

PARENT MANAGEMENT TRAINING FOR SOLO MOTHERS

Parent Management Training for Solo Mothers of Children Diagnosed with Attention Deficit

Hyperactivity Disorder: An Effectiveness and Multiple Baseline Evaluation.

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Abstract

Assessed the effectiveness of ‘The Incredible Years Parent Training Program’ on the functioning of families of children with ADHD within a community clinic setting. A multiple baseline across participants design was employed with four research participants in a group of nine parents attending a 2-hour treatment session weekly for twenty weeks, with planned booster sessions at 2 and 4 months following treatment. Participants were all solo mothers with sons between 6 and 9 years of age who met the DSM IV criteria for ADHD. Family functioning was assessed from the pre-treatment interview schedule, measures of child behavior (Conners, Strengths and Difficulties Questionnaire, daily ratings of child behavior) and parental functioning (BDI-II, Parental Stress Index, weekly ratings on specific areas of family functioning, group goals). Participants also completed program satisfaction and evaluation measures. Results overall showed (a) some improvement in teacher and parent reports of child behavior, including targeted child behavior goals, (b) improved targeted family functioning problems, (c) increased parental confidence, (d) reduced stress and depression levels for most parent participants, and (e) reports of better parent-child relationships. Additionally, participants all reported being highly satisfied with the program. Findings support the use of the Incredible Years Parent Training Program and planned booster sessions as an effective low cost intervention to improve the functioning of solo mothers and of children with ADHD. Discussion considers the use of this intervention in an overall multiple gating, stepped care approach, particularly in light of a need for continuing services for one of the mothers.

Parent Management Training for Solo Mothers of Children Diagnosed with Attention Deficit
Hyperactivity Disorder: An Effectiveness and Multiple Baseline Evaluation.

Attention-deficit/hyperactivity disorder (ADHD) is a commonly diagnosed behavioral disorder of childhood that is characterized by symptoms of inattention, hyperactivity and impulsivity. There has been a dramatic increase in diagnoses of ADHD in recent years. Currently it is the most common diagnosis given to children in child and adolescent mental health services in New Zealand (Ministry of Health, 2001). Prevalence rates for ADHD in New Zealand are around 5% of school-aged children with rates for boys 3 times higher than for girls (Ministry of Health, 2001). Similar prevalence rates are found in the U.S. and internationally (Barkley, 1999).

Children with ADHD often have pronounced difficulties and impairments across multiple settings such as in the home, at school, and with their peers. They can also experience long-term adverse effects on academic, vocational, psychosocial, and psychiatric outcomes (Barkley, 1998). Children with ADHD use mental health services more frequently than the general population, and the cost of caring for these children in primary pediatric settings is estimated to be at least twice that of the general population (Power, Russell, Soffer, Blom-Hoffman & Grim, 2002). The impact of difficult child behavior on family functioning has a compounding effect on the physical, emotional, and psychological welfare of the child, the family unit, and the wider community.

Indeed, apart from the impact on the child, recent research has confirmed earlier findings that parents of children with ADHD experience elevated stress levels, and have less effective parenting practises relative to parents of children without this disorder (Treacy, Tripp & Barid, 2005). In order to address parenting issues and these other factors, an effective, low cost intervention strategy would obviously be a useful addition to the range of services available in everyday settings.

Combined Pharmacological and Psychosocial Treatment

Although stimulant medication is reported to be the single most effective treatment in the short term for ADHD (Barkley, 1999; MTA, 1999), reliance upon pharmacological therapy alone may not be sufficient, given that the disorder is complex and stimulant medication has limited long-term efficacy. Combined pharmacological and psychosocial treatments have the potential to target not only the core symptoms of ADHD but the associated social, academic and family factors as well.

Parental Factors

Parenting is a difficult and challenging task, made more so in the case of solo parenting (Cainey, Boyle, Offord & Racine, 2003; Herbert, 1995; Mash & Johnston, 1990). Raising a child with ADHD often puts added stress on the family system (Treacy et al., 2005). Pertinent to this study, mothers of children with ADHD are more depressed, socially isolated, and restricted in the parenting role compared to mothers of normal children (Mash & Johnston, 1990). Additionally, parents experiencing high levels of stress in their parenting role are more likely to make negative appraisals of their child's behavior, become overly directive in their parenting style, and view themselves as less skilled and less knowledgeable about parenting practices (Mash & Johnston, 1990). Therefore, using a combination of medication and psychosocial skills to address both the symptomatology of ADHD for the child, as well as the social interactions and behavioral patterns within the family, has potential to enhance outcomes for solo parents and families of children with ADHD. Parent training is one vehicle through which this psychosocial assistance can be provided and the Incredible Years Parent Training program has some established efficacy (Webster-Stratton & Herbert 1993; Webster-Stratton & Taylor, 1998; Scott, Spender, Doolan, Jacobs & Aspland, 2001).

