literature (Hiebert-Murphy et al; 2008;, McKernan-McKay et al; 2005; Reijneveld et al; 2008) and one could argue that learned helplessness theory plays a crucial role in understanding parents perceptions and behaviours. Within this study, parents were attempting to plan an "escape" from their sense of entrapment and this was evident in their search for answers. Abramson et al; (1978) argue that when a person finds that they are helpless they question why they are helpless. The causal attribution they make then determines the generality, chronicity and intensity of their helplessness.

Causal attributions reflecting the generality of the helplessness parents felt within this study were evident when some parents generalized their helplessness to other parts of their lives where they felt inadequate. Other parents, particularly those who were working appeared less inclined to generalize helplessness. There were two nurses who held responsible and demanding positions, which would be challenging but satisfying in terms of their own personal development. Mothers who experienced depression, who were not working outside the home, were more inclined to generalize their helplessness and see themselves as passive and without self efficacy. In particular there was a tendency for mothers with depression to generalize feelings of helplessness towards their relationships in terms of this sense of lack of agency in marital break-up or marital satisfaction.

Chronicity of helplessness can be applied when examining the discourse of parents within the study. Parents had gradually become more disempowered at coping with ongoing behavioural and relationship difficulties within their family. For many of the parents, chronicity was heightened as they had waited some time, often many years for the symptoms to improve. They often did not seek help until the child was at school, or were encouraged by professionals to apply a 'wait and see" approach. Chronicity was heightened as parents waited because family members or others disputed the parent's beliefs that something was not quite right about their child. The lowered self- esteem of these parents may have resulted in the parent questioning their own beliefs about their child's behaviour i.e that "he is just being a boy".

The intensity of helplessness suggests that the sense of helplessness will be greater based on the extent that the event about which the person considers themselves helpless, is highly preferred or valued. Having an "ideal family" or being the "ideal or perfect parent" is a belief that

many parents model their own aspirations of parenting on as society places emphasis on these ideals. For one parent with depression, the intensity of helplessness was evident in her depiction of IYrs PMT vignettes as depicting "American perfect families".

Helplessness has also been defined as universal or personal helplessness (Abramson et al; 1978) and used to explain the low levels of self esteem and or depression for parents of children with conduct problems (Webster-Stratton & Spitzer, 1996). Universal helplessness applies when the individual does not believe they or anyone have the ability to solve the problem. Personal helplessness applies when the person believes that the problem is solvable but that they lack the ability to solve it. Parents in this study appeared to exhibit both types of helplessness. When parents felt that they had lack of ability to solve the problem, they engaged in activities in attempts to enhance their knowledge to help resolve the problem, such as reading self help books or attending other parenting programmes. Parents who experienced personal helplessness would compare themselves to other parents, and feel that they did not live up to expectations and were incapable of resolving their child's disruptive behaviour. The comparisons that parents made of themselves with other parents, was reinforced when they felt judged by other parents or parties. Consequently, parents experiencing personal helplessness have been reported to show lower self-esteem than those who experience their helplessness as universal (Abramson et al; 1978). Universal helplessness occurred when parents indicated that their child's behaviour was innate, was part of them and they did not know if anyone could change or alter the way their child was and that it would only be resolved by the child themselves, as they developed and matured.

When parents experience situations in which they have no control over what happens to them, they have been described as developing certain motivational, cognitive and emotional deficits (Webster-Stratton & Spitzer, 1996). The motivational deficits are described as being characterized by a lack of ability to voluntarily respond to a situation. The cognitive deficit is defined as a belief or expectation that outcomes are uncontrollable and the emotional deficit is defined by a depressed affect (Abramson et al 1978; Maier & Seligman, 1976 & Seligman, 1975). The general premise of learned helplessness theory applied to parents within this study is that they have come to believe that their efforts to resolve their child's disruptive behaviours will be ineffectual. This is because they cannot identify contingencies within their own parenting behaviours that have resulted in improvements in their child's behaviours. They perceive no discernable relationship between their actions and the outcome (Webster-Stratton & Spitzer, 1996). They have reached a point where they may feel that nothing works. Often parents feel helpless and inadequate in their parenting role (as a "bad parent") and often perceive these attributions to be confirmed and reinforced by extended whanau, friends, teachers and other professionals.

Coercion Theory

Coercion theory (Patterson, 1982) was reflected in the emphasis on power struggles within relationships between parents and the child with disruptive behaviour. Power struggles are frequently reported in the literature describing the relationship between children with disruptive behaviours and their parents (Segal, 2001). Parent-child conflict has also been cited as representing one aspect of the broader construct of parenting stress. Stressful parent-child interactions are characterized by high levels of control orientated and negative interchanges and are often accompanied by a lack of positive and mutually responsive interactions (Mash & Johnston, 1990).

The structure of the family appeared compromised when parents perceived children to launch a 'take over bid' of the parental position in their attempts to secure control. Parents' understandings of this conflict were that they needed to explicitly confront or challenge this opposition to their role by putting the child in their place. This resulted in the escalation of even more conflict as the child responded to this negative attention from their parent. The more that parents focus on this assumption of control that their child is trying to obtain, the more the child will attempt to challenge their response. As parents became more desperate, the harder they try to exert their role as 'boss' or control over their child. The means used to do so was usually doing more of the same or increasing the intensity of correctiveness. Erdman (1998) has demonstrated that this cycle is more likely to result in an angry, aggressive and resistant child. Prior to seeking help, parents had limited insight into the intricacies of family relationships and how to promote positive family relationships to decrease the intensity of their power struggles with their child.

Patterson's theory of the coercive process (Patterson, 1982; 1986) assists in increasing our understanding of this conflict. Children learn to escape or avoid parental criticism by escalating their negative behaviours. This in turn leads to increasingly adversarial parent interactions. Parental negative responses directly reinforce the child's 'deviant' behaviours. Patterson (1996) postulates that conflict involves a dynamic cycle between parental distress and child aggression, with each problem exacerbating the other.

The early childhood coercion model also identifies how conflict in the form of coercive parent-child interactions, has been shown to diminish children's emotional regulatory capacities (Scaramella & Leve, 2004). This occurs through a process of mutual reinforcement, harsh parenting, negative emotional reactivity, and poor emotional regulation which become coercive parent-child reciprocities during early childhood. These theories of behaviour which are evident in the descriptions of parent-child patterns of interactions can be used to explain why it is so difficult to effect change for patterns of child behaviour without external sources of support such as those provided by the experiences and insights offered in IYrs PMT programmes.

Parental Attributions

Attribution theory can be used to explain the meaning parents attribute to their child's behaviour within this study. Attribution theory can be applied when describing and predicting human behaviour and emotional responses to stressful events. Attributions of cause and controllability have been shown to consistently mediate human response to, and coping with stressful events such as illness and loss (Harrison & Sofronoff, 2002; Miller, 1995). Therefore attributions are predictive of the quality of the parent-child relationship and the child's development in general (Bugental et al, 1989; Dix et al; 1986) and as reflected in the literature, are potentially a risk factor for coercive parenting. Attributions that parents make about the causes of their child's behaviour can partially explain the emotional and behavioural responses of parents toward their child and further assist clinicians to formulate and conceptualize the child's behaviour (Johnston & Freeman,1997; Joiner & Wagner, 1984).

Evidence of this emerged from the data in parental explanations of the meaning behind their children's behaviour. Parents often regarded the child's behaviour as intentionally vindictive, inciting the parent to a strong reaction, feeling that the child wanted to 'be the boss' in attempting to control the parent. There was a tendency for parents to see themselves as victims, life had become too hard and they became angry and resentful. Parental mental states and coercive parenting have been previously investigated (Campbell, 2002; Peterson et al; 1994). Parents had applied the construct of "being naughty" to formulate the causation of their child's disruptive behaviour. This understanding suggested that the child was deliberately setting out to make their life difficult. Consistent with findings from Johnston & Freeman (1997); most of the parents within this study had gained an awareness that prior to CAMHS involvement and intervention from IYs PMT, they had assumed that most of their child's problems resulted from deliberate noncompliance rather than incompetence, and as parents they had been less responsible for the behaviour. They also had misinterpreted their child's behaviour as intentional and responded negatively in accordance with these attributions.

Psychological Distress and Stressors

The narratives of several parents reflected psychological distress and stress, evident in disclosures of depression precipitated not just by their child's behaviour but various other psychosocial stressors. Parental psychological distress and the stress of caring for a child with disruptive behaviours such as ADHD/ ODD (and associated co-morbidities) is well documented in the literature. Parents within this study reported psychosocial stressors that have been previously observed. This included marital difficulties or separation (Wymbs et al, 2008), financial difficulties, lack of social support and difficulties securing resources, difficult family dynamics (Lin et al; 2009; Webster-Stratton, 2007), parental mental illness (Nigg & Hinshaw; 1998) and parental alcohol abuse (Pelham & Lang, 1999).

Consistent with both the literature and the study's findings, parents developed hypotheses about their child's diagnosis i.e ADHD/ODD or behavioural difficulties and the links with parental psychopathology. The interplay of parental symptomology with child symptomology is complex and various inferences are made by parents about causal pathways. Parents' understandings also related to genetic pathways such as one of the parents having mental illness and the likelihood that the child had inherited this from one of the parents, or that the child's temperament was linked to the parents temperament and emotional response. For the six children who featured within this study, four were identified in the dialogue as having a parent who had experienced some form of mental illness (either disclosed from the parent who was interviewed, or from the child's other parent). One child had two parents who had experienced mental illness.

The interplay between parental psychopathology with that of the child can exhaust the ability of the family to maintain or implement an appropriate response. It is well reported in the literature that a correlation exists between parents of children with disruptive behaviour and parental mental health (Biederman et al, 1987; Harrison & Sofronoff, 2002 & Hirshfeld-Becker et al; 2008). Parents' emotional availability to their child is likely to be diminished during a depressive illness. They are more likely to infer negative attributions regarding their child's behaviour, thus resulting in more negative encounters and reactions with their child. The literature also reports that parents with depression have more negative encounters with professionals based on their negative self bias (Webster-Stratton & Sptizer, 1996).

Being the sole parent within the household without father involvement appeared more of a stressor if marital dissolution had occurred in close proximity to the parent's attendance at IYrs PMT and if mental health issues were present for the parent. Having no input from the child's father was not necessarily a stressor for parents without the fathers' involvement, particularly when the status quo had remained for some time. Two mothers who did not have involvement from the child's father were both working mothers with extended family/ whanau support. They presented as articulate, insightful and resourceful parents. 'Solo parenting' may not appear as an appropriate term which is culturally sensitive nor applicable when exploring concepts of parenting for Maori as it implies an individualistic focus and suggests that the remaining parent has the sole responsibility for the child's upbringing. For the Maori father who was living with his son independently, it was apparent that there was fairly amicable communication between the parents, with his son spending weekends with his mother as more of a shared parenting situation. The child's mother was also planning to attend IYrs PMT with the father advocating the programme to her. For a Maori mother who attended, her support was from her parents who lived within the home. The child's behaviour was found to be stressful for all caregivers within the home. However, having more caregivers living within the home also provided a supportive environment.

The ongoing difficulty securing resources and services for their child was particularly difficult for some families and exacerbated further by the presence of co-morbid diagnoses creating difficulties in finding appropriate treatment options for their child. One mother spoke of the stress of securing approval for high and complex needs funding, the relief at securing this, and then the bitter disappointment that the plan could not be executed due to the lack of the availability of experienced people to implement the treatment plan. Access and entitlement to appropriate services as well as funding difficulties have been found to generate stress for parents of children with disruptive behaviour and even more so for cultural minority groups (McKernan-McKay et al; 2005). Another mother who worked in child health was particularly appreciative that IYrs PMT was a free resource accessible to parents of Whirinaki clients and that this was not so easily accessible in other services due to various referral policies and funding restrictions.

Parental Self-Efficacy

Knowledge of ADHD has been correlated with parental perceived control in that mothers who are lower in their knowledge of their understanding of the disorder tend to perceive that they have less control over the child's behaviours. Lower perceived control has also been related to higher levels of reported parenting stress and depression (Harrison & Sofronoff, 2002). This was evident in the narratives of parents. Lower perceived control was evident in their understandings of the "child as boss".

Many of the parents within this study were coping with children with co-morbid diagnoses. These are complex and difficult to understand for health professionals and researchers, let alone for parents who daily have to apply their own understandings and responses to the disruptive behaviour. The difficulties experienced by parents with children with co-morbid symptomology and diagnoses supports the literature regarding the complexity of assessing and treating the symptomology of such disorders (Barkley, 1997; Danforth; 2007, Van Everdingen-Faasen et al 2008). Parents often reflect a frustration in managing their child's behaviour and it is apparent that a scarcity of research and knowledge of these relevant co-morbid conditions still impacts greatly on the ability of clinicians to advise and support parents. When parents were provided a comprehensive formulation of potential and possible causal factors for their child's disruptive behaviour (and that parenting behaviour is one component), they appeared less likely to make judgements and deflect blame onto others (on the child) but to focus on possible solutions.

For some parents, the child did not have a formal diagnosis. These parents reported less satisfaction with their clinicians. Unresolved issues about treatment were present following IYrs PMT. It was also of note that there was also the presence of mental health issues for these parents. The presence of co-morbidity for children with disruptive behaviours is common but further research is required to understand their inter-relationship. The presence of co-morbidity

in many of these children indicates these parents have an extremely challenging task to find, adapt, and manage strategies that will work best for their child. It also emphasizes the high level of skill that these parents are required to develop to challenge assumptions that parents are not coping because they do not display adequate parenting skills.

Parents clearly expressed a difficulty in regulating their own emotional responses of anger in retaliation for their child's behaviour. Parents frequently reported that their expression of anger would escalate the child's behaviour. Parents felt that they did not have time to reflect on their own behaviour. There was limited insight at this point of how their own behaviours were impacting on their child's responses. Parents did acknowledge that they did become frightened about their own responses at times, particularly when they shout at their child.

Insularity

Parents within this study often expressed a lack of support from extended family who reflected varying perceptions of meaning attributed to their child's behaviour at variance from their own. Parents had encountered negative responses from many people and professionals about their child and were often reluctant to continue to engage within these interactions. The literature defines this process as insularity. This relates to a specific pattern of social constructs within the community that are characterized by a high level of negatively perceived social interchanges with relatives, and/or helping agency representatives, and by a low level of positively perceived supported interchanges with friends (Wahler & Dumas, 1984, Webster-Stratton, 1998). Networking and connecting with other parents within a group setting helps ameliorate insularity. Parents become aware that other parents have frequent negative interchanges with others concerning their child's behaviour.

Societal Contextual Factors of Parental Experience

Parents displayed insight into how their parenting styles may have evolved from their own parents and the appropriateness of these in the current societal context. New Zealand has undergone legislative changes over recent years and there has been public awareness of the anti-smacking legislation with the repeal of section 59 of the Crimes Act which had stated that parents were able to use 'reasonable force' to discipline their children. This legislation at the time created a sense of uneasiness among some parents who had used coercive discipline to cope with their child's disruptive behaviour, without being aware of possible alternatives, or report that popular alternatives (such as time out or withdrawing privileges) were ineffective for their children. It left parents feeling they had limited strategies to parent their children. Since this time a referendum has been held and despite a majority vote that smacking should not be a criminal offence, the government have decided to retain the legislation. No parents within this study explicitly stated they had hit their children. Some did admit to shouting at their children and others implied that coercive strategies were used. This was reflected in more general discussion about parenting techniques and the integration of previously held attributions with

awareness of alternative strategies from IYrs PMT. Parents did recommend to others following the programme that it is possible to discipline children without shouting at or smacking them. This suggests there indeed may have been major shifts within their behaviour. However they may be cautious about disclosing this in the current environment, due to possible repercussions from government organisations in particular.

CLINICAL WORK AND TREATMENT

Clinical work preceding IYrs PMT had not been an anticipated focus within the study but dialogue from parents indicated that their experiences with clinicians preceding IYrs PMT impacted on their experience of the group. This theme found that parents required the opportunity to debrief and to engage with clinicians preceding IYrs PMT, that parents have commonly shared attributions about their child's behaviour, and that clinicians have a key role as gatekeepers for parents to IYrs PMT in order to scaffold them for success. It also demonstrated how the delivery of IYrs PMT exists within a specific clinical setting and that an organisation's structure and delivery of service has direct implications for how clinicians are able to prepare parents to attend the group (Appendix F).

Parental Help-Seeking & Scaffolding for Success

The importance of preparation prior to parents attending IYrs PMT dominated the theme of clinical work and treatment. Clinicians' interactions with parents were pertinent to scaffolding parents for success as they embarked on the programme. The dialogue from parents often reflected a sense of regret that they did not seek help earlier when the child was younger and that earlier intervention may have helped alleviate the intensity of the symptoms of their child's behaviour. Segal (2001) has previously described the concept of 'long delay mothers' who are unaware of where to turn for help, whose children are often misunderstood or mishandled, where professionals are not sure how to handle their child, and the regret of lost learning (in various areas) by delay in obtaining appropriate assistance. Certainly, parents within this study reported similar experiences in their contact with services.

As previously mentioned, the reluctance to seek help is related to learned helplessness, insularity and to perceptions of being judged. However, it is also related to the parents' contextual circumstances. Many parents within this study did not display circumstances of great adversity. Several parents were professionals who were resourceful and knowledgeable within their disciplines, and likely placed high expectations and demands on themselves to perform as parents. It would also seem that in terms of their role in the employment sector, they had much at stake in managing their family life. Seeking assistance for their child may influence their professional integrity if others become aware of the issue. It was evident that following IYrs PMT and intervention from CAMHS that parents were in a better position to review their experience as productive for their work environment whether it was because of less intrusion of

family life into work, or that they had gained skills and experience that could compliment their professional role.

Therapeutic Relationships between Clinicians & Parents

Parents reflected varying experiences of clinical work for their child and family preceding IYrs PMT. It was apparent that parents who developed a therapeutic relationship with their child's clinician and felt accepted were well engaged for future possibilities that could occur from treatment as well as adhering to various treatments for their child. Instilling a sense of hope in parents is an important part of the process which can occur from clinical work with the parent preceding IYrs PMT. Often, for parents, there are barriers to accepting help. Reijneveld, de Meer, Wiefferink & Crone (2008) report that a very large proportion of parents of young children have concerns regarding their child, but agreement on these concerns with child health professionals is relatively low. Hiebert-Murphy et al; (2008) have also reported that parents do their own research to understand the behaviours of their child and to identify possible diagnoses. They have also found that the interaction between health professionals and families during the process of diagnosis greatly impacts parents and there can be a wide range of variations in experiences. Consequently some parents can emerge from the experience feeling unsupported, frustrated and invalidated. Similar findings were found within this study regarding the variation of experience. Parent interactions with clinicians were not a central focus of this study. However, they were central to the parents' experiences and they created meaning from their interactions with clinicians whether they were positive or negative experiences. These interactions were also influenced by the parents' expression of mental health issues.