The Present Study

There have been many studies that have used a parent training model, mainly for disruptive behaviors. However, not many have examined the efficacy of parent training with children specifically identified as having ADHD per se (Anastopoulos, Smith & Wien, 1999). While there are numerous parent training programs available, few have been as well researched and empirically supported as Webster-Stratton's Incredible Years program. This program has been shown to be effective in the U.S., Canada, and Britain in the treatment of noncompliant and younger children at risk for conduct disorder as well as those with ADHD (Webster-Stratton, 1994). It is also cost effective.

While the Incredible Years has some established efficacy, it has not been trialed specifically in a clinic setting for ADHD children and solo parents. Given the increasing call for evidence-based practice, and the fact that this study was carried out in a public mental health service, this study was designed as a pilot to a larger effort to assess treatment effectiveness. The issue of effectiveness research was particularly salient here as all four solo mothers and their families had multiple problems including histories of maternal depression, substance abuse, and a history of wider family problems. This study used a multiple baseline across participants design with four research participants receiving treatment in a group with five other parents not participating in the research.

The aim of the present study was to assess the impact the Incredible Years Parent Training Program had on the functioning of these parents, their child with ADHD, and their families. It was hypothesized that child, parent, and family functioning measures would improve with the treatment program, and that improvement would be maintained at follow-up.

Method

Design

The study consisted of four single case studies using a multiple baseline across participants design. Participants had varied baseline periods (that ranged from 4 to 23 days) prior to commencement of treatment. Daily and weekly baseline measures (described below) provided information on family and child functioning prior to intervention. Child behaviors were collected daily during baseline, across the twenty week treatment period, and again for a 2-week period at 4-month follow-up. Family functioning scores were collected weekly beginning at baseline and continuing during treatment, and again at 4-month follow-up. Child behavior and parent functioning measures were collected at pre-treatment, post-treatment, and at 4-month follow-up. Trends in the continuous data were identified to assess the impact of treatment over time. Other data collected at pre-treatment, post-treatment, and follow-up was used to help identify the overall magnitude and rate of change. At post-treatment, evaluations also included additional satisfaction and program evaluation measures.

Participants.

Participants were four parents whose children met the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM IV) (APA, 1994) criteria for Attention Deficit Hyperactivity Disorder (ADHD). They were referred through the Child and Adolescent Mental Health Specialist Service (CAMHSS) of a public hospital setting. Participants were part of a group of nine parents who attended the training program. All four participants were of European descent, had no tertiary training, and were all solo mothers. At an intake interview, they all reported they had experienced depression, had abused drugs and alcohol in the past, and three of the four participants identified psychiatric history in their wider family. They also reported lack of employment (n=4) and a general lack of family and social support (n=4). However, one participant did report a support person in the community who was encouraging of her participating in the current program. Participants reported no difficulties during their pregnancy and stated that their children's developmental milestones were normal. It is also of note that during the time of the study all families experienced a significant transition. They either moved (n=3) and/or changed schools (n=3).

Children.

Children were male between 6 and 9 years of age (6, 8, 8, 9 years) and all met the DSM IV criteria for ADHD (see next section). The children were all on stimulant medication monitored by a psychiatrist and a case manager. All children were reported by their mothers at intake to have major behavioral difficulties in the home and school environment, including the maintaining of friendships. Additionally, they all experienced a number of learning difficulties and were behind in reading and writing skills for their age.

Assessment

ADHD diagnosis was established by a child psychiatrist according to the criteria set out in the DSM IV (APA, 1994), and was supported by intake interview information and observation, along with parent and teacher comments and rating profiles on Conners' Rating Scales.

Child behavior measures.

Child behavior was assessed from parent and teacher rating scores on established measures: Conners' Parent and Teacher Rating Scales, (Conners, 1997) and the Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997). These were collected at baseline, post-treatment, and follow-up. In addition, parents collected daily records of child behavior for varying baseline periods prior to the commencement of the training program, throughout the 20-week treatment period and for a 2-week period at 4-month follow-up.