Hiebert-Murphy et al (2008) have also acknowledged that some parents may have unresolved feelings about their interactions with professionals, and have great emotion around the process of diagnosis. Their feelings may need to be acknowledged and validated. There are also varying responses that parents can have to a diagnosis or a lack of diagnosis. Many mothers within this study had actively researched answers from sources encompassing self help books, popular NZ experts on parenting, other parenting programmes and media such as television. When parents engage at CAMHS, clinician constructions of meaning about the child in question is set in an evidence base and informed by their experience of working with other children with mental health issues. Here lies a potential conflict. There may be a tendency for clinicians, based on their own constructions of meaning, to dispute the reality of parents' knowledge that has already been accumulated. Disregard for the work that parents have done (particularly mothers), irrespective of the accuracy of the parents' constructions or formulations, is likely to play a role in the judgement and lack of acceptance that parents feel. Parents frequently engage in services when they are most vulnerable, often when self-esteem is low, when stressors are evident and are therefore not in a position to strongly assert themselves. In fact, Kendall (1999) has found that children and adolescents with ADHD are viewed as poorly parented children by clinicians, not as children with a disability. This often isolates families and

decreases the likelihood they will seek out needed support. It indicates that there may actually be some evidence to suggest that what parents perceive clinicians may be thinking about them may actually be a fairly accurate account of what clinicians do perceive about their abilities as parents. It suggests that clinicians may need to be cautious about making assumptions about parents. This is particularly relevant during the absence of a therapeutic relationship and when the parent has not been allowed the opportunity to debrief and relay their experiences and the meanings they attribute to their child's behaviour, and the help they perceive that they need.

Clinicians as Gatekeepers

It is evident from parents' dialogue that clinicians are perceived as the gateway to IYrs PMT and therefore hold the role as gatekeepers. They are in a pivotal role to provide information about the programme and the way that this linkage occurs is important. Parents reflected various experiences of how IYrs PMT was initially introduced. It appeared that not all parents were fully informed about IYrs PMT and were given various descriptions and information about the programme. Two of the fathers were included in the discussion with the clinician while the other father was contacted by phone and provided with written information. It was likely that the ability of the clinicians to engage fathers from the outset assisted in their willingness to attend and provided support for mothers who were also encouraging the fathers' attendance. One clinician was particularly skilled at accessing a parents' world and their reality. They provided the opportunity to meet alone with the parent on several occasions, prior to even meeting the child. This resulted in enhanced engagement with the parent and parental receptiveness to complete IYrs PMT. Parents are therefore the 'agents' who can dictate the likelihood of success of any therapeutic work with the child. The 'parents as expert' focus reflected in IYrs PMT is not emphasized in clinical work. In fact, by parents perceiving clinicians as the 'experts' with their child's behaviour, there is greater potential for developing a dependency on the clinician, rather than the emphasis on transitioning a parent and family/whanau to coping on their own. One parent provided an example of how the clinician had helped empower her to resolve her own problems therefore enhancing parental self efficacy. Similarly, the way clinicians introduce the concept of IYrs PMT held important relevance for the receptiveness of parents. If the parents perceived that the concept and rationale of IYrs PMT was introduced in a manner which directly challenged their parenting skills and would undermine their parental capabilities, then the ability for the parent to 'buy into' the programme was ultimately reduced (as articulately portrayed by one mother).

Parents present at a time when their perception of their own ability to cope is at a low and reinforcement of their perceived shortcomings only serves to reinforce these. Psycho-education with reassurance and encouragement can demonstrate that there are often many factors which impact on a child's behaviour. It helps parents to realize that parenting approaches are one of these. It has potential for more buy in from parents, as evidenced by one couple who discussed how it was perceived as a more holistic solution and that IYrs PMT was one component of this.

Other parents appeared to be receptive to the concept of IYrs PMT when it had been portrayed as an extension of their parenting repertoire and acknowledgement that they were in fact parenting very challenging children. The receptiveness of parents to IYrs PMT appeared to be optimal when clinicians had a collaborative relationship with the parent, when parents felt that their experience had been heard (i.e opportunity to debrief about their child), felt accepted when the rationale was portrayed in a manner which heightened parental self efficacy and where the parental role was emphasized as central to improving their child's behaviour.

INCREDIBLE YEARS GROUP

Parents' discourse revealed rich information that provided insight into pertinent issues regarding IYrs PMT (Appendix F). It is most evident that this is a challenging intervention for most parents to attend both physically and emotionally. This is previously reflected in the literature in relation to IYrs PMT and family risk factors (Webster-Stratton, 2007; Webster Stratton, 1998). The study also reveals how parents interpreted some of the material reflecting culture and context as a central issue that may require further exploration and development. The dialogue from fathers was particularly intriguing as it revealed how the expression of masculinity and gender roles of fathers can impede or enhance therapeutic change within a forum such as IYrs PMT. These findings can possibly enhance treatment outcomes and challenge our thinking as clinicians and group leaders to deliver an intervention which is more conducive to supporting and engaging fathers. Previous research has not directly explored links between masculinity, gender roles and fathers participating in IYrs PMT. Parental mental health is also extremely central to the group experience as it influences how parents interpret and construct meaning of the group experience and their interaction with others. This is previously well documented in the literature (Webster-Stratton, 2007, Webster-Stratton & Spitzer, 1996). Group therapeutic processes and social learning processes operate and provide an environment where clinicians attempt to maintain treatment fidelity and enhance treatment outcomes, new parental attributions about child behaviour emerge, self esteem and self-efficacy is enhanced, parenting becomes more consistent and family scripts are rewritten. These processes will be further elaborated on in this section.

Diversity: Learning & Culture

Previous research of IYrs PMT has predominantly focused on efficacy and effectiveness. There has been less emphasis on parental experience within IYrs groups within a qualitative analysis. Stern et al (2008) has previously examined adherence to fidelity by group leaders and has noted a reduction in the maintenance of fidelity for videotape modelling dosage, role plays and buddy calls. This study further extends this finding by exploring the resistance of parents to some of these components of the programme and the factors which may contribute.

Performance training approaches such as DVD feedback, role play and rehearsal have also been reported to be effective for improving parenting behaviours, rather than a reliance on

written and verbal methods which are less effective (Webster-Stratton, 1998). Parents did acknowledge the diversity of learning approaches and that they were interactive. Whilst the vignettes are reported to be very diverse in their representation of parent and child factors and demographics, the parents within this study found the vignettes culturally restrictive. Although parents acknowledged that the purpose of vignettes were to promote discussion and not merely for passive observing, the vignettes had a tendency to distract parents and potentially detract from some of the messages that were being portrayed. Parents' dialogue was found to express some agitation that group leaders had to spend time redirecting parents and acknowledging their emotional response to the vignettes. The vignettes in fact actually appeared to offend some parents. Cultural context may be one explanation. Firstly, New Zealanders have long been exposed to the importation of American products such as overseas television programmes i.e American sit-coms and have had to struggle to develop their own national identity for television. Particularly the 1970s (when some of the BASIC vignettes were developed) coincided with the beginning of exposure for New Zealand to an in-flux of 'Americanized culture', and probably where the term 'Americanized' originates from for parents who used this term. The societal context of New Zealand is important to the delivery of IYrs PMT as there was a 'do it yourself' culture which had developed and one where New Zealanders became annoyed when ethnocentric views of other cultures were imposed over our own.

For New Zealand there is a long history of colonization where rights of Maori were violated by European settlers. The Treaty of Waitangi 1840 seeks to address the inequalities of colonization and oppression over our indigenous people. There are direct implications concerning the responsibilities of implementing Treaty principles and the application of IYrs PMT within New Zealand. Cultural relevance of IYrs to Maori is of prime importance and further exploration and research is required to meet the needs of Maori within the context of IYrs PMT with CAMHS. Even NZ European parents acknowledged that incorporating vignettes of families more representative of the Counties Manukau demographic would be appropriate. Unfortunately, specific exploration of experiences for Maori is beyond the scope of this study.

Male Concepts of Masculinity & Gender Role Stress within IYrs PMT

Socially constructed gender roles are recognised as important factors affecting the developmental, psychological and relational wellbeing of men and women (Gilbert, 1992). When fathers violate societal expectations of gender roles, negative psychological effects can be experienced. Gender role stress refers to emotional distress arising in response to a situation involving perceived violation of traditional gender role norms. Restrictive gender roles have been found to contribute to men's psychological distress. Gender role conflicts can create intra and inter-personal conflicts such as low self-esteem, low capacity for intimacy, higher anxiety and depression, abuse of substances and general psychological symtomology.

Therefore, for fathers attending IYrs PMT, the experience is one where gender role stress is induced to varying degrees reflective of how fathers have constructed the meaning of masculinity. This also has an important influence on fathers' involvement in fathering roles. The behaviour of fathers participating in IYrs PMT is guided and constrained by masculine gender roles in the context of being a man and father raising his children within South Auckland, New Zealand. As argued by Law et al (1999) cultural context and place in history is of prime relevance, and aids our understanding of the potential needs of fathers attending IYrs PMT within our population.

The identity and roles of fathers are challenged within IYrs PMT in the sense that their meanings of being a father, husband, in the NZ context have been guided by their own childhood experiences, their interactions with other men and societal assumptions or stereotypes. For example, there are the roles of 'breadwinner'. Providing for the family's wellbeing, and having an inner strength where they need to be stoic, all impact to reflect the responsibility that is devolved onto fathers. Consequently fathers have high expectations of themselves, particularly in coming up with solutions. The assumption of the kiwi bloke mentality reflects a dichotomy with the perception that attending a parenting programme is a sign of weakness. In early work, David & Brennon (1976) emphasized that traditional messages given to men are engrained and are thwart with assumptions of how men should behave. In fact, these still beset men and fathers today. Within the study, whilst fathers observed other fathers in the vignettes, these were fathers of a different time and place. It did not address the underlying struggle with roles and identify as a father living in NZ at this point in time.

Consequently, masculine gender roles emerge from a specific socio-cultural context and must be understood within that culture. Men are socialized to enact a wide variety of behaviours including family roles, work and sexuality. Pleck (1995) defines masculinity as a set of specific cultural messages reflective of a culture's socially constructed attitudes, behaviours and roles proper to men. National culture is an important contextual variable affecting masculinity. Law et al (1999) describes the traditional masculine role of the 'staunch kiwi bloke' who is a hard worker, resourceful and fearless, who provides for his family but is somewhat emotionally removed from them. There are a range of negative behaviours which stem from male stoicism such as the reluctance to reach out for emotional support. However, it is also recognized that NZ European fathers are increasingly only one representation of a culturally diverse population within Counties Manukau.

Culture and place in the life span appear to be salient influences on how men's gender role conflict relates to their feelings of self esteem and intimacy which they report in their relationships (Mahalik et al; 2001). Contextual variables affect how masculinity relates to psychological wellbeing-the culture in which they develop and live, and their chronological stage in life. This may suggest that for programmes such as IYrs PMT, fathers who are older may

have enhanced ability to relate to the programme, they may be less apprehensive about forming relationships within the group environment and sharing their experiences with others, they are more confident about contradicting expectations or norms of stereotypical fathering roles.

IYrs PMT was developed over 25 years ago in the United States but only in recent years within the NZ context. Its appearance is timely. We don't have to look too far within the Counties Manukau region to examine the effects of masculine gender roles. Fathers are now more involved in parenting and are actually challenging some of the traditional norms of masculinity that may contribute to interpersonal disconnection and psychological distress. It would be assumed that most men who attend IYrs PMT are involved fathers who provide nurturing and emotional support, just by their consent or interest to attend the programme. It would also be assumed that they therefore would be less emotionally restricted. However, there will be fathers who are reluctant to seek help and attend because they are persuaded to by their partner, spouse or clinician, but are motivated to become more involved. These fathers may exhibit more of the traditional masculine gender roles and accordingly exhibit behaviours that group leaders commonly have experienced and defined as resistance in the past.

The application of such beliefs to IYrs PMT can help us to understand some of the experiences and meaning that the programme has for the fathers who participate. Restrictive masculine schemas will restrict positive experiences fathers can gain from the programme and impede progress. Men may have been taught to neglect or repress the feminine parts of themselves. They can become frightened by feelings that seem womanly. They are socialized to be stoic and not show emotion, particularly vulnerability. Fathers do feel vulnerable within IYrs PMT. Fathers are required to participate in an environment that is acknowledged by both fathers and mothers as reflecting a feminine atmosphere. Fathers sit within a circle and may feel vulnerable when others are observing them. The programme emphasizes emotional expression which is incongruent with the messages of being in control emotionally i.e 'If I share my feelings with the group, they will think I am weak'.

Restrictive masculine schemas relevant to IYrs PMT must be acknowledged and addressed to prime fathers for success as they embark on IYrs PMT. For example, attending IYrs is incongruent with traditional masculine gender roles such as self reliance and having emotional control over vulnerable emotions. Therefore, IYrs PMT has the ability to seek to address the expression of anger or aggression that has been portrayed as an emotion historically viewed as acceptable for men or fathers to express more readily.

Parental Mental Health Implications for IYrs PMT

The prominence of psycho-social stressors for both mothers and fathers is another external conflict which exists and impacts on the group process and acquisition of learning, particularly when stressors are heightened and there has been recent disruption for parents. For example,

IYrs PMT may coincide with a period where the parent is still adjusting to life as a single parent. The ability of parents to form connections with others in the group can be jeopardised. To complete IYrs PMT during a period where mental illness may be acute (i.e a major depressive episode) can be detrimental to the parent attending. Unaddressed mental health issues cannot be attended to within the scope of the programme as it is not a therapeutic group for parents with mental illness. This can have profound implications for the child as it not only defeats the principles of IYrs PMT which contribute to and consolidate protective factors for the child with disruptive behaviour but should also enhance relationships. Research has frequently found the presence of mental health issues in parents attending parent management training as an associated risk factor to conduct problems in children. The programme does incorporate material for parents with depression by focusing on helping them to stop spiralling negative self talk and modifying negative thoughts (Webster-Stratton, 1998). However, parents who have severe symptoms often lack the ability to integrate the material at home and would require extra support if they were to complete the programme at this time i.e adult mental health services, support groups, mentoring or medication.

Group Therapeutic Processes

IYrs PMT has been defined as a skills-based group, but this does not preclude the programme from providing a therapeutic experience for parents. It is most evident that parents encountered processes that contributed to their personal growth and development (Drum & Knot, 1977) and factors that contribute to their group experience (Yalom, 2005).

Various co-morbid diagnoses of the children and the diversity of children's symptoms as well as the varied stressors within families reflected the complex behaviours with which the parents had to contend. This resulted in some parents reflecting that they found that they had more unique or difficult circumstances than other parents within their groups and the programme content had not covered more difficult aspects of their child's behaviour. However, in the parents' narratives, IYrs PMT was also shown to disconfirm a parent's feelings of uniqueness. This has been described as a powerful source of relief and relates to the concept of universality (Yalom, 2005). Many parents soon perceived similarities to one another when other parents disclosed problems similar to their own. In terms of the principle of universality, cultural issues for Maori may include different cultural attitudes toward disclosure, interaction and affective expression. In fact, it has been recommended in working with other cultural groups, that group leaders encourage groups to move past a focus on concrete cultural differences to trans-cultural, more universal responses to problem situations (Tsui & Shultz, 1988). This has also been reflected by Webster-Stratton in her recommendations that IYrs PMT is cross culturally appropriate but she cautions against adaptions. This remains an area for further debate as under Treaty obligations Maori are entitled to both indigenous and culturally adapted mainstream programmes (Manawanui Marae Based Group Evaluation, 2009 & Cargo, 2008).

Parents in this study did start to feel more hopeful in many respects about their child's disruptive behaviour when they were attending IYrs PMT. Instillation of hope occurred within the group process and it is necessary for parents to be receptive and engage with the group's principles. Yalom (2005) states that having faith in the mode of therapy can itself be therapeutically effective. It is well evidenced that a high expectation of help before the start of therapy is significantly correlated with a positive therapy outcome. Therefore, clinicians have a primary role in structuring parents for success prior to embarking on IYrs PMT. This is reflected within the theme of therapeutic work and treatment.

Altruism was a feature of the parents' experiences within IYrs PMT and they reported personal gains, not only from receiving help but from giving help. Parents profited from something intrinsic to the act of giving. Most parents felt they had something beneficial to offer the group. Role versatility was encouraged within the group. This required parents to shift between the roles of help receivers and help providers (Holmes & Kivlighan, 2000). Parents who worked in related field's i.e nursing also felt the IYrs PMT could be applied to helping others in their own employment setting.

Social Learning Principles

Social learning is present within IYrs PMT and is an opportunity for parents to enhance their own social skills. IYrs PMT helps parents become attuned to process, learn how to be helpfully responsive to others, acquire methods of conflict resolution, and become less judgemental and more capable of experiencing and expressing empathy.

There is considerable evidence that group leaders influence communication patterns within the group by modelling certain behaviours. This is referred to as imitative behaviour. Parents may model their behaviours on aspects of other group members as well as the leaders. They learn from watching one another tackle problems. Bandura (1969) has demonstrated that imitation is an effective therapeutic force. In IYrs PMT parents benefit from observation of the process of another member with a similar problem constellation. This has also been described as vicarious therapy (Bandura, Blanchard & Ritter; 1969; Bandura, Ross & Ross; 1963). Imitative behaviour can help unfreeze an individual enough to experiment with a new behaviour.

Interpersonal learning has been identified as the need to be closely related to others and is defined as being as basic as any biological need (Yalom, 2005). Parents require acceptance by and interaction with others. A person's sense of self is constructed through their appraisals from others. Parents also acknowledged and praised in their narratives parents that they had admired or the transformation they had observed. Improving interpersonal communication is the focus of a range of parent interventions. This is a focus as poor communication of children's needs and of parental expectations, can generate feelings of personal helplessness and ineffectiveness in both children and parents.

Yalom (2005) also argues that internalized images of past relationships do not occur primarily through interpretation and insight, but through meaningful here-and-now relational experience. This has the potential to disconfirm the client's pathogenic beliefs (such as parents practicing different patterns of communication with children). When such disconfirmation occurs, Yalom argues that change can be dramatic. Clients may express more emotion, recall more personally relevant and formative experiences, and show evidence of more boldness and a greater sense of self. This corrective emotional experience reflected within groups is also relevant to IYrs PMT and consists of several components. It was evident that parents did display a strong expression of emotion at times, which was interpersonally directed and constituted risk taking by the parent (evident where parents may be reluctant to engage in role playing for example). Parents generally found IYrs PMT to be supportive and encouraging enough to permit risk taking. Reality testing occurred which allowed parents to examine incidents with the aid of consensual validation from other group members. This was particularly apparent in discussion of home activities for parents. There was recognition of the inappropriateness of certain interpersonal feelings and behaviour or of the inappropriateness of avoiding certain interpersonal behaviour. This can relate to both mothers and fathers who are testing their assumptions of gender roles, their expectations of each other and related behaviours. The group leaders encouraged facilitation of the individuals' ability to interact with others more deeply and honestly. The collaborative emphasis enabled parents to validate their feelings and explore their communication patterns by testing these within the group and then within their own families.

Some parents within the study provided negative feedback towards the programme and despite the difficulties that were expressed by some parents, particularly with mental health issues, or other stressors, they did keep attending the programme (parents were included in the study if they had participated in over 50% of the sessions). This suggests that there were enough positive aspects of the programme which attracted parents to continue attending, that they had the support to attend (such as a couple attending and encouraging each other), or had developed a connection to the group experience

Fidelity/Enhancing Treatment Outcome

Ensuring the fidelity of the programme is maintained in delivering the group also has repercussions for the connectedness of the parents within the group. Buddy calls were not consistently applied (as previously found in a study by Stern et al; 2008. This resulted in more vulnerable parents feeling less supported and connected to other parents within the group. Depression can also detrimentally affect the process of learning when parents are exhausted, have a negative self-bias and continually compare themselves to others that they may see as "better" parents than they are.

The study highlighted the benefits for two families of medication and parent management training in combination which is widely reflected in the literature (MTA Cooperative Group, 1999). Parents of children with ADHD reported that strategies from IYrs PMT were easier to implement once children had commenced on methylphenidate. The presence of co-morbidities where clinicians and parents were still trying to understand the child's behaviour in diagnostic and treatment terms; did generate more ambiguity in relation to the progress the child had made due to their parents attendance in IYrs PMT.

Emergent Attributions

Attribution theory is particularly relevant in understanding how the meanings parents attribute to their child's behaviour changes following their attendance at IYrs PMT and in forming new actions and behaviours. Parental knowledge acquired assists in the child's development of compensatory behaviours. Segal (2001) postulates that the parent assimilates the information and utilises it for the benefit of themselves and their child. They then must recognize how the disorder impacts uniquely on their child, discern what areas of cognition or perception are affected, and then attempt to understand how their child's behaviour can be framed in the light of that understanding. If they are successful in achieving this learning, then they will be in greater control of the situation. They will no longer view their child's behaviour as controlling, deceitful, lazy or vindictive. Rather than exhibiting annoyance because parents may feel they are being manipulated by the child, they come to view the behaviour as the child's way of seeking a response to a need and they can attempt to understand the need and develop a helpful response to the child's behaviour. Segal's explanation may help us understand why parents who do not have a formal diagnosis of their child's behaviour encountered more difficulties in applying IYrs PMT. It appeared that any ambiguity regarding diagnosis or understanding of the children by mental health professionals (such as having no formal diagnosis or explanation) resulted in greater difficulty for parents in applying the programme and sustaining the learning from the programme. This may be in part because the parent needs to process how the disorder impacts uniquely on their child first for example understanding the expression of symptomology. Therefore, the more thorough the assessment that occurs prior to IYrs PMT, the more likely the parent can assimilate the information and utilise it in the context of IYrs PMT.

Enhancement of Self-Esteem & Self Efficacy

The group environment is one where parents' self esteem is enhanced by positive reinforcement from others. Parents are not judged by others and are supported and reassured in the company of other parents. Self care strategies are employed more regularly by parents. The development of an enhanced sense of self is inversely related to the concept of learned helplessness. As parents overcome learned helplessness their sense of self and self esteem is re-established. The study highlights how parents attending IYrs PMT can feel that they do have the ability to improve child, parent and family functioning and wellbeing.

Parents of children with disruptive behaviour have been reported to have forgotten their identity as individuals other than parents (Webster-Stratton, 1998). This had certainly been evident for parents within this study. The emphasis on parents nurturing themselves was highlighted for parents particularly as they observed the transformation of other parents within the group. The group experience appears particularly significant for the development of self care and self esteem as parents will receive positive reinforcement from other group members, and therefore are more likely to continue these behaviours from the support that they receive.

It was evident that following IYrs PMT parents' self efficacy had been enhanced. Parenting self-efficacy was initially identified by Bandura (1977) as an estimation of the degree to which parents perceive themselves as capable of performing the varied tasks associated with their highly demanding parenting role. Parenting self efficacy has been associated with a variety of characteristics including greater awareness of opportunities to educate oneself about parenting. Therefore, the process of parental self efficacy may have commenced as parents initially started to escape from positions of learned helplessness (particularly for mothers as they embarked on researching) and become more established as they were provided with psycho-education and embarked on IYrs PMT. Further, efficacious parents can be described as working diligently to combat risks and provide positive experiences for their children, even in the presence of multiple stressors (evident in their advocacy with skills and other services). Therefore, it is evident that parents with high efficacy in parenting will be in a much better position to deal with the unique challenges associated with parenting their child with disruptive behaviour.

Consistent Parenting

'Being on the same page' highlighted the benefits of couples attending IYrs PMT training together. The benefits include more consistent use of parenting strategies. Because parents were incorporating collaborative approaches with each other and the child, it also enhanced relationships between parents and children, as well as the marital or couple relationship. Parents who had attended together, could problem solve future behaviours they wished to resolve using more effective means of communication and problem solving applied from principles within the programme. Further, they were aware that supporting one another was crucial to maintaining changes. The importance of both parents attending IYrs PMT together is well reported in the literature. The benefits are largely due to improved maintenance of treatment gains (Bagner & Eyberg, 2003; Patterson, Mockford & Stewart-Brown, 2005; Strain, Young & Horotiz, 1981 & Webster-Stratton, 1984). This study has further articulated the benefits of parents attending together. This is related to consistency and enhancement in the parental relationship.

A higher level of authoritarian parenting has been found in families of children with ADHD (Lange et al, 2005). Whilst the study did not explore actual levels of authoritarian parenting,

parents did discuss differences in parenting style of authoritarian versus more permissive parenting. It is likely that parents exhaust all positive avenues at their disposal including behavioural strategies when managing their child, and consequently parents can become increasingly polarized in their approaches. This was particularly evident in couples where mothers researched the literature, whilst fathers were more reluctant to do so.

Rewriting Family Scripts

The Incredible Years group can resemble a family in many respects. This can include authority/parental figures, peer/sibling figures, deep personal revelations, strong emotions and deep intimacy as well as hostile competitive feelings. It has been stated that once the initial discomfort is overcome, it is inevitable that, sooner or later, the members will interact with leaders and other members in modes reminiscent of the way they once interacted with parents and siblings (Yalom, 2005). Of important significance, is that early familial conflicts are relived correctively. This is achieved by exploring and challenging fixed roles and having ground rules which encourage the investigation of relationships and the testing of new behaviour. Working out problems with group leaders and other parents can help work through historical unfinished business from families of origin. The role plays which are a central component of IYrs PMT are crucial to practicing, trialling and discussing new behaviours. This occurs with support from others in a positive learning environment prior to implementing new strategies at home where more barriers are encountered.

In many ways the purpose of IYrs PMT is to effectively re-write the 'family script'. Byng-Hall (1995) defines a family script as the family's shared expectations of how family roles are to be performed in various contexts. Expectations include anticipation of what will be said and done in family relationships, as well as involving family pressures on members to perform the role as expected. There is a shared working model of how the family functions. Parents' expectations of how roles are to be performed are based on those experienced in their family of origin, following what is called a replicative family script (Byng-Hall, 2008). The concept 'being on the same page' applies to couple relationships where the family script has been re-written. One example is one mother describing how her husband no longer "rescues" her or where the child diagnosed with ADHD no longer has the expectation of the role of "being naughty" or "being the boss".

Byng-Hall (2008) refers to 'corrective scripts' where parents may do the opposite to their parents in an attempt to correct mistakes they felt their parents made. Often there is a blend of corrective and replicative behaviour. Mini-scripts can be acted out over a few seconds or a few minutes. This would include cycles of interaction such as when a child is yelled at to go to time out and refuses, the parent has to take them kicking and screaming, locking them in bedroom, the child 'trashes' the room and shouts at parents, parents engaging in an argument from the other side of the door. Scripts also include plots where meaning is given to the pattern of

interactions and these meanings are linked to belief systems. Family scripts are linked to shared belief systems. The experiences of the family will create a set of beliefs about its members and their reciprocal patterns of behaviour. These beliefs are stored in cognitive models of their relationships, which in turn influence the behaviour of each individual as the interpersonal context triggers customary responses. The cycle can become like a precise script which is rolled out for every occasion, even novel situations. There has to be new behaviour and ideas but this has to be compatible with the beliefs of the family if the new way is to be maintained. This may explain why parents who are completing IYrs PMT may face opposing beliefs from other family members, or extended family members. The solo parent who is raising her son on her own may face opposition from other family members (in particular from her own siblings) about the new ideas she is discussing with them. They may have had shared replicative scripts, which have historically united them and are now being challenged, as one sibling strives to employ what she views as a 'corrective script'. Culturally, the model of family scripts has important ramifications as cultural parenting practices may also indeed be challenged and conflict may occur in the home as attempts are made to introduce new corrective scripts to the detriment of traditional ones which are embedded in cultural practices. In essence a script provides stability for a family. If members wander beyond the scripted routine it will be noticed and if the 'errant' behaviour seems to threaten the stability of the family, attempts are made to bring that family member back into line. Parents are likely to be more aware of the opposition that they face from their child when they initially implement new strategies at home, but Byng's theory may help explain why extended family whanau are important in influencing the parent's success, particularly when they are more involved with the child and parent(s). The change in family practices threatens the stability of the family/whanau. Many of the families within the study encountered multiple stressors in their environment which at times threatened their stability. Therefore, they became sensitive and vulnerable to change.

NEW MEANINGS AND ACTIONS

The theme of new meanings and actions encapsulate the parents' process of change within psychological processes such as cognitive restructuring; self efficacy and empowerment and enhancement of family relationships (Appendix F). Irrespective of many of the difficulties, criticisms or issues raised regarding the delivery of IY's PMT most parents rigorously advocated the benefits of the programme in enhancing family wellbeing. This was particularly evidenced in the children who had exhibited self harm or suicidal ideation preceding their parents' attendance at IYrs PMT and the parents' report of a reduction in these symptoms.

Cognitive Restructuring

Cognitive restructuring was central to parents' ability to implement the strategies acquired from IYrs PMT. Therapeutic change occurred when parents were able to apply alternative explanations to their child's disruptive behaviour than those which had been presented prior to IYrs PMT. These prior explanations had predominantly implicated the child and resulted in

negative ruminations about the child as well as coercive parenting strategies. Cognitive restructuring enabled parents to alter their emotional and conceptual view of the experience of their child's behaviour, which is described by Webster-Stratton (1998) as placing the experience in another 'frame' which fits the fact of the situation well, therefore altering its meaning. Parents' narratives within this study reflected the changes in perception by most parents so that their child's behaviour was not perceived as intentional and vindictive, but as a reflection of the expression of their symptomology, their developmental stage and the interactions of parental behaviours on child behaviour. Once parents understood the implications of their own perceptions they appeared more receptive in applying the advocated strategies. Segal (2001) has also reported that mothers of children with ADHD were sustained by adopting unique attitudes that enabled them to cope. This included a 'reframing', of what life was about, the need to dream different dreams, to change expectations, and not to cling to old ones that were not particularly relevant.

Family Empowerment & Advocacy

Family empowerment and the development of advocacy skills for parents have been previously cited as a positive outcome of IYrs PMT and other variations of PMT (Singh & Curtis, 1997; Webster-Stratton, 1998). In the context of mental health services delivery systems, family empowerment has been conceptualized as a process by which the families access knowledge skills and resources that help them to gain positive control of their own lives as well as improve the quality of their life styles (Singh, 1995). The benefits of parents learning advocacy skills and becoming empowered once they obtain knowledge about their child's behaviour, is that they can start instructing other professionals and family members in the management of their child (Segal, 2001). The overall goal is that the parents become experts, therefore negating the necessity of the presence and intrusion of agencies unnecessarily into the parents' life. Several parents within this study appeared to have made progress in developing and consolidating advocacy skills for their child and also were able to generalize their knowledge to help others if this was relevant in a professional or personal setting. The study highlights the importance that IYrs PMT and CAMHS services have in serving a vital role in facilitating or assisting families to empower themselves within the mental health system and educational systems as well as securing services for their child and family.

Enhancing Parent-Child Relationships & Promotion of Wellbeing

Enhanced parental-child relationships following IYrs PMT were found in this study and are frequently reported in the literature (Patterson et al; 2005; Grimshaw & McGuire, 1998). As parents learned and modelled more desirable behaviours to their child, these behaviours were also transferable to others such as partners and professionals. The acquisition of knowledge, the awareness of parenting behaviours on child behaviour and the development of more empathy toward their child appeared to contribute to enhanced wellbeing within relationships. The primacy of the focus of the parent-child relationship is at the base of the parenting pyramid

used within the programme. It is a principle which is continually emphasized. It is encouraging that parents continued to reflect on these principles up to 18 months following their attendance, and consciously made the time to spend with their children.

It was acknowledged that some parents were still struggling with their relationships with their children. In these instances, it was likely that psychosocial stressors were having an impact on the ability of parents to make and sustain beneficial gains from the programme or that parents were still struggling to understand the meaning of their child's behaviour. This was more difficult when parents had not received a formal diagnosis for their child or when co-morbidity was present.

Two children within the study had exhibited either suicidal ideation or self-harming behaviour. Billy's (7) mother had sought help after he had made a suicide attempt and he was found with a belt around his neck. Research suggests that younger children tend to use less complex and more easily available strategies such as hanging. This incident came as a shock to Billy's parents who were extremely alarmed. Thompson et al; (2005) has found that parents of approximately 75% of 8 year old participants reporting suicidal ideation were unaware of the problem. Young children exhibit fewer warning signs and links to precipitating factors than adolescents. In Billy's situation, his father spoke of his heartbreaking dilemma in having to cut off all ties to his brother (Billy's uncle). This was due to a suicide attempt he had made prior to Billy's attempt. The rationale for this decision was due to Billy's parents questioning how this had influenced and impacted on Billy, and whether this had precipitated Billy's behaviour. If this had been the case, then they could not possibly risk any further exposure to prevent the possibility of re-occurrence. It appears that there is a foundation to the insight that Billy's parents expressed about this potential link. In fact, research suggests that the attempted or completed suicide of a close relative can have tremendous impact on children and can lead them to consider or attempt suicide (Tishler et al; 2007; Pfeffer et al; 2000).

Another child within the study was exhibiting self-harming behaviour such as "whacking himself"; he was having thoughts about death and expressing hatred of himself and his mother. Whilst the behaviours that children exhibited prior to their parents attending IYrs PMT were very distressing for parents to cope with and attempt to manage, it is highly likely that these children were frequently experiencing a range of negative thoughts. Research indicates their vulnerability to suicidal ideation (Tisher et al; 2007). Negative thoughts are probably not always articulated by younger children towards their parents (as suicide attempts often come as a complete surprise to parents of younger children). Nor were parents aware of the detrimental impact that these constant negative interactions had on their children's emotional wellbeing.

Environmental, contextual and demographic factors all impacted on the child's vulnerability to suicidal ideation. It was encouraging that the symptomology of suicidal ideation in these

children was reduced following the attendance of the parents at IYrs PMT. It was extremely reassuring to parents when they could track the progress of their children's behaviours and observe distressing self-destructive behaviours diminish and be replaced with more positive behaviours (both parent and child) enabling the development of self-esteem and enhanced relationships with their child.

PRESERVATION

Relapse Prevention

Maintaining treatment effects from IYrs PMT has been well explored in the literature (Reid, Webster-Stratton & Hammond, 2004). However, there has been little to reflect how parents feel they manage preservation of treatment outcomes. This study provided some insight into how parents felt they were managing over 1-18 months post IYrs PMT. Parents attempt to remain peacekeepers within their household following IYrs PMT (Appendix F). They are most aware that they need to review information that has been learned to prevent difficulties from re-surfacing. In clinical terms, we refer to this process as relapse prevention. Clinicians are required to implement relapse prevention planning into their clinical work with clients to ensure they have resources or skills to prevent their child's behaviour from deteriorating, and where possible, from being re-referred to a Child and Adolescent Mental Health Service (Dunnachie, 2007).

The difficulties for parents in sustaining behavioural changes can be explained by Bandura's social learning theory (Bandura,1969). Parents who have acquired and are capable of reproducing new behaviour as a consequence of learning from modelling and rehearsal, may still not produce this behaviour in the absence of positive reinforcement (Patterson et al; 2005). This can explain the difficulties that occur when other family members are not supporting the new strategies and skills. Parents within this study advocated the benefits of attending as a couple. The recommendation that parents should attend together has previously been advocated by researchers as it ensures greater maintenance of treatment effects (Bagner & Eyberg, 2003; Webster-Stratton, 1984). It is also apparent (due to the important influence of extended family) that parents attending on their own would benefit from having another close family member attend. This appears particularly pertinent for parents within this study who disclosed that the impact of mental illness impeded their ability to participate within the group and make sustainable changes. A support person attending is highly recommended by Webster-Stratton and also has been shown to reduce the risk of relapse (Webster-Stratton,1998). The barriers of course, for many parents in having their closest family member attend, was that this person was often the babysitter. Whilst Webster-Stratton advocates that quality child care is essential in order for parents to be able to attend parent training; this availability is confounded by funding restrictions, the bureaucratic red tape for agencies to meet health and safety standards for providing childcare services, and the lack of skilled staff, centres

and accessibility to provide the care for children with disruptive behaviour within the region. CAMHS services within New Zealand would acknowledge difficulties resourcing supports for parents to attend in the capacity that is recommended by Webster-Stratton such as assistance with transport, childcare, and meals.

It is apparent that parents often feel personally responsible for lapses in sustaining the positive effects of attending IYrs PMT. Based on the dialogue from parents and supporting literature, parents with mental health difficulties and mothers parenting without father involvement may find it more challenging to sustain their progress. Parents who still do not fully comprehend the meaning of their child's behaviour also seem to struggle to support the principles within the programme (sometimes during and after the programme) as well as parents with complex interactions of symptomology present within their child's behaviour, reflective of co-morbid conditions. It is acknowledged that it is probably more likely that parents of children who reflect these complex behaviours are still receiving assistance from CAMHS clinicians who may assist in providing wrap around services for these children and require constant medical reviews and monitoring by clinicians.

THE RESEARCH PROCESS

It is acknowledged that the researcher has played a role in influencing the research process through researcher-participant interactions, more specifically referred to as reflexivity and relationality. The data was created through interviews. These have involved interactions and creation of meaning between researcher and participant. Therefore the quality of the data has been influenced by the nature of the relationship between researcher and participant.

Relationality addresses power and trust relationships between participants and researchers. Trust within the relationship may have been influenced by the researcher's role as a clinician at Whirinaki, as a group leader of IYrs PMT and as a student. The environment where the interview was conducted would have also contributed to the ability of the participant to engage with the researcher, as interviews were conducted at participants' homes, at a workplace and the researcher's workplace-Whirinaki which was an environment which participants were also familiar. For example, one couple were interviewed in their caravan, (individually) which was parked in the driveway to avoid disturbance from children within the household. Unfortunately in this environment, the positioning of seating arrangements (facing closely directly opposite one another) was not conducive to creating an easy flow of discussion and was also interrupted at times by trains going past the back fence. Another two participants were interviewed after work as they were employed full time. Tiredness was likely to have impacted on the interview and one participant had commented on this at the time. Confidence and participants believing they had the ability to contribute quality information was also a barrier. Initially at the beginning of interviews interactions involving reassurance were required to place participants at ease. Relationality also recognizes connections between the researcher and the participant. There

were commonalities between the experiences of participants and researcher at times which assisted in the ability to develop trust within the relationship. This was particularly evident where the participants were nurses, for a father who was a youth worker, and for other parents who had completed university papers in human behaviour or counselling.

LIMITATIONS

The data within this study was collected from parents who had completed the IYrs PMT approximately 18 months preceding the interview. Therefore, specific details and information were potentially lost for those participants who had difficultly remembering their experiences of the programme.

There were no psychometric measures or rating scales that had been regularly compiled from the groups that had already been held at Whirinaki. It is acknowledged that incorporating quantitative measures would have complemented the data collected. However, they were unable to be sourced for the current study. HONOSCA (Health of the nation outcome scales for children and adolescents) were considered but discarded due to the information being collected for other purposes and ethical consent would have been difficult to source.

The participants were not representative of the ethnic diversity of the Counties Manukau population, although the participants were representative of the parents who are likely to be referred to the programme. There were few Maori or Pacific Island parents participating in Incredible Years in 2007. Extent of transferability of findings to other cultures is limited as most participants in the study were NZ European. The transcripts of the two participants who identified as Maori indicated that they had positively benefited from attending the programme. They had both attended on their own within a mainstream framework (no specific cultural adaption was included for Maori parents or incorporation of Maori models of mental health). The experiences of these two participants cannot be generalized as they had unique circumstances which would not necessarily be reflective of other Maori participants who attend IYrs PMT within this setting and may have contributed to their enhanced outcomes within the mainstream delivery. The researcher was not Maori and explicit cultural understandings of meaning and experiences of IYrs PMT for Maori participants was not within the scope of this study. However, this has the potential to be explored at a later date with the expansion of IYrs PMT delivery within this setting to incorporate kaupapa Maori protocols within a marae-based setting and delivered by Maori group leaders trained in IYrs PMT and Maori models of mental health.

It is likely that parents participating in the study were reluctant to discuss experiences which would be very personal for them such as family violence issues, child abuse, marital satisfaction or alcohol abuse. Parents appeared more open to discussing some of these factors when it was about an ex-partner or about a childhood experience, where there were no direct

implications from disclosing such issues. Parents were likely cautious about disclosing coercive parenting strategies due to the current legislation making physical discipline a criminal offence. Therefore, there was limited information acquired regarding the effects of IYrs PMT on coercive parenting.

It is possible that those who agreed to be interviewed had more positive experiences than those who were not interviewed. No prior knowledge was known about parents' specific demographics when they were contacted. It is acknowledged that there would be parents who did not attend IYrs PMT after it was recommended by their clinician and there would have been others who dropped out of the intervention. Therefore, it is unknown what the experiences of these parents might have been. The inclusion criteria had stipulated that parents needed to have completed at least 50% of the sessions. Therefore the study would have gathered data from parents who were more committed to attending and may have failed to gather more negative experiences or the impact of having more difficult circumstances (as it is more likely that these families would have dropped out). Fathers may also have been more unwilling participants in IYrs PMT because they have not attended of their own volition. It is predominantly the child's mother who accesses services.

IMPLICATIONS FOR CLINICIANS AND FUTURE DEVELOPMENT OF IYRS PMT WITHIN WHIRINAKI, CAMHS

The delivery of IYrs PMT within a CAMHS service has many benefits to child, parent and family functioning. Group leaders are drawn from a large pool of clinicians (Whirinaki now has over 70 Staff); from multiple disciplines and cultural backgrounds, and reflecting a diverse range of experience within child and adolescent mental health. Clients are regularly reviewed by multidisciplinary teams and each child has a case management plan. IYrs PMT is not an isolated intervention but is located within a systemic focus incorporating various treatment options. Delivery of this treatment option to parents requires planning, timing, discussion of relevance and progress. Group leaders, key clinicians and other team members can update one another regularly on the progress of families participating in the intervention. The environment can provide flexibility for family circumstances such as holding evening groups outside office hours. This is crucial in enabling both parents to attend, or solo working parents to attend.

The study has highlighted areas of clinical practice which parents have appreciated and acknowledged as having contributed to a more positive experience for their participation in IYrs PMT. Engaging parents and adopting a collaborative and therapeutic relationship is a key message that reminds clinicians that this is of prime importance prior to any clinical intervention. Parents' perceptions of the service they receive also serves as a reminder to clinicians to express humility that parents (particularly mothers) can actually be more resilient and resourceful than clinicians often give them credit for, and demonstrate a commitment to seeking

out knowledge to enhance their understandings. Parents may perceive they are being judged by clinicians. Clinicians may display a wariness regarding information that is collected by parents, believing parents to be ill-informed, or that they are making their own assumptions regarding diagnosis about their child. This can also be an impediment to the parent's progress at overcoming their sense of learned helplessness. The contrast of the IYrs PMT approach is that parents are the experts for their own child. Therefore, a more in depth and collaborative approach for clinicians with parents regarding their understandings, the meanings they ascribe to their child's behaviour based on any knowledge that they have gained and what has been the most helpful formulation at this stage for them, may actually help enhance understanding from the parent's perspective. Entering into a collaborative relationship with parents helps dispense with the notion of judgement. When parents believe they are valued and have a voice, then they feel they have a sense of empowerment and can contribute equally within a therapeutic relationship. Experience of collaborative relationships helps provide a framework for coping and enables parents to resolve problems in conjunction initially with their clinician or group environment and then with their child or other family members. The parenting role of mothers and fathers vary and require acknowledgment. Clinicians should endeavour to encourage both parents to attend IYrs PMT. Parents' attending together is crucial as it enables parents to have the ability to work consistently and be united as parents and is also shown to improve relationships within the family unit including the couple relationship.

The varying experiences for parents reflect the need for a consistent approach in the way in which IYrs PMT is introduced. New strategies have been implemented since these parents were introduced to IYrs with the introduction of information sessions for parents by group leaders more familiar with the programme. However, it is acknowledged that further improvements could be made such as staff training about IYrs PMT for staff less familiar with this treatment option and incorporating an information package for families to take away and discuss. Parents do need reassurance and specific information prior to the group which has the potential to lessen their apprehension about attending. There is a need to emphasize the importance of IYrs PMT as a psychosocial intervention which requires reflection by the clinician as to the appropriateness of a referral. The scaffolding which is required to ensure that the parent has been adequately prepared for the programme is also important. It is imperative that parents who display psychopathology are carefully screened for their ability to participate and are well supported and encouraged to attend with a support person.

Parents would benefit from being provided the opportunity where possible to meet with clinicians individually to help process the meaning they apply to their child's difficult behaviours, to provide the opportunity to develop a therapeutic relationship with clinicians and the forum to debrief about their experiences of their child's disruptive behaviour. This process will help prepare the parents referred to the IYrs PMT and provide an opportunity for the parent to collaborate with clinicians regarding the information that is presented about the programme as

well as discussing goals they would like to work on. Due to pressures within CAMHS services, with increases in referral numbers and more formal processes around assessment protocols, often this work is short circuited. Parents don't have the luxury of necessarily having their own needs upheld within this process. The intricate cause and effect relationships between parent and child wellbeing is a complex one to address. If clinical work prior to IYrs PMT focuses more on developing an awareness of how children's behaviour is conceptualized within families and the meaning of this for the parent; rather than it being more focused on psycho-education for the parent, then parents may become more open and receptive to interventions involving them. They may be more receptive to IYrs PMT as their own ideas have been presented and acknowledged.

Group leaders can also capitalize on parents who have a high expectation of help before IYrs PMT by using their skills to increase the parent's belief and confidence in the efficacy of the Incredible Years Group and orientate parents to the IYrs PMT Philosophy from the outset of the group. Information evenings or group leaders meeting parents prior to the group are a great opportunity to reinforce positive expectations, correct any negative preconceptions and present future benefits of IYrs PMT prior to the group commencing, allowing parents to be more engaged and prepared when the group does commence.

Ensuring that information evenings are maintained would provide an opportunity for parents to be fully informed about the programme so that they are in the best possible position to make the decision whether the timing is right for them to complete the programme, that they are personally ready for the programme, and that this be discussed in conjunction with the clinician following the parents' attendance at the information evening. Timing has been shown to be an important factor in scaffolding parents for success and relates to other commitments and interventions that the parent is currently completing, or psychosocial factors such as financial restraints/work commitments and even mental health factors.

Demographics of parents within the group composition and how parents felt similar to other parents were observed as contributing to the group's connectedness. It is apparent that the composition of the group requires more planning to ensure that parents are able to have opportunities where they can learn and relate more effectively to others (i.e more balanced composition of couples within the group, or the presence of more than one stepfather within a group)

The ability of parents to cope with their child's disruptive and challenging behaviour within the context of IYrs PMT is enhanced by co-existing treatments provided through Whirinaki. The benefits of delivering IYrs within a CAMHS service is that it exists within an organisation where various other treatments can be provided using clinicians from multi-disciplines and incorporating a systemic approach which has the potential to tailor treatment plans according to

the effectiveness of treatments for the child and changing needs of the family. It is noted that the introduction of methylphenidate enables some parents to be able to sustain their own behavioural responses. They appear to demonstrate more resilience to deal with difficulties when the child is more attentive and compliant to instruction. When the children are extremely oppositional or challenging, parents experience a heightened emotional response in attempting to implement strategies such as time out. It is likely that their ability to endure these moments are met with cognitions that there is not much point, therefore creating a re-emergence of helplessness and resulting in a lack of follow through with required actions.

The study highlights the need for regular supervision, mentoring, training and accreditation processes that are followed in conjunction with the Werry Centre Parent Management Training project to further up-skill group leaders and help ensure that the fidelity of the programme is maintained. Several aspects of the programme were not maintained that would help ensure that particular parent cohorts received desirable treatment gains. This would include parents with mental health concerns. For example, buddy calls did not occur, success for parents with role plays and the structure of the group demographic at times resulted in parents feeling uncomfortable about being too different from the other parents. This was evident for parents who indicated that they had been the only couple, only sole parent, that they were the only one who was suffering depression, or that they had multiple stressors and difficulties that other families did not experience.

Group leaders do frequently face challenges encouraging group members to make buddy calls to support one another. Parents who feel they have nothing in common with other parents are often reluctant to contact people. When this process is not maintained, it appears to be the parents who face greater challenges or adversity that struggle the most. Flexibility around contacting others is a possibility and using technology to enhance the level of support that parents offer one another could be encouraged such as texting, emailing, or even having a blog site where they can chat to one another as they try to implement their strategies at home. Male Group Leaders are important in the sense that they can potentially play a central role in the ability of fathers to start to feel comfortable in an unfamiliar environment which is described as being more conducive to mothers. Male group leaders have been reported to have the unique opportunity to be a powerful role model, exhibiting behaviours, values and beliefs that are not constrained by the typical male gender stereotype. Even more evident is having male group leaders who represent the needs of the Counties Manukau population particularly Maori, Pacific Island, and other immigrant groups who are demographically increasing in population (i.e Indian, and Asian).

An emphasis on involving fathers in clinical work preceding IYrs PMT and encouraging fathers to attend the programme is clearly required. The experience of couples attending the programme together suggests outcomes are further enhanced when parents attend together.

This results in unity and consistency in parenting. It has important ramifications for relapse prevention as both parents are empowered to problem solve (using the programme structure) and will need to communicate effectively to do so, as they will inevitably experience new challenges as their children develop. Clinicians should be cautious about deflecting responsibility solely to mothers, and advocate the involvement of fathers in IYrs PMT where possible, taking time to involve the fathers in clinical work prior to IYrs PMT and to be persistent with this. The fathers who were interviewed had been involved in clinical work and the father who wasn't had been personally contacted by the clinician who ensured that he had written information and was well informed about IYrs PMT preceding the group.

The clinician's role in engaging fathers prior to IYrs PMT also has the potential to assist in modifying restrictive masculine schemas. There are various therapeutic modalities which may be appropriate such as cognitive therapy or family therapy models. Information evenings could include a component of discussion of how fathers may experience gender role stress as they have been socialized into societal expectations of gender roles and that attending IYrs PMT would actually violate these and create stress, as they are involved in behaviours such as help seeking, feeling vulnerable, and talking about one's emotions. However, the benefits in the long term will contribute to enhancing their family/whanau wellbeing. As fathers they also have an important role in challenging many of these restrictive schemas which have been shown to be detrimental for their own psychological wellbeing as men, as well as to their relationships and family.

Group leaders can also play a role in encouraging cognitions for men that challenge traditional masculine restrictive schemas and promote their understanding of why they are restrictive. Whilst the programme includes vignettes of men, these are American examples. Masculinity is defined by specific cultural messages reflective of a culture's socially constructed attitudes, behaviours and roles proper to men. Therefore, the argument could be raised that fathers' experience of IYrs PMT is grounded within their culturally socially constructed meanings of masculinity and their discomfort is created by the degree to which they deviate or conform to these meanings, therefore creating the expression of gender role stress. One could argue therefore, that vignettes which have examples of fathers pertinent to the culture of the men attending IYrs PMT, would provide more illustrations to men about their own restrictive masculine schemas and how these can be challenged by the evidence presented to them in the form of vignettes and the discussions stimulated by the vignettes. This may likely result in more receptiveness from men.

There are other possible solutions for addressing gender role conflicts for fathers within IYrs PMT. Clinicians or group leaders could help fathers search for disconfirming evidence of their restrictive masculine schemas by examining past experiences. This can be achieved by having fathers examine their own experiences as fathers, noticing how others react to certain behaviour in men, as well as recalling how they have reacted to behaviours of their own fathers.

The structure of IYrs PMT makes it too difficult for group leaders to pursue any discussion of gender role conflicts in great depth. There are several possible alternatives. This could include marketing or promoting the programme to acknowledge such issues more specifically for fathers to break down barriers to help seeking, attendance and in challenging traditional masculine gender roles which constrict the wellbeing of children and families. Such campaigns could be more relevant to the diversity of ethnic groups of the Counties Manukau Region and in enhancing accessibility to services. Similar messages have been used for male depression, family violence and child abuse.

Fathers who have benefited from IYrs PMT are a potential resource for sharing their experience with other parents who are contemplating attendance. There can be value in having fathers who have attended IYrs PMT, share the changes that they have made with others at Information Evenings. It could also potentially be productive to ask fathers at the end of the group to document the benefits of the programme for their family. This could be used for pamphlets or in formats such as frequently asked questions etc.

The presence of fathers in IYrs PMT enables a mode of comparative analysis for mothers to their own experience of fathers (their own father; their husband as a father). Alternatives to these experiences of fathering, or what they believe to be positive or negative aspects of fathering, helps inform their cognitions about what elements have been lacking and areas which need further development for their own children. Mothers do not usually have the opportunity to interact and have in-depth discussions with fathers not within their own family. It is predominantly with other mothers that these discussions occur. This helps challenge assumptions that all men/fathers parent in similar ways such as fathers being more authoritarian. This process can be very enlightening particularly for solo mothers who reflect on the behaviours of their ex-husbands or partners and the qualities or characteristics that they brought to the fathering role when they were a united family, and whether these continue or have changed since being separated or divorced. It is also relevant as they continue to have to communicate as parents and discuss their children. Having experienced different perspectives of fathering from fathers attending IYrs PMT can help solo mothers become aware of gaps that have been present which they were not explicitly aware of, and the different elements that mothers and fathers bring to parenting as well as the benefits of maintaining contact between the child's father and the child (where appropriate) as much as possible. It is evident that many solo mothers value the role that fathers bring to their children.

It is apparent that the IYrs PMT delivered at Whirinaki would further benefit from enhanced support or a 'wrap around' type approach to address the needs of parents who have a mental illness. Parents with mental health difficulties require opportunities to feel a sense of accomplishment, progress and success in managing their child's behaviour. Otherwise, IYrs PMT certainly has the potential to confirm a sense of inadequacy, low self esteem, and negative

self bias and may therefore be detrimental to the parent's own experience. Developing the delivery to further enhance a positive experience for parents with mental illness is paramount to enhancing the mental wellbeing of the family. Further, mothers without father involvement or parents who have mental illness may benefit from refresher sessions or even future groups which cater more to their specific needs. It also may be advantageous to collaborate with other agencies to support attendance, progress and sustain the positive gains of IYrs PMT. This could include non-governmental organisations or adult mental health services . Such initiatives may prove intensive in the short term and reduce the likelihood of re-referrals and re-engagement within Whirinaki.

All parents who have attended IYrs PMT would also benefit from reassurance that relapse of their implementation of IYrs PMT material is a natural progression, and clinicians and group leaders can play a role in transitioning parents to coping on their own, and develop a plan for when difficulties may resurface or new problems arise. .

Enhanced self efficacy was reflective of the advocacy skills that parents acquired following their attendance at the IYrs PMT and which is related to the theme of preservation. Having the confidence and communication skills to be able to advocate for their child assists parents to effect and sustain change, particularly within school environments. As parents gain further knowledge about causal factors for their child's behaviour they are more equipped to make informed decisions about their child which may include choice of school environment, accessing services, addressing issues of stigmatization, whether or not to use medication and how to be assertive against non-supportive family members.

Of particular significance when examining the mental health aspects of children within this study is the lack of awareness of the risk of suicidal ideation in younger children and the prevalence rates in NZ (which are vague). It is alarming that child suicide is reported to be a leading cause of child death in the United States and there is no role for complacency despite assumptions that rates are low within N.Z. The children of parents within this study present with various risk factors that contribute to a vulnerability and susceptibility to suicidal ideation. Enabling parents to be aware of these vulnerabilities and ensuring clinicians explore and screen for these thoroughly may ensure that suicidal risk factors for children are not over-looked within clinical practice. It is also evident that promoting IYrs PMT to parents of children who have suicidal ideation may be an effective intervention for promoting a home environment that has the potential to enhance the wellbeing of the whole family as well as reduce child risk of suicidality.

The needs of Maori parents require a specific focus and one in which Kaupapa Maori protocol is followed. Delivery within a marae setting is an initiative that is currently being explored within CAMHS. This will be more conducive to the needs of extended whanau. Situations identified in this study included a Maori parent attending the programme on her own but living with

extended whanau. Best practice would be to ensure that the whole whanau was provided access to the programme as parenting is not restricted to one individual.

IMPLICATIONS FOR FUTURE RESEARCH

There are various benefits for the delivery of IYrs PMT within CAMHS services resulting in an environment conducive to future research prospects and initiatives. The multi-disciplinary environment has the potential to encompass a diversity of research methodology to broaden and extend knowledge of outcomes for parents, children and families.

More specifically, this study has identified the necessity for incorporating psychometric rating scales in relation to pre and post group. This would provide more specific quantitative data for evaluation and research purposes of IYrs PMT within a CMDHB setting.

Male concepts of masculinity have not been accentuated in studies of parent management training. As it is, there has been little emphasis on parent management training for fathers. It is only more recently that research is focusing more on exploring outcomes for fathers. Research needs to provide more detailed understanding of the processes of IYrs PMT for fathers and focus less on superficial elements and generalizations about fathers' participation which only serve to confirm assumptions that fathers attending are more resistant to elements of the programme, that they are not involved enough, or want quick results. It is also important not to focus on men as generic and assume they all will have similar responses to IYrs PMT.

The processes which have arisen from this study have the potential to be generalized to wider community settings and further research could focus on delivering the programme more collaboratively with other agencies to help enhance outcomes particularly for children most at risk or cohorts of parents who experience more difficulties completing IYrs PMT. Inter-agency collaboration has been implemented in other ways incorporating memorandums of understanding to ensure effective working relationships across agencies. This has the potential to secure more opportunity and flexibility for families who experience various stressors. Pertinent strategies are required to address issues for Kinship carers, parents with mental illness, fathers, Maori, Pacific Island and other ethnic groups. The current economic climate creates limitations on the ability of services to deliver IYrs PMT due to various restrictions and promoting collaboration amongst agencies could ensure that the needs of children with disruptive behaviour difficulties within the Counties Manukau Region are enhanced.

SUMMARY

The study highlights the important role that the contextual environment has for scaffolding parents for success with IYrs PMT. There are core components of clinical work which need to be promoted to ensure parents are receptive to IYrs PMT. These components need closer integration with the core principles within IYrs PMT. Parents require the opportunity to debrief about their child's behaviour to their clinician without the presence of their child. Parents value acceptance, collaboration and the promotion of the importance of their parental role in order to be more receptive to IYrs PMT. Mothers are more likely to instigate help and fathers are often persuaded by mothers to attend. Mothers require support from clinicians in obtaining greater input from fathers in clinical work. Mothers are often in a state of learned helplessness and have low parenting self efficacy. Mothers in particular need acknowledgement of their efforts to learn about their child's behaviour. They also need to be given the opportunity to discuss what knowledge they have acquired whether from previous programmes, self help books etc. Clinicians require an awareness of the variability between the ways in which parents apply meaning to their child's behaviour compared to their clinically derived formulations. They also need to be prepared to work towards mediating parents' attributions about their child in order to bring about changes in behaviour.

Further understanding of the experience of IYrs PMT for fathers is pertinent to enable the needs of fathers to be met and to begin addressing some of the meanings underlying their experience. This should be a priority as fathering roles change as well as the expectations that others have for fathers and the impact this has for family functioning.

Parents had a variety of experiences based on their introduction to IYrs and consistency is required to ensure clinicians express the rationale and the potential benefits to parents within an approach that scaffolds the parents for success and addresses barriers to their attendance. Clinicians not involved in the delivery of IYrs require training on the structure of IYrs so they have confidence in promoting IYrs to parents. Advocating the attendance of fathers and extended family/whanau is also pertinent to securing support for parents prior to attending IYrs PMT. Family Therapy may have a vital role to play in assisting parents to obtain 'buy in' from other significant others and to acknowledge concepts such as 'rewriting family scripts' as well as overcoming barriers for fathers in terms of their concepts of masculinity and their fathering roles. In other situations, psycho-education may suffice in the form of handouts to parents to ensure they are aware of some of the processes that are encountered in the group.

Close attention needs to be given to delivering IYrs PMT with fidelity and clinicians need to be supported in their delivery of IYrs PMT. When components are dropped from the programme such as buddy calls and the consistent application of role plays it is often the most vulnerable parents who attend that are affected. This results in poorer outcomes i.e vulnerable parents thinking they are 'a failure' on the programme. Parents require a group composition where they

can feel connected to others as well as introducing (without adapting) cultural components that ensure a NZ flavour. This would assist in a connectedness and commonality which acknowledges a diverse array of cultures within group settings and is reflective of the contextual environment in which the families live.

Creativeness and flexibility are required to reflect how IYrs fits within the context of a CAMHS service and within the wider culturally diverse community to assist in the future planning of IYrs PMT. More intensive short term support is likely to be required preceding IYrs PMT. This in the longer term should assist families to prevent relapse with less likelihood of being referred back to CAMHS services.

The study supports the benefits of IYrs PMT for improved family functioning and despite the need for further development and refinement of its delivery within Whirinaki, CAMHS, the use of this intervention is well advocated among the parents who have attended. The positive outcomes and examples which the parents have revealed are both enlightening and encouraging. IYrs PMT is indeed a key psychosocial intervention that is conducive to improving outcomes for individuals, parents, children and families within Counties Manukau and indeed other District Health Boards.

Chapter 12

Incredible Years Group

"INNER CONFLICTS OF GROUP EXPERIENCE"

- Being Americanized & Cultural Relevance
- Reconstructing Ideologies

"EXTERNAL CONFLICTS OF GROUP EXPERIENCE"

- Psychosocial Stressors
- Developmental Stages

"COMRADESHIP"

- Group Processes
- Group Dynamics
- Group Connectedness

"INNER CONFLICTS OF GROUP EXPERIENCE"

Being Americanized & Cultural Relevance

Cultural needs and the adaptability of the programme were present in participant dialogue, particularly relative to the vignettes and role plays. Parents reflected disappointment that IYrs PMT was a programme from the United States and there was a sense of disconnection to the portrayal of elements such as vignettes. The relevance of the programme was acknowledged, but would have created greater ease of understanding if aspects of NZ culture were included. Participants felt strongly that the programme required relevance to Manukau, South Auckland.

> *"It would be interesting to see it done by New Zealanders, the tapes/videos it would be quite nice to see them because it just seems so very American so very perfect families whereas a lot of the parents here were just average you know we weren't that perfect, that's why we do the course"* (Linda).

One mother, who attended on her own (identified as Maori), lived with her parents and son and encountered difficulties attempting to implement strategies at home when her parents had not attended the programme. Her parents had assisted with childcare, their support was important but so would have been the opportunity for everyone to have benefited from IYrs PMT

simultaneously. In this instance, cultural needs of the extended whanau were not being met. Conflict had been created within the household and conflict resolution was required within the whanau.

> *"It caused a bit of conflict between me and his grandparents because it was like I was trying to encourage them to do things um yeah from what I'd learnt, so that he was getting consistency, and cause they weren't coming to the programme it was a bit harder for them to buy into it, but we're smoothed past that now"* (Mere).

Not only did the vignettes have to bridge their application over culture but time as well. Participants felt that the vignettes did not deliver in these aspects. It appeared too much for some of the participants to bear at times. This is reflected in their strong opinions and criticisms of the vignettes, describing the vignettes as "old-fashioned", "out-dated", "tacky" and the acting as "terrible".

> *"Oh, the video's. Those dated, dated videos. I know they are funny at first, cause they are so 70's and it was, some of the acting is pretty terrible, you know it got the message across, but yeah, maybe a little more updated aye, you know I remember in the 70's watching the 6 million dollar man and that was cool, you watch the 6 million dollar man now and you think oh, my goodness"* (Brian).

There was an opinion by one parent that IYrs PMT was pertaining to a bygone era in which the programme originated and role plays were now out of date.

> *"I think we need to drop the role plays and go with the modern age and look at DVD's and internet and videos and use technology-we don't need to do role playing anymore, I don't like it"* (Sally).

Re-constructing Ideologies

Mothers and fathers were aware that men and women think differently and therefore their experiences and perceptions of IYrs PMT varied according to their gender. These differences were reflected in how women like to think and talk about problems, which doesn't necessarily equate to needing the solution immediately, whereas the goal for men was to want to have the problem resolved.

> *"Guys I think are not too good at expressing themselves and how different things make them feel and so to have someone-it's hard, especially in the initial stages and there's people you don't know and you try to tell them how you feel where I think women do that more naturally because for them-guys we talk about a problem, we want to fix it, when women talk about a problem they don't necessarily want you to fix it and I found*

this out the hard way that sometimes they just want to talk about it and be heard" (Brian).

"Being an engineer I look for techniques for sort of practical solutions to things you know…. it's easier for me to have specific things I can do or not do you know I need rules as same as they do" (Tony).

Mothers observed fathers to be more resistant to components of the programme or appearing to take longer in grasping the structure such as the rationale of the parenting pyramid. There was the assumption that fathers were more impatient and wanting to move on or that they were very resistant or weren't ready for change.

'I think the Dads were very more resistant to- the Dads in the group that I was in-the mums were very more open to take in what was being said and the Dads were like saying 'No, I want this done now', they weren't prepared to build the base-not all of them but a good majority of them didn't want to do the bottom level stuff to get up to the next one they just wanted to jump straight into how do I punish my child…..they found that difficult, they couldn't seem to understand, they gave the impression that they didn't understand that you needed to do things to get to the next level they just wanted to-like the first question was how do I punish my child? How do I do better punishments? But they weren't getting-I think some of them got it towards the end but there were a couple that were very very resistant, very set in their ways and they just say ah, it was a waste of time" (Sharon).

Further to this mother's reflection of fathers wanting more instantaneous results, was the experience of a father who felt the material cumbersome.

"It took a long time, it wasn't until several weeks into it that it seemed to resolve itself into what they were getting at you know, which could have been in a much shorter time I'm sure. Well obviously they have to play to the lowest common denominator I suppose, um and it would be difficult I guess to sort of customize and focus it on the people's individual needs so I can understand why it is a nebulous thing um but it's yeah it um it took a long time for them to hit the salient points you were gradually crawling your way toward them and you could intuitively see by then what they were going to say and a lot of its common sense, it is a lot of common sense and I don't think, it shouldn't be necessary to bludgeon common sense in such a blunt manner, it doesn't seem to be-to mean it's not necessary (Tony).

It was acknowledged that mothers and fathers bring their own unique aspects to parenting.

"We really only had one Dad, he's the only who came....we just think differently. How he thought and how his wife was, was quite different, what he did with his son is totally different to what his wife did with him, it was really quite neat to hear what he was doing with his son, and they stood -he still managed to work and hold down a job but he still had time with his-he was like one of those ideal Dads really, he was really cool" (Linda).

Interestingly both mothers and fathers commented that more Dads needed to attend the programme and there needed to be more male clinicians involved in leading IYrs PMT.

"There weren't too many guys going there-I think you need more guys... more guys as fathers coming in, or even presenters-we need a guys perspective sometimes" (Brian)

"I think it's great that you have a male in there talking to them because I don't think it would work, not being sexist or anything but I don't think they would listen to a woman's point of view" (Sharon).

There was also the perception that the way the programme was designed, it did not have the average "bloke" in mind.

"It's almost a programme designed by social workers for social workers it will be too hard for the average Joe blow to want to go" (Tony).

Father's appeared to experience various internal conflicts during their involvement in IYrs PMT. Their own constructions of the meaning of masculinity were challenged in various ways. This resulted in many experiences of feeling vulnerable or uncomfortable.

" I don't think it's necessarily the environment that is indicative for guys opening up that, how, it's very, you know everyone can see, it was a little bit of a squirmy sensation that goes on there for a guy"..... it's also being vulnerable you know...I might be wrong, it's not natural for a guy to- in front of strangers, be vulnerable, you know, it's just harder. (Brian).

Mothers displayed less awareness of the challenges that fathers faced completing the programme. There was an inclination to think that father's may not be ready to change, that they were still "angry" at their child. Fathers were required to gain emotional strength and emotional energy to relate to the programme, such an emotional commitment was not likely envisaged. The whole sense of self, identity, role as a father or man was challenged and that fathers were required to harness the answer from within which required a considerable amount of emotional processing. Fathers were required to be out of their "comfort zone", IYrs PMT was described as a "feminine atmosphere".

"It would have to be more bloke friendly because it isn't really, It would be nice to have a man and a woman doing it, presenting it, would be good. It would be nice to have a more male dimension in any of it really, you know the presentations done by women, the things done by women, and everyone else at the thing were women. You know I mean I'm relatively comfortable in my own sort of- I wasn't that worried about being the only male there, but I can see some blokes would be you know it would be pc bullshit and guys wouldn't be interested. It would be hard enough to get them to go in the first place…. I wouldn't say they weren't male friendly, they were friendly, of course they were, but it was definitely a feminine atmosphere a feminine sort of driven programme" (Tony).

This father also acknowledges the difficulty for men and fathers to seek help. For the fathers interviewed, their presence at IYrs PMT had been requested either by their wife or their clinician. Two of the three fathers interviewed had attended with their wife. It was likely that they obliged dutifully based on their perceptions of parenting programmes and of a father's role which was incongruent with getting advice from a mental health service about parenting their child (Brian had indicated not being that receptive, it was yet another "parenting programme", but his perception had changed after the first session). For the solo father who attended on his own and identified as part Maori, he indicated that as a first time Dad, he had a strong desire to learn everything he could to assist his son. This father indicated a strong relationship with his son from the start, they had a mutual respect for one another and this bond he shared with his son was paramount. This appeared to supercede any gender role stereotypes that were held about being a man or father and seeking assistance. It is also evident that cultural aspects are strongly embedded in understandings of gender roles and relationships, where varying dimensions contribute to mental health wellbeing and the emphasis is one of collective responsibility, not of individual relationships.

Gaining knowledge within this programme is not prescriptive or instruction-based. It involves elements where collaboration and relationship building are important to enhancing family wellbeing. Being able to express one's emotions is essential to changing parenting patterns, which is in contrast to behaviours of remaining emotionally in control that men and fathers have been socialized into.

"I was the only male there and it I could see why a lot of blokes wouldn't wanna do it, it was-the actual content was great you know, and all the content was great, but it must be possible to condense it and still have the same amount of impact. The amount of time spent with the role playing particularly was just abysmal. I found that- I mean I worked with a large company for years and been involved with numerous team building exercises and corporate mind game events and to walk into another one was just- I was so upset I just didn't want to -I had been through the role playing thing before, it's

puerile, I mean obviously it must work for some people but for me it instantly puts my back up and I would say most blokes would be the same and it would be-you would instantly lose them-the moment that came up I mean I was on the back foot I was defensive and didn't really want a bar of it or I was there was to-, I didn't want to sit on the ground and play with blocks, thats not why I was you know throwing up 50 bucks an hour to sit and play with some lego, it was just no, I wasn't into that at all" (Tony).

It was apparent that fathers who did promote the programme to others, were very careful how they framed it to their mates, by acknowledging the aspects of being out of their comfort zone, but despite this, it being worthwhile. After all, these fathers had attended most of the sessions, had endured the discomfort and were acutely aware of what was "at stake" and how others would perceive them as having attended the programme. They were honest and frank.

"I have already recommended it already to one person and I said you know once you get past the touchy feely, this is how I feel sort of thing I said, you can actually pick, up some good tips of other parents you know" (Brian).

"Yeah, I was blow arsing about it, um I guess the only way to say is how it helped me"... it's like myself you know I'm part Maori you know but I went there and I just put in a bit of effort in you know. I guess you know if they're having problems....you know behavioural problems with their children then it will be a good thing for them to go along and learn from cos it helped me a lot so I guess if you tell them that" (Hone).

The message and contribution that these fathers are making to other parents is extremely important as they are challenging assumptions that have contributed to mental health difficulties of children within the social context in which they live. The necessity and value of father involvement is advocated, the courage and determination that is expressed by these fathers, sends a message to others in the community who may dispute the benefit of such programmes as IYrs PMT.

"I have got some friends that are actually solo Dads you know, they're actually doing a really good job but a lot of it comes down to the individual you know- if they can deal with it, cos I know there are a lot of people out there that can't aye, and thats why we've got a lot of abuse- on tv an-you know when we think of it- they're the ones that really need to go through something like this, but then again are they going to listen? and unfortunately a lot of them are into drugs and alcohol....so it makes a huge difference" (Hone).

The fathers attending the programme had the courage to challenge varying concepts of what it meant to be a father, and also being a father to a child with disruptive behaviour. This was

admired by mothers who made comparisons with their own husbands or partners who were not present on the programme, or did not respond to the same degree.

> *"I think more Dads need to really come I think like I would have really loved my husband to come-but I know what he's-he's a workaholic, I just know what he's like he would just say this is a load of mumbo jumbo shit. He wouldn't come, or he would come twice and go (snort) the whole time, the whole way through it and say this is not the real world you know you just your'e just talking this mumbo jumbo rubbish"* (Linda).

The ability of fathers to respond to IYrs PMT despite the dominance of the feminine element, was related to previous experiences of such environments. One father who was a youth worker was particularly insightful about the differences in working with girls and boys, and related this to the experiences for fathers during IYrs PMT.

> *"I work with at risk youth-when I am working with the boys I'm better-if I want to talk to them I'm better to be doing something and be alongside them than have different-, not even having direct eye contact most of the time, but if you are having the girls you can sit down across the table from them, you know and get to the crunch of the matter... there's just those subtle differences I suppose. I don't know what you could do, you know. I find it a little bit uncomfortable being in that circle"* (Brian).

Changes were recommended to help alleviate some of the difficulties fathers experienced during the programme. Interestingly, the changes that were considered were to remove some of the aspects that resulted in father's discomfort.

> *"Well ok role play might work with some people, but with the majority of people and with the majority of males, it does not and the leader was just not willing to drop it, you know every week she would push the role play and she would absolutely refuse to do it and we would begrudgingly do it. You know role play just does not work in today's day and age. You know sitting down and acting like a child just does not achieve anything"* (Sally).

> *"I can't think of any way of getting around it unless you were to set it up more like a classroom where you can sit at the back or you know at the front so that you can't see everybody. It's less vulnerable I suppose"* (Brian).

> *"I don't know how you could get some of these males to change their minds I don't know even if you should have a group on their own or you know maybe something like that"* (Sharon).

Mothers were able to rationalize their participation in role plays as providing future benefit for their own learning and personal development once they had been reassured and encouraged to participate. There appeared to be less reluctance expressed by mothers who saw it potentially as an opportunity to practice their new skills.

> *"It was slightly difficult when it came to have to practice things, I don't like doing like that in general.....yeah, wasn't a fan of participating but recognised that I should"* (Mere).

> *"Oh gosh-I remember other people being quite reluctant to get into it. But it puts you out there, if you don't do the role play it doesn't put you out there and you know-it gives you the opportunity to talk about the scenarios"* (Naomi).

Mothers tended to enjoy the structure of the programme, commenting on the simplicity and basic methods of the programme such as not being too complicated, and that principles or concepts were introduced in a way which was concise. In terms of other parenting courses, the IYrs PMT was cited as different by the way in which it broke things down into specifics. The diversity of learning methods, "being interactive" contributed to a stimulating atmosphere. Mothers reflected that this was an interesting way to learn to retain their attention and capture their interest and contributed to their enjoyment. It appeared that women related well to the structure of the programme as it represented their styles of learning and needs.

> *"I have found the programme really good- from a womens point of view, it was run by women, there were all sorts of women there, it was great!...the things I liked about it- the things it contained was that there was some group discussion, there was watching the tape, so it was quite-a lot of different things, so it wasn't boring"* (Rebecca).

Parents exhibiting various forms of mental illness also encountered emotional battles throughout the programme. Tiredness and exhaustion was a barrier to implementing home activities. For parents on their own, there was also the lack of support finding time to complete all the household tasks that needed to be doing as well as juggling the needs of other children within the household. The practicalities of making or finding time to complete home activities were yet another hurdle for parents.

> *"I just felt I wasn't putting what they were teaching totally into practice- I was really struggling putting it into practice I was trying to do some of the things you know like the praising when they are good, not focusing- but its finding those moments and finding moments that you can have 1 on 1 with the different kids its when there is one of you it just doesn't happen and thats what I find a lot of things that everybody is telling you to have 1 on 1 or to have time out from your children because you feel so much better but*

putting it into practice as a solo mum is not as easy as people tell you it should be" (Linda).

It was acknowledged that for some groups, "buddy calls" were never introduced or occurred consistently. The goal of "buddy calls"; were for parents to support each other. This would occur by contacting another parent from the programme that week, to enquire about their progress with home activities.

"We are supposed to change phone numbers so that you could ring each other and just sort of say, this is happening what do you know, from what we have done, or do you think how should I approach it? but yeah we didn't really get that up and running" (Linda).

Having a mentor was postulated as one avenue that would have been helpful. This was something separate from the system of buddy calls and one which a parent with mental illness, thought would have been worthwhile for her.

"Perhaps having a mentor that can just ring you up and say, have you read?... when you're a husband and wife team coming there is not a problem..... so if there was a little bit more support and just yeah to make sure I am reading it and going over things when you are reading them-it just seemed to-thursdays just seemed to come around so incredibly fast I found" (Linda).

EXTERNAL CONFLICTS OF GROUP EXPERIENCE

Psychosocial Stressors

Psychosocial stressors also created difficulties for parents to attend IYrs PMT and many parents had to make sacrifices in order to attend. Parents were insightful regarding the psychosocial situations of others in their group and acknowledged some of the stress and hardships that were encountered.

"It was a big thing to get here and do it and then I just felt all this time and petrol to get here..." (Linda).

Another father was aware of transport difficulties for some people and commented how this impacted on parent's ability to attend depending on whether they had money for petrol or whether the car needed repairs. The length of the programme was postulated as contributing to the burden for families already struggling with their situation, particularly with finding babysitters. Parents were more inclined to ask extended family to assist. Issues with finding appropriate babysitters were experienced by one family and consequently one mother reported that this

meant that they couldn't attend as a couple, and this had added complications implementing the programme at home. There was satisfaction at the meal provided and this helped alleviate some of the pressure for parents; trying to organise finishing work at the end of the day and rushing to attend the programme and organising children.

> *"The pizza was nice....yeah, it was a great excuse to eat junk food, I mean I had to-I couldn't eat my dinner before I came"* (Naomi).

Developmental Stages

The specific IYrs PMT which was delivered was also highlighted as not being appropriate for the developmental age groups of the children of some of the participants. In 2007 when the participants were completing IYrs PMT, the basic programme for children aged 3-7years was being delivered. Consequently, this programme was targeted at parents of an age group much younger than circumstances for those parents attending. Parents felt that vignettes and role playing involving child led play did not meet their need. Parents' perception that this was not relevant may have resulted in reluctance to implement those strategies with their children; believing their child would be unresponsive.

> *"I think we all struggled a bit sometimes with the role playing stuff because most of us had children that were older than 2 or 3-most of our children were 5 up that we were having-struggling with and that didn't totally correspond with where we were at"* (Linda).

COMRADESHIP

Group Processes

Parents recognised the different perspectives that people bring to group. Dialogue with others, when they were not their wife, husband, partner (or other family member) was acknowledged as being able to reinforce or consolidate what might have been advocated to the relevant person previously. It also contributes to "being on the same page". Awareness is enhanced that opinions are commonly shared by others in the group.

> *"Especially because doing it with a partner it was really good for them to hear someone else saying some of the stuff, and not for it just always come from me, you know it was really nice to be proven right..... it is so helpful-to hear it from someone that's not part of the family, that's not your wife"* (Rebecca).

Noticing change in other parents appears to help the group dynamic and interaction, group members encourage and feel proud of the development in this person, and that they had helped promote and empower this change. Observations of change in others allowed parents to

recognise how they might help themselves or how they had not paid attention to their own self care.

> *"I did see some big changes, in one woman in particular, another single mum who had a couple of difficult children and you could tell that it was working for her because when she first turned up she was pretty-not just judging her or anything, it was just an observation but she was pretty run down...pretty haggard looking and by halfway through the thing she was happy and she had gone out and had her hair done, you know she just looked better, you know she looked happier and different to the person that you met on the first night. She was really run down and I think by the end of it she was a lot more positive, so I think-I mean it showed in how she was- that things had had a big impact on her, as well as me- I think I became a lot happier as well. It was good to see that, you see someone turn up one week and she had had her hair done, and she'd her nails done-you know she took some time out for herself cos I think her two boys ran her into the ground and that she had forgotten all about herself, because it took me a while to figure that out too, you can't help somebody until you help yourself"* (Sharon).

Parents were apprehensive or uncomfortable at times, particularly when first commencing the group and not really knowing what to expect. One father stated that a lot of people in his group had not shown up and thinks there were supposed to be at least 20 people. He indicated a sense of relief when in reality the group which eventuated was 8 or 9 people, which made it much easier to express himself and talk. Most parents could not attend every week of the programme. However, some groups appeared to have natural attrition with group participants dropping out. One group held during the day had its numbers drastically reduced with hardly any parents left at the end which makes the participants still attending very uncomfortable, particularly when it is unpredictable who is going to turn up.

> *"But even us in the last few- there were 3 of us there- there was one other female depending on who had happened to turn up on the day"* (Sally).

Participating in a group environment may have been a new experience for some fathers who were not accustomed to the process. However fathers did reflect positive experiences within the group and were receptive to input from other participants and group leaders. There was acknowledgement that the group was a collaborative process where one could share information as well as receive it. The collaborative process appeared comfortable for a father identifying as Maori and empowering for his own learning experience.

> *"Probably my favourite was sharing different ideas, when we sit in a circle and stuff and share problems and different ideas you know and how to deal with it and I'd just sit*

there and try and listen…. I was quite comfortable talking about it because I knew I could get a bit of feedback and try and help me out because we were going through quite a few problems (Hone).

Group Dynamics

One participant expressed the issue of some parents raising personal issues within group discussion and that there needed to be a different forum for dealing with these issues. It was acknowledged that this was difficult for leaders at times particularly when parents who would tend to do this were described as having stronger personalities and it was challenging for these people to be re-directed. There were times in the group when some people went off track and it was noticed that sometimes group leaders had difficulty getting the group refocused on the group activity at that time.

"I'm very much a person, we are here for a reason, this is what we're supposed to do if you've got little personal issues on the side then there needs to be another forum for that to kind of happen" (Mere).

Some parents were cited as having strong personalities and wanting their things discussed, perhaps to the detriment to the rest of the group. There was the perception that facilitators sometimes struggled to reel others in. However, there was understanding by parents that there needed to be a balance between parents participating in discussion and when personal disclosures became too intrusive for the group process i.e. time management to get through all the material.

"I really liked the facilitators, I thought they were really nice people and um even thought they did struggle with sometimes with reeling others in, they just had to go with it to some degree" (Mere).

Group Connectedness

Some parents indicated that they felt different from others when they believed they had more complex family issues to contend with. This included when they felt that their child's symptomology did not respond to IYrs PMT in particular ways, such as dealing with more oppositional behaviours such as destructiveness or property damage.

"The children that are under Whirinaki are so different. It's hard because there isn't necessarily a lot of information for a child like Lisa who is really oppositional" (Rebecca).

Other parents felt different because of their parental role such as different issues experienced as a stepfather in comparison to the natural father and would have preferred meeting other stepfathers within the group setting. This stepfather remembered his struggle to form and

understand his relationship with his stepdaughter who had a co-morbid diagnosis of ADHD and ASD.

> *"It's that bond that you form with your genetic children"* (Brian).

Buddy Calls are encouraged in the programme and parents select a buddy that they can contact during the week to discuss any issues that arise and how they are progressing with their home activities. One parent commented that she was quite frustrated with some of the other parents in the group. She felt that they were encouraged to bond with others in the group, but as a couple they felt they couldn't do that because they had little in common with the other parents other than being parents of children with difficult behaviour. This was mainly due to being the only couple in the group. Consequently they didn't ring anyone. This parent said that they did actually get on well with the others in the group session, but the unwillingness of this couple to ring anyone may have been because that they had not formed enough of a connection to go this extra step which would involve more familiarity, that perhaps they were not ready to share. The formation and selection of group participants therefore impacts on the ability for people to connect with others in the group. There is a diversity of parents who attend from various backgrounds and family formations. However if a parent or parents feel they are very different from others then this will impact on their experience.

When parents saw themselves as "markedly" different from other parents such as being a couple when other parents are all single parents; or when only one parent from each family is attending, this impacts on "group connectedness". As parents who see themselves as markedly different in terms of their cohort or status i.e marital, sole parent, or mental health issues, will have less desire to connect with the group as they may believe they have less in common.

Feeling unique or different from others in the group did allow one mother to express appreciation for her family situation and feel grateful for what their family did have. Being the only couple in the group helped reinforce that there were many parents who were raising children on their own. It was evident that this couple left their mark on other solo parents within the group, as one parent had commented earlier that this father was an "ideal Dad". This couple had also provided the group with the insight of what it took to work at the marital relationship. They would have "a date" prior to the group and at the time of the interview, were regularly having one day a week together as a couple. The couple were acutely aware that Dad working from home and Mum working part-time allowed them this flexibility that other families did not have.

> *"It's amazing when you share your situation that your kids are just the same and in fact we felt really lucky as a comparison. I mean we always have in that you are always aware that 1 in 5 kids or whatever have you know made up families or divorced families*

or whatever so we were lucky that there are 2 of us dealing with it and it sort of made us feel lucky in a way being in the group that we were in" (Sally).

Some parents felt that they did not get the same results as other parents, that their own child was more extreme or unique than what other parents were describing, or that they had particular stressors or issues that they thought other parents did not have which contributed to their challenges implementing the material at home. Even though the children all had symptomology of disruptive behaviour, there was a wide range of co-morbidities and other factors which contributed to a diverse array of difficulties that not everyone had experienced or thought was relevant to their own situation.

"I felt that we had quite different circumstances like with my husband having problems and myself having problems, it was different from the other participants" (Naomi).

Comparing their situation with other parents within IYrs PMT appeared to help the parent to assess their own situation. This related to how their parenting was impacting on their child's behaviour. It assisted parents to piece together the puzzle of understanding. There was awareness that the group did not solve all the issues of their child's behaviour due to other factors that were impacting on their situation at the time of their attendance; but that the group process and content did contribute to the overall journey of understanding.

"I mean it's the piecing together of a lot of stuff that was coming together at that time yeah" (Naomi).

One parent had some recommendations regarding the formation of groups as her experience of attending as a couple had left her "wanting" and was a missed opportunity in a sense as they had not experienced input or connection with other couples.

"We felt that they could have got the groups better sorted in that it could have been a bigger group um and I don't know whether you- I mean I don't think it probably works if you matched up the same type of kids, I mean the same type of couples, but if they had had more couples in the group it would have been more useful for us um so you know whether you start with a bigger group because there is always that fallout in between um I mean whether you have a group for singles and a group for couples probably you need to mix just to get that experience" (Sally).

Chapter 13

New Meanings and Actions

"TACTICS"

-being on the same page

-problem solving

-skill acquisition/implementing strategies

"COURAGE UNDER FIRE"

-mediation & negotiation

-advocacy

"COMPENSATION/RECLAMATION"

-relationships

-self

-pay-offs

-child's behaviour

"TACTICS"

Being on the Same Page

The experience of attending the programme together as a couple provided the opportunity to "be on the same page". This refers to how parents know what to expect from each other in their responses to their children's behaviour. Couples who attended the programme together simultaneously (which enabled them to receive the information at the same time) reflected how it allowed them to become more consistent in their parenting by implementing the strategies. Many had described differences in parenting style prior to IYrs PMT i.e more lenient versus more authoritative. "Being on the same page" also relates to the ability to compromise with one's partner regarding parenting strategies. By both parents changing their patterns they can work towards a "united front" and "middle ground" therefore alleviating the more lenient or permissive style and authoritarian parenting style.

> *"Brian and I are more on the same page than what we were previously. He's pro more authoritarian than I am, and so it's like I'll be a bit more permissive to try and counter that, so that I think we have-sort of moved closer to the middle ground, which has been really good"* (Rebecca).

Other parents who attended the group on their own had noticed the process of change which comes with couples working to be on the same page. One mother had observed a couple of parents being able to "be on the same page" by the end of the programme, but another couple hadn't due to the Dad's attitude, which reflected a rigidity. The mother discussing this couple stated that it had been "his way or the highway" and that it was too difficult to reach someone who didn't want to be helped.

> *"One thing I noticed the most about them is they weren't–the Mum and the Dad weren't on the same page and so I was thinking well it's easy to comment on someone else's life but I think that's probably half the problem was that they were –the Dad was too hard and the Mum was too soft and they weren't on the same page and so everybody was confused"* (Sharon).

"Being on the same page" can apply to revising the information at the same time to avoid being critical to one's partner who may have forgotten parts of the programme therefore reducing any judgement, "nagging" and encouraging a supportive approach.

> *"The whole benefit of it was that we were doing it at the same time, because if I went through the notes then I know that I would be picking up on things that Brian was doing wrong and then I know I would be quite annoyed at him and vice versa so you really need to do it at the same time again or go through the notes together so that your'e both got it in your heads where you are going because otherwise it's just going to end up with one person nagging the other and you know, yeah, and not coming at it together"* (Rebecca).

"Being on the same page" enhances the parental and marital relationship. When parents are united regarding their strategies and responses, the potential for conflict, disagreements over approaches is minimized. Awareness is enhanced by understanding the variations in parenting styles and why this occurs.

> *"Everyone was brought up differently so they've all got different preconceived ideas so it did- it put both of us on the same page as far as how we manage them which was the best thing, you know really it gave us a framework to hang you know whatever action we did, we now had a common purpose in something united us together against the problem you know and that was probably its biggest salient point'* (Sally*).*

"Being on the same page" also relates to being an equal in the parenting relationship.

"He doesn't come to my rescue as much, you know- do as your mother says sort of thing, he's more aware of the dynamic or the sort of dynamics and the useful things that work" (Sally).

"Being on the same page" can also apply for parents who do not attend the programme together but it is more difficult to get consistency or collaboration from the parent who does not attend, or attends at a later time.

"I don't really know how people cope on their own or if they don't go together because you just gotta be on the same page" (Sally).

There is the likelihood of information being "lost in translation" a bit like "Chinese whispers" according to one father. This applies to situations where a parent attends and is living with their parents (child's grandparents) or when the parents are separated and only one parent attends. The parent has to go home and "sell the programme and ideas" to other necessary parties, consequently this can create some confusion, potential for disagreement. This is an extra step that the parent has to take or overcome before they can implement at home.

"Being on the same page" has positive consequences for siblings in the family as consistency and a sense of fairness is provided. Parents realized how they may have been previously targeting their children's behaviour at the expense of their other children.

"Doing the Incredible Years programme crystallized for us in fact she has problems that need to be addressed. It is not all about- you know she grizzles and whines and plays on things and does typical girl tactics um and so I think you know we often probably ignored her behaviour probably because it wasn't as bad whereas we should of got on to that as well and I think it sort of made us more consistent between the both of them and we were always quite careful not to play favourites but because Billy's behaviour was that much worse I think you're probably onto him and badgering him more and whereas I think it's made us more consistent so it is more fair for her and I mean it's still the same she still whines and grizzles and he doesn't do what he's told, it's still the basic behaviour problem but your more aware of both of it so I think it's sort of benefits or spinoff effect for her and um although she's quite a tell tale tit and comes and says Billy did this and Billy did that I think it's a benefit in a way they both feel they can come and talk about what behaviour annoys them" (Sally).

"Being on the same page" relates not only to parents but can be generalized to other environments. Reinforcing the same rules as the school can be applied.

"It was just a matter of us coming more on board to reinforce rules the same as the school so yeah I think it's had a spinoff for her (sibling*) and in some ways for our siblings" (*Sally).

Problem solving.

Problem solving occurs on multi-levels. It needs to involve collaboration with the other parent or family members within the household. Problem solving is related to the parent's mood and when a parent is angry or frustrated their ability to problem solve rationally or in an effective manner is reduced. When they are calm, patient, tolerant, the parent is in a better position to be able to process what is happening and to communicate in a matter which is engaging for others interacting with them.

Having a calmer household is related to this process. When the parent models the appropriate behaviours such as remaining calm and in control, this in turn impacts on the child's behaviour, leading to better communication between parent and child. Having a calmer household is a goal which many parents aspired to and one which many parents achieved.

The parents ability to problem solve is enhanced by the emphasis that is placed on parents being the experts for their own child and the ability to shape the strategies according to their child's developmental needs. Parents appear to have become more confident when they are "given permission" for particular strategies that they have received various reports or opinions on.

"That ignoring thing has really stood out for me and that is something I really had to struggle with like when he's saying a lot of hurtful things I wanted to say something but it was best just to let him have his rant and rave and he got over it a lot faster" (Mere).

Parents are also encouraged to persist at problem solving and become more apt to cope with issues as they arise. There was realization and/or reinforcement that sometimes you needed to tackle a problem in a different way to get the result you want, that you don't always get it right the first time, or that sometimes you need to persist at the strategy. The parent develops awareness that their child may not respond straight away as children too need to get used to their parent's change in approach or behaviour.

"Just putting other ideas forward on how to handle situations because obviously what we were doing wasn't working and just making you think more about um how the kid thinks as well and how to tackle a problem in a different way to get the result you want" (Sharon).

There is the rationale that problem-solving is never-ending and as long as you're a parent there will be problems to resolve. Fear of the future is a response as the foreseeable future holds anticipated difficulties of adolescence, risk taking behaviours and the child's ability to become independent is thwarted by their difficulties. Parents learn that there are multiple approaches to a problem and that IYrs PMT helps provide a framework for this. It is also apparent that many parents will need outside influences to assist their problem solving at times due to the nature of their child's behaviour and mental health needs and that it is acceptable that this may be part of the whole process of re-formulating, etc. A parent's ability to focus on problem solving requires careful thought, attention, concentration and the nature of their busy and disrupted lives at times impedes this.

Skill Acquistion/Implementing Strategies

The message of the importance of play and giving special attention to children is a core element of the programme and is a pre-requisite for the use of other components and strategies. It had been clearly emphasized to parents.

> *"I think is really important to us to just reinforce what we already knew but that was the most important spending time with your kids and it sort of I mean it sort of makes you more analytical and makes you think is this really important what I am getting upset about or is it not important and it gave us a lot more techniques in how to deal with behaviour"* (Sally).

The application of how to implement parental commands and warnings was cited as particularly effective for parents in de-escalating behaviour.

> *"You know doing the whole warning ok if you don't do this I'm going to take away this from you and thats really helped because he always gets a forewarning rather than me saying right, I'm taking this off you. I guess thats caused less frustration for both of us"* (Mere).

Parents expressed difficulties with the use of time out particularly when their child exhibited oppositional and volatile behaviour and refused to comply with their parent's requests. Parents' understanding in these situations was that time out would not work out for their child. It was likely that the whole process of trying to get a child to time out who had refused, was distressing for the parent to implement and when support was limited, parents did not persist at mastering this skill. The interplay of symptoms would also make it challenging for parents particularly for a child with co-morbid ADHD and ASD.

> *"How to deal with the oppositional behaviour and how to get a child to time out if they are not going, um just those kinds of things that you know are more for a child that's*

violent than what these children were and obviously because the children that were shown on the thing were quite normal children" (Rebecca).

"Making them go to time out, taking them down not dragging them down..... there is no way that my son will just walk down to his bedroom for time out, or sit in the chair for time out. He's just, yeah- things like that I just struggle with" (Linda).

Parents aspired to being in control of their emotion when coping with their child's disruptive behaviour and the ability to remain calm was a skill that many parents had acquired following IYrs PMT.

"How to control myself when he's you know like annoying me or he's not listening you know if I need him to do something" (Hone).

Staying calm by removing one-self and taking a step back, provided some techniques to stay in control. These were beneficial strategies of emotional regulation for parents. The ability to remain calm also reduced the frustration that parents encountered when dealing with complex child behaviour and in changing some engrained longstanding patterns that had developed. The ability to remain calm also assisted parents with other difficulties such as a child with encopresis.

"It did help with the encopresis as well because it helped me to take a step back and um give me some techniques of calming down and techniques to help him as well and um it was sort of a bit of a tough one" (Sharon).

Planning responses to disruptive behaviours in advance by having an action plan which enables parents to remain calm, it removes the indecisiveness.

"I suppose for us it allowed us to be a bit more calmer because you've got like an action plan and it gives you somewhere to go so you sort of think ok if this happens we can try this" (Sally).

Two mothers found implementing strategies much easier once their children had started on methylphenidate following a diagnosis of ADHD. They experienced a reduction in resistance from the child regarding the changes that they were attempting to implement at home.

"I think once he got started on medication and he could concentrate a bit more it made it easier to put the techniques into practice um because there wasn't the same resistance that there was before" (Sharon).

"He had started the Rubefin in the small doses, he may have been on a 3 or 6 hour tablets a day at that point which means at that stage the school had the benefit of his behaviour so it was pretty hard to manage his behaviour at that time and now that he's been on the Concerta since the end, like after we'd finished the course, at the end of last year I mean he's a different kid" (Naomi).

COURAGE UNDER FIRE

Mediation & Negotiation

Parents learned skills on how to negotiate with their children regarding tasks they needed to complete. This was achieved through collaboration with their child and encouraging their children to contribute their ideas in conjunction with parental oversight.

"One of the things we do for cleaning out the bedroom is a treasure hunt so we get a bowl of chocolate money from the warehouse and I hide it and they clean up their bedrooms reasonably well so even some little ideas like that, they come up with that" (Sally).

Parents used concepts gained from other programmes to initially introduce ideas which were then reinforced by IYrs PMT such as the importance of quality family time, playing games and having fun as a family. They could also then incorporate family discussions as the children would be more receptive after having positive parental attention.

"We started um to have Friday evening family fun night and again it's not something Tony's into playing games, but I play games with the kids and you know it's been a useful sort of time to meet together and sort of look at where we are going-you know this is what we need to work on and these are the rules and that sort of thing. I think it sort of helped focus us as a family on where we were heading and what you needed to work on and what were the rules" (Sally).

As understanding of their child's behaviour increases, the ability for parents to advocate or mediate or their child is enhanced. The search for knowledge of the rationale underlying their child's behaviour appears to be the starting point. When the child is behaving in other settings differently from the parent's view of how their child is behaving at home, for example, this creates a dichotomy which can become the catalyst for change.

"The thing that I found hard to understand, they were saying that he had these problems, but he didn't have these problems with me or other people that he socialized with, you know what I mean aye? so it was really hard for me to sort of understand I

could remember going on he's got adhd he was doing all this stuff at this school, it was really hard, we went through a lot of stress" (Hone).

Parents become collaborators and negotiators with their children. They negotiate relationships continually within their actions with family members. Parents require negotiation skills to persuade others of the value of IYrs PMT. These skills are practiced when parents encourage others to attend or when they are attempting to enlist the support of other family members for their "buy in" of the programme.

Advocacy

One parent's experience of IYrs PMT assisted her in her employment as a nurse by enabling her to identify with families who have children with difficulties. Consequently she has recommended to several people the programme, particularly families that she has worked from and is able to draw on her own personal experience to engage them and recommending where to go. She was aware that it is often difficult for families to know how to access services and that part of her role was making people aware of the resources out there. This raises the question of access and equal opportunities to access services such as IYrs PMT as the ability to access the programme varies across regions.

"I think we really need to embrace it and look at how it might be different for us. I think depending on what the national government is going to change in the health system um you know I think the health system is looking more generally at prevention and you know building families particularly with the um parties that are looking at- "Family First" and so on I think generally nationally people are looking for that-there's a real need so I'm sure there must be money out there to actually be able to create NZ videos and NZ scenarios and develop a bit further as well" (Sally).

One father described IYrs PMT as making a "huge difference" to living with his son. Over the year that he had completed IYrs PMT he had his son come and live with him permanently, changed his son's school, and withdrew his son from medication (methylphenidate). He strongly advocated for his son when his son was victimised within the school environment. He gained the confidence to express himself within a group setting and participate in role plays when he didn't think he was capable. He was able to generalise and transfer the support that he received within the group environment to making some dramatic differences for his son's wellbeing. He indicated a strong desire to help his son from the outset and was open to learning anything he could to help resolve some of his difficulties.

The knowledge that parents hold therefore has the potential to influence others that they interact with and there is the ability to become strong advocates for their child particularly within the school environment.

"I understand more of where he is coming from you know what's actually causing his behaviour and what's causing his problems at school and so I can work better as his advocate too at school in making sure they are providing the best possible fit for his adult development" (Sally).

COMPENSATION/RECLAIMATION

Relationships

In many of the interviews it was most apparent that IYrs PMT had enhanced the parent-child relationship. The focus on play and praise was emphasized within the programme and parents became creative in adopting activities to complete with their children.

This was reflected in the descriptions and comments that parents made about their children and the progress they had made. One Dad described a close relationship with his son from the beginning and that many of the difficulties were with his mum due to their different parenting styles i.e more authoritative versus lenient. This Dad appeared to have gained further insight on why he did have such a strong connection with his son, he did not seem to take this for granted and the programme appeared to help consolidate many positive aspects of their relationship as well as providing the basis for addressing problems that they encounter. When it came to trying out new ideas, he has his son well engaged in the process.

Parents described having a closer relationship with their child as they became aware of their own resentment to their child. Consequently parents would become less resentful once they had an improved understanding of some of the explanations that were underlying their behavioural responses.

"I think it brought us closer together I stopped resenting him I mean loving him's got-that never changed but I did resent him for a bit that he was making my life very difficult and I think it opened my eyes up to the fact that he wasn't doing it-it wasn't that way at all, it was just what he does" (Sharon).

"I guess one of the things it was like I was making more of an attempt to have fun time with him so that I could build my relationship with him so that when I was being the mean mummy it wasn't so bad for him" (Mere).

Couple relationships are enhanced by "being on the same page" and having a consistent parental response when interacting with their child reduces conflict within the home and promotes positive relationships. There was a sense of reclamation of couple or marital relationships. Couples acknowledged how their busy lives impacted on their ability to make time for their relationship and how they could support one another in their interactions with their

child and with external relationships outside the immediate household i.e with ex-partners, extended whanau or schools.

For parents living alone with their child, the support of their child's clinician and group leaders was particularly important. Parenting on their own without father involvement enabled a focus of reclaiming their own identify as the sole parent and over-coming challenges they frequently faced. Confidence and independence in their role was extremely important, particularly for two mothers where the father was not a part of the child's life. Sole parents with only one child at home were most advantaged in improving their relationship with their child as they were not privy to complex family dynamics of competitive sibling relationships or difficulties in couple or marital relationships. Strategies were able to be implemented within the home without any contention from other family members within the immediate household.

Parent's development of more empathy towards their child and understanding about their child's cognitions or feelings, contributed to improved relationships within the household and enhanced child, parent and family wellbeing.

Self

Parents were able to acknowledge the importance of looking after themselves and self care strategies.

> *"It ushered in a period where Sally and I would spend a bit of time together each week because it forced us to and eventually we turned it into a bit of a lunch date thing but again, it's a bit of a luxury that we can enjoy because of our situation that yeah so we've kept that up we've tried to have one day a week-as Tuesdays where we do have time together and we can discuss plans and what's going to happen without having to you know stop fight"' (Tony).*

The importance of having a break, respite, or time out from their child was emphasized within the programme and parents realized that their child's behaviour had become such a major and significant focus that it had been at the detriment of their own sense of self. The absence of enjoyment and satisfaction in parenting their child for some parents had created a negative cycle where they had felt trapped. There was a sense that they had failed as parents and therefore did not respect themselves or deserve to treat themselves well. The content of the programme helps parents reclaim their sense of self and was observed within group dynamics (such as the parent whose whole appearance and demeanour changed). Parents became aware that they held multiple roles and that these roles had become subsumed by their parenting role. They were required to forsake precious time to attended appointments or intervention related to their child's behaviour. They feel they are not adequately committing to

their work-life, time with their child is not "quality time' due to the likelihood of conflict, there is guilt that others needs in the household are not being met.

Pay-Offs

There was an awareness that if the parent played with their child and gave them some quality one to one time, then the child was more accepting when the parent asked them to do something the parent wanted done or needed to do.

> *"He's more receptive for doing the things that I want him to do, um he's not as defiant and um he-I find that if I spend a little bit of time doing what he wants me to do, then he'll do what I want to do so it's that little bit of give and take-I kinda think that's what I wasn't what I was doing before whereas before yeah I was just saying you have to do what I say and that was that and it wasn't working"* (Sharon).

There was an element of "lost time" for parents who expressed regret that they did not attend IYrs PMT when their child was much younger. They felt that behaviours may have not been quite as engrained and easier to change at that time when they first started appearing. Therefore, there was acknowledgement that there had not been access to services such as IYrs PMT on more of a preventative basis.

> *"It's really good to get in early do it when you're really young. Like I recognise with Steven that there was something-between 5 and 7 and I think if you've got to get people to come, come before they turn 8 or 9....to change those patterns....so you don't have to retrain..... but then you don't know about it. There's nothing out there unless you're in the system you don't know about things like this. I don't know where you would read about it"* (Linda).

Parents were able to weather difficult situations and remain calm, by thinking about the longer term aspects of their response in building positive memories for their children. There were attempts to become more child-focused as parents attempt to focus on the experiences for their children. A particular situation could be an extremely challenging and difficult experience for parents but it could be endured for the goal of deliberately building positive memories, acknowledging that children's perceptions of things can sometimes be totally different from parents' expectations.

> *"One time we took her up to the mountain to go sledding and she was as snotty as anything and when we got up there she said you told me, it's cold, it's wet, I don't think she realized that snow was wet, but she grizzled and moaned and it was horrible. Then, about 6 months later she was saying how wonderful it was when she got up there and we were thinking, come on were you on the same trip or what"* (Brian).

Parents acknowledged developmental aspects and external factors which may assist in the reduction of their child's symptoms. Parents hoped that as the child matured the child's ability to relate to others in their environment would improve. Parents were aware that the journey toward their child's independence would be a slow one. Some felt that it would not be until the child had become more independent and had left home that they would have the capacity to reflect on how their actions impacted on others.

> *"It will just probably be more him growing up and going away from me and seeing what he does you know- what he's been doing, whether he'll recognise what he's been doing or just carry on doing it and get bored.. I wanted to break that before its too- that I think I left it too late to try"* (Linda).

Parents were apprehensive about what the future would bring for their child, particularly as they embarked on adolescence. Parents reflected on their own adolescence, and experience of risk taking behaviours.

> *"If he's got this penchant for risk taking behaviour well then that's not good for his adolescent years coming up you know…you have to have risk taking behaviour, god…. I'd raced motorcycles for years, I had a bit of a wild youth, I played in bands you know I did the whole wild side of thing for years and I came out the other end of it and so did most of my mates. I don't know how- and it's going to be really hard, knowing what it's like. It's going to be hard. I mean I didn't have a sheltered upbringing-I lived life hard and fast for years…..as a parent obviously you'll looking down the other end of the telescope it's a terrible thing to see coming"* (Tony).

There was the awareness that as parents they could only do so much. Parents ultimately felt that their child would need to learn from their own mistakes. This was due to the difficulty in listening to instruction, impulsiveness and lack of attention at times and the likelihood that this would expose them to dangerous situations, some potentially life threatening. There was acknowledgement by parents that there was no "quick fix", or "cure" regarding their child's behaviour. Parents were often acutely aware that there were no long term interventions or ongoing support for parents of children with disruptive behaviours either diagnosed or undiagnosed. There was awareness that this would be primarily their responsibility.

> *"But the problem with Billy is his seeming inability to obey anything instantly to the point where it's going to endanger his life, like I do a lot of sailing and marine engineering here and he loves the boat…..but at the moment you can't trust him, if you say to him, put that down, or let go of that line, you know, it's too late it will kill him and someone will have to dive in and endanger their life to save him because he just won't do, he just won't…..I don't know what you could do in that boy's head to make him just obey you*

immediately when it's important I don't know, he's constantly, oh yeah, just wait, or you know or that just drives me to distraction, not because he's doing it to confront my authority, but it's dangerous" (Tony).

Child's Behaviour

Some parents began to think about the reasons behind their child's behaviour rather than their child deliberately setting out to annoy them. They reported changes in their perception of their child's behaviour.

"Even though it can appear that she's deliberately doing something that you realize that that's not always the case" (Brian).

"It kind of puts it into perspective in the sense some of it was just attention seeking and I guess some of it was just the way in which I reacted um yeah so like I kind of built things up because of the way in which I decided to deal with it, so trying to deal with it in a different way comes out with a different result" (Mere).

*"I think it taught me to not over intellectualise what your kids-I mean they're kids, they're not deliberately setting out to piss you off. I think that was one of the big things, it takes a while to dawn on you that it's not, they're not evil, they're not trying to wind you up even when they are you know, that it's- a lot of its not intentional" (*Tony).

Parents began to realize that their commands to their child could be misinterpreted, that developmental aspects required consideration. Parents learned that patience was required and their instructions encompassed commands that were clear, concise and specific.

"You take it for granted that they should do what they say but really they don't understand (Sharon).

During IYrs PMT, their cognizance transformed from the understanding that the disruptive behaviour of their child was intentional and deliberate, in some instances a personal attack, to the awareness that it is not and can be explained as being part of the disorder. For parents of children that were not diagnosed, understanding also changed.

"They can't diagnose him with anything, he's actually one of these kids that hard work you know and that was a relief and a frustration in a way it was good to know that there was nothing organically wrong with him or intellectually wrong with him, it's just his personality" (Tony).

Parents benefited from skill acquisition that had enhanced their understanding pertaining to causal factors for their child's behaviour. Awareness was created regarding the motivation behind behaviours. This was designed to receive parental attention. The effect of positive parental attention was most beneficial for the children who had exhibited self-harming behaviours or suicidal ideation. There were observations that the child's behaviours had become more positive as well as language with a reduction in negative self talk and expression of hatred toward their parent.

> *"We noticed a big change in Billy's behaviour particularly with the concerns with him- especially with suicidal ideation. He really came right back out and was a lot more positive and initially did as he was told quite a lot" (*Sally).

> *"I guess we are able to talk through things a little bit better I you know I tend to explain to him when he's not getting what he wants why that's happening. When he gets upset over something we can talk through it a bit better"* (Mere).

When parents were dealing with children who had complex co-morbidities; some of the strategies helped with these behaviours. They were described as going in "hand in hand". The influence of parental behaviour in maintaining behaviours was evident when parents had been dealing with distressing, engrained behaviours. .

> *"It did help with the encopresis as well because it helped me to take a step back and um give me some techniques of calming down and techniques to help him as well and um it was sort of a bit of a tough one"* (Sharon).

Chapter 14

Preservation

- MAINTENANCE
- REAPPEARANCE
- REVIEW
- REFORMULATION

Maintenance

The ability to maintain the gains parents had made from the programme was a challenge for parents, who may have become complacent. When they noticed their child's behaviour starting to deteriorate, this often precipitated parents into taking action.

> *"We are finding now that we have to re-address that every few months um and a part of it is you are slipping as parents and not being as consistent and being tired and involved with other things and stuff and having to get back on board* (Sally).

Parents feel a sense of personal responsibility and regret that they forgot components of the material. Maintaining what parents learned during IYrs PMT encompasses the ability to sustain the changes and strategies they have made; and to remember what was learned. Admitting they had "slackened off" was met with justification that it was their responsibility to keep up the momentum but that time had lapsed since completing the programme. Parents were busy and recalling the information of what works well was met with difficulty, particularly in crisis situations or in the "heat of the moment".

There were difficulties being unable to remember information because one was tired at the time of attending the course, and did not take in all the information. The importance of practicing was acknowledged, which enabled the parent to remember the strategy more effectively as it became a more learned and immediate response.

> *" We slackened off after awhile, you know what I mean aye, but a lot of it's me, you know, when you're working and really busy sometimes you slacken off a little bit but yeah no yeah we were trying out different things it was good"* (Hone).

Fathers expressed the difficulty and pressure they placed on themselves in attempting to try to remember the material in the heat of the moment.

> *"I think that the incredible Years training has helped to handle him um but again as I say it's almost incidental now because the difficulty in trying to use that whole corpus I find it difficult to hold and particularly in the heat of the moment I'm a quick tempered sort of guy and I can't suddenly refer to 15 handouts in the fraction of a second it takes me to lose my rag"* (Tony).

> *"I'm not very good when it comes to-when there's a crisis time recalling information of what's necessarily worked best in the past"* (Brian).

Parents also spoke about continuing to refine their skills as part of maintaining what was learned.

> "*The play and praise bit-that was very important because that was something that I'm still working on- is to be more involved in his activities and things and not just stand back"* (Sharon).

Re-appearance

Following IYrs PMT, re-appearance of behaviours (that had initially reduced or diminished when parents implemented strategies); would precipitate parents into taking action in their attempts to maintain the improvements in their child behaviour. Reappearance of behaviours therefore preceded the reviewing stage. Reappearance was evident where parents lapsed in the use of their strategies within the programme, when other stressors were impacting on their implementation or when they did not generally believe the strategy would be helpful for their child such as time out.

Review

Parent's acknowledged that it was ok to make mistakes, and they would catch themselves out. It was inevitable that mistakes did occur but the important factor was realizing when this occurred. Making mistakes was recognised as a natural human behaviour and in fact can motivate the parent to strive to improve their own performance as parents by reviewing their own behaviours.

> *"You know sometimes you muck up and let things slide and start back at the beginning again but I guess we're all human"* (Sharon).

Parents were constantly reviewing their child's behaviour as they matured. They encountered new situations and difficulties. Reviewing was achieved by having the ability to resolve

problems using the framework of IYrs PMT and knowing they could not return to ineffective strategies of the past.

> *"Part of it I think you know they're growing and changing and continually having to use different techniques as well um so I mean we do go through oh god they are not doing anything at all but you are always conscious in the back of your mind this doesn't work, shouting doesn't work, what else can we use whereas previously you were just so frustrated nothing was working, we didn't know what to do you know whereas now you can sort of think oh what else can we do and talk about it more as a family"* (Sally).

The use of visual aids to assist the parent at home and providing a folder they could get out and review was emphasized. It was acknowledged that the ability to recall the information and strategies that were learned would become more difficult as time progressed, but to compensate for this phenomenon were the handouts and folders which enabled the parent to have a resource to refer back to.

> *"I haven't read it from cover to cover again but I will flick through a section and remind myself-I haven't lately but I have done and it's always there if I need to remind myself"* (Sharon).

> *"I've probably lapsed back into my old ways and I keep thinking I must get it out and re read it and just try and re read it to go through and just see if there is anything that I can put into practice yeah"* (Linda).

There was also an understanding by others that this would not be enough and that maybe re-doing the programme was required. This was connected to added difficulties at the time that IYrs PMT was completed. One couple who had both attended (but at different times), had various mental health issues interacting in the family which contributed to having a difficult year and where the programme strategies had been difficult to implement at home. For one parent, her husband was going to re-do the programme and she was going to complete home activities and readings to support her husband better in the background when he re-did the programme.

> *"My husband's actually going to repeat it again next year, so yeah, its an ongoing thing, as is their behaviour"* (Naomi).

> *"We probably do use some of it now just not as much it's not forefont in our thinking. I can understand why they say to do it more than once, because I think each time you probably pick up extra things"* (Rebecca).

Reformulation

Reformulation of behaviour occurs by the parent or family when strategies are not working or new insights are gained. Reformulation occurs also within a clinical sense and it is acknowledged by parents that they may require assistance from their child's clinician at times as the nature of the process is that there are a numerous variables that will impact on the parent's ability to be peacekeepers.

> *"I've probably reverted back too tight in a lot of ways. You know you start off with the best of intentions, yeah, changing is a constant battle in that you have all the will in the world but like I said earlier, push comes to shove, you know, it can be hard"* (Brian).

> *"It by no means solved all your problems- it's always a work in progress"* (Sally).

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Appendix A

Print on Whirinaki Letterhead

In collaboration with
[Print on Massey University departmental letterhead]
Logo, name and address of Department/School/Institute/Section]

PARTICIPANT INFORMATION SHEET

Kaye Wolland
Ph 265-4104
Fax 265-4199
Email: wollanK@middlemore.co.nz

"Parents Experiences of Incredible Years Parent Management Training delivered within a Child and Adolescent Mental Health Service."

You are invited to take part in this study as our records indicate you attended our Incredible Years Programme last year (2007) and your child was a client at Whirinaki. It is likely that things haven't always been that easy for you as a parent and as a family managing your child's behaviour which can be disruptive. I would like to talk with you about your experiences.

My name is Kaye Wolland and I am conducting this study for my Master's thesis (Psychology) which I am completing through Massey University, Albany. My supervisor for this study is Cheryl Woolley who is based at the Massey University campus in Palmerston North (my supervisor will ensure my competency and safety as a "grounded theory" interviewer). I currently work as a Social Worker in the Child team at Whirinaki, Child & Adolescent Mental Health Services.

I would like to talk with both Mums and Dads about the meaning that Incredible Years has had for you. I am interested to hear about what happened as you went through the programme, how it affected your family and what it was like being part of a group.

You are invited to be part of this study if you have attended the Incredible Years Parent Management Training Programme delivered by Whirinaki in 2007 and your child is:

-aged between 5 years, 0 months to 12 years, 11 months (at the time of completion of Incredible Years)
- your child shows disruptive behaviour
-you have attended at least 50 % of the Incredible Years sessions.

If you decide you would like to be part of this study, you will be asked to complete:
-a brief participant profile form
-I will interview you for approximately 1 ½ hours. I will interview you either at Whirinaki or at your home at your convenience.

The interview will be audio-taped. You have the right to ask for the audio tape to be turned off at any time during the interview. The tapes will be transcribed, you will be offered the opportunity to edit the transcripts after they are transcribed. Data from

the tapes will not identify you in any way. After the tapes are transcribed they will be destroyed. The transcripts will be securely kept in a locked cabinet for 5 years at Massey University, after which they will be destroyed.

Participants will receive a voucher to compensate for any parking or petrol costs which may be incurred.

As a participant you have valuable experiences to share that can create an awareness of the journey parents go through whilst attending Incredible Years. The knowledge that you also share has potential benefits for other parents who may complete the programme, for clinicians, Child and Adolescent Mental Health Services and the development of Incredible Years within the New Zealand context.

You are under no obligation to accept this invitation. Your decision whether or not to participate will not prejudice you or your child's future relations with Whirinaki, CAMHS. If you decide to participate, you have the right to:

- decline to answer any particular question
- withdraw from the study(at any time)
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used
- be given access to a summary of the study findings when it is concluded.
- have cultural needs respected i.e have a Maori interviewer conduct the interview or complete the interview in Maori
- access immediate support from a Whirinaki Clinician should you experience distress during the interview.

If you agree to participate in the study please make contact with Kaye Wolland by Thursday 28-August-2008
Ph 09-265-4104 (Tues-Thurs) Fax 09-2654199; Email: wollanK@middlemore.co.nz
Address: Whirinaki, Child & Adolescent Mental Health Service, Private Bag 93311, Otahuhu, Auckland.

If you have any questions please do not hesitate to contact the researcher Kaye Wolland. Alternatively you can contact her supervisor Cheryl Woolley, School of Psychology, Massey University Palmerston North . Ph 06-3569099 ext 2076, Private Bag 11222, Palmerston North

This study has received ethical approval from the Northern X Regional Ethics Committee.

If you have any questions or concerns about your rights as a participant in this study you can contact an independent health and disability advocate. This is a free service provided under the Health and Disability Commissioner Act.
Telephone: (NZ wide) 0800 555 050
Free Fax (NZ wide): 0800 2787 7678 (0800 2 SUPPORT)
Email (NZ wide): advocacy@hdc. org.nz

Appendix B

"Parents Experiences of Incredible Years Parent Management Training delivered within a Child and Adolescent Mental Health Service."

Participant Profile Form

The purpose of this form is to obtain information about your family composition and the nature of your child's difficulties. All information provided will be treated with strictest confidentiality. Pseudonyms will be used for your family's names. The profile will take approximately 5 minutes to complete.

If on any question there is not enough space for your response, please continue on the back of the page, with the question number indicated. If you have any concerns or queries regarding this profile, please feel free to contact me , Ph 265-4104, or email wollanK@middlemore.co.nz

Name: _____

Ethnicity: _____

☐Female ☐Male

Who are the family/whanau members who live with your child? Please state their relationship (i.e stepfather) and their age (no names required).

Is there anyone else that lives with your child? (i.e your partner, boarder) Please state their relationship to your child and their age (no names).

Does your child live part of the time with anyone else i.e mother/father, respite caregiver? Please describe the arrangements.

What is the nature of your child's difficulties with disruptive behaviour?

If your child has a formal diagnosis, please state:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Did you attend the Incredible Years Programme-

☐ **By yourself**

☐ **With a partner or spouse**

☐ **With a support person**

Thank you for taking the time to complete this profile.

Kaye Wolland

Appendix C

[Print on Massey University departmental letterhead]
[Logo, name and address of Department/School/Institute/Section]

Parents Experiences of Incredible Years Parent Management Training delivered within a Child and Adolescent Mental Health Service.

PARTICIPANT CONSENT FORM

This consent form will be held for a period of five (5) years

I have read and I understand the Information Sheet dated 17/July/2008. I have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being audio taped.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: ..... **Date:** .....

Full Name - printed .....

Appendix D

Interview Schedule

1. Can you please describe how you came to be involved in the Incredible Years programme?

2. What were your experiences of Incredible Years?

3. Do you think it has contributed to enhancing parent, child and family wellbeing? If so, how? If not, why? *(are there any positive effects of changes in your family)? Can you talk to me about that?*

4. How could the Incredible Years be further improved to benefit your child, parent and family wellbeing? *i.e Based on your experiences is there anything else that would have benefited you?*

5. What happened as you progressed through Incredible Years i.e as a child

6. What happened as you progressed through Incredible Years for you as a parent, for your family? What has happened since completing or finishing the programme?

7. How do you think Incredible Years has affected your understanding of your child's behaviour? *Do you view it differently?*

8. Please comment on the experiences/perceptions of being a mother/father participating in Incredible Years. *If negative things: are there any things that you would suggest that would make you more comfortable?*

   Would you recommend this programme to a friend, what would be the 3 things that you got out of it?

9. Are there any other aspects of your involvement in the programme that you would like to comment on? *Is there anything else that was particularly helpful, or anything that you would like to change?*

10. Is there anything else you would like to talk about that we haven't covered.

Appendix E

[Print on Massey University departmental letterhead]
[Logo, name and address of Department/School/Institute/Section]

Parents Experiences of Incredible Years Parent Management Training delivered within a Child and Adolescent Mental Health Service.

AUTHORITY FOR THE RELEASE OF TRANSCRIPTS

This form will be held for a period of five (5) years

I confirm that I have had the opportunity to read and amend the transcript of the interview conducted with me.

I agree that the edited transcript and extracts from this may be used by the researcher Kaye Wolland in reports and publications arising from the research.

Signature: ..... **Date:** .....

Full Name – printed .....

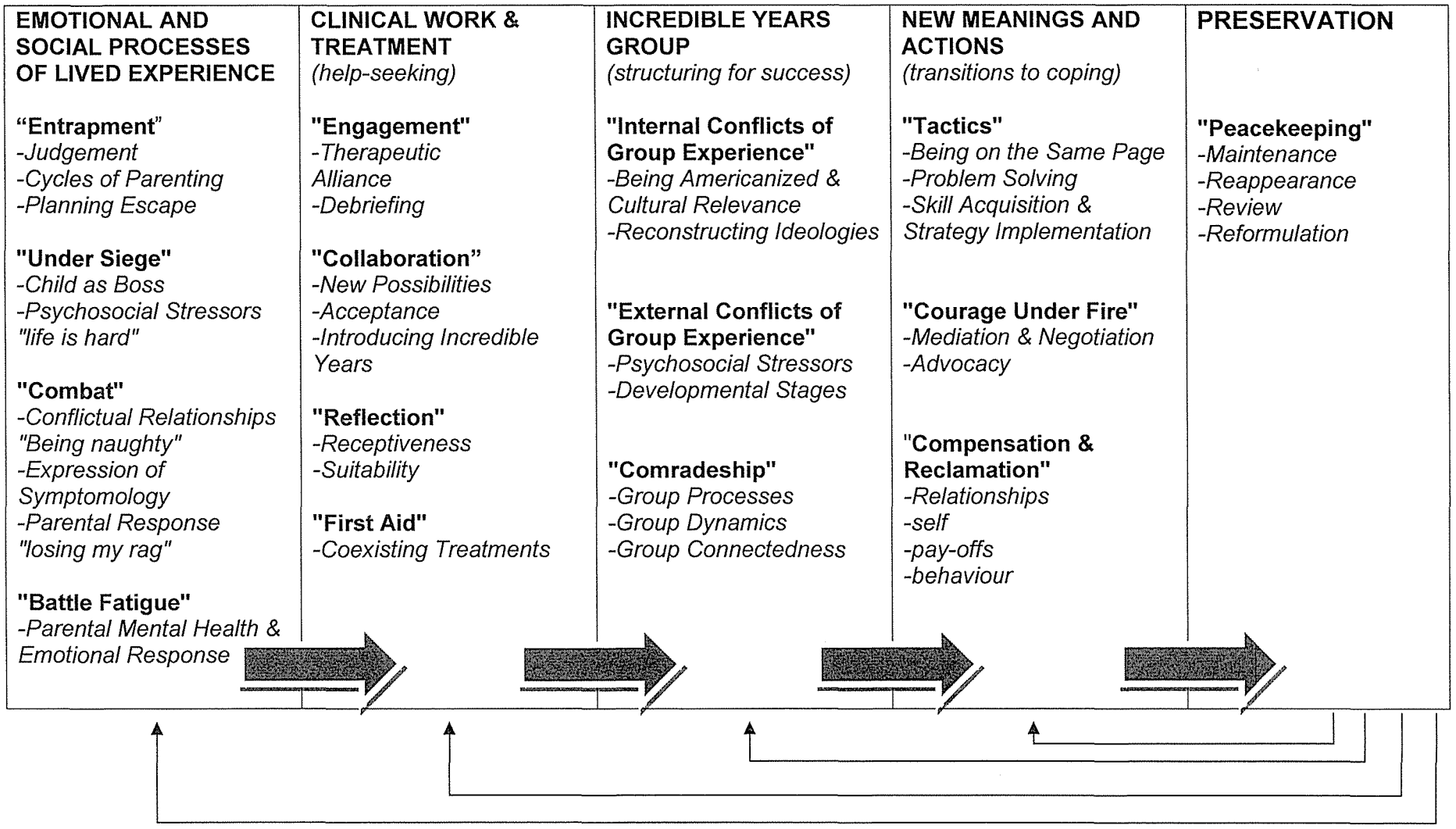

Figure 1 "War Zone to Cease Fire" Parents Experiences of IYrs PMT within Whirinaki, CAMHS