Daily behavior record.

A checklist of 10 child behaviors was established for this research. It included both positive and negative behaviors and reflected aspects of hyperactivity, impulsivity and attention deficit. The checklist was used to record frequency of behaviors daily using a likert scale of 1 (not at all) to 7 (a lot). Participants began recordings from the beginning of baseline and continued through the 20-week training program and again for 2 weeks at 4-month follow-up.

Parental and family functioning measures.

Parent functioning was assessed using established measures: the Beck Depression Inventory (BDI-II) (Beck & Steer, 1987) and the Parental Stress Index (PSI) (Abidin, 1983). Parents also completed weekly ratings for family functioning from the time of interview until the completion of the training program, and again at 4-month follow-up.

Weekly family functioning measures.

Parents identified three target difficulties in family functioning they wished to address, and rated each item on a scale of 1 (least quality) to 7 (most quality). These ratings were assessed weekly from baseline to course completion, and again at follow-up.

Group goals.

In an initial session, the group identified a set of goals related to family functioning (17 items in total) that they wished to achieve during the training program. Each participant scored the item on a 1-7 likert scale at mid-treatment (week 10), post-treatment (week 20), and at 4-month follow-up.

Parent satisfaction and program evaluation.

At post-treatment, all participants completed a standardized satisfaction questionnaire and a program evaluation which evaluated aspects of the course content, facilitators' role, and skills learned (Webster-Stratton, 1999).

The Training Program

Treatment involved parents attending a 20-week Parent Management Training Program (The Incredible Years). The sessions were 2 hours in duration and were held weekly except for a 2-week break for one school holiday period. Planned booster sessions were carried out at 2 months post-treatment, and again at 4-month follow-up. Assessments that were non-continuous were carried out at pre- and post-training and 4-month follow-up. Continuous evaluation was done across variable baseline intervals, across treatment, and across a 2-week interval at 4-month follow-up.

The training protocol used in this research was an integrated combination of the Basic Parent Training, Advanced Parent Training, and Supporting Your Child's Education Program. This combination was in accordance with an already established protocol developed by Webster-Stratton, combined in a logical sequence after training and consultation with C. Webster-Stratton (personal communication, June, 2001; protocol outline available from the authors).

Intervention.

Each session included a review of the previous session, teaching on the new topic, video-vignettes showing examples of parents and children interacting, group discussion, and opportunities to role-play and practice new strategies. A homework activity to reinforce new techniques was provided, along with a fridge magnet summary of the main points to help remind parents of the new learning. Participants were also encouraged to read the relevant chapter from the accompanying parent book (Webster-Stratton, 1992). Each participant recorded daily measures of child behavior and weekly measures of family functioning. Mid-week phone calls

from the researcher served to encourage parents, assess any difficulty they might have been experiencing, and to ensure the daily measures were being recorded. Sessions were audio taped and 25% of sessions were randomly selected and rated by a senior clinical psychologist not involved with the intervention, but with several years' experience in parent training and manualized interventions. No protocol violations were found.

Results

General Trends in Child Behavior Psychometrics

Child behavior psychometrics.

Conners' Parent *T* scores (see Table 1) for two participants (B&D) showed an overall improvement in behavior between pre-treatment and follow-up. For the two other participants (A&C), the improvement was very slight. Teacher *T* scores indicated the greatest improvement was across treatment for each child except child A (no improvement). Parent scores overall tended to reflect more problems than teacher scores (except child B), and teachers reported more overall improvement than parents.

Strengths and Difficulties Questionnaire.

Parent scores on the Strengths and Difficulties Questionnaire for Total Difficulties did not reflect any major trends across pre- and post-treatment across participants (Table 2). However, by follow-up, there was an overall improvement in impact scores for all participants, and two of these (B & D) had scores in the normal range.

Daily behavior measures.

Parents monitored daily positive and negative child behaviors for varied baseline periods, and throughout the treatment period for all participants (Figures 2, 3, 5, 6, 10, 11, 15 & 16).¹ There was no fully consistent trend across baseline for all children. All children showed some fluctuations in positive behaviors during treatment and there was a general trend towards increased frequency of positive behaviors by post-treatment. Negative behaviors showed mixed results with improvements for child D and C but little change for child A and B across treatment. Generally, positive behaviors tended to improve early in the treatment period while negative behaviors seemed more resistant to initial treatment effects.

Follow-up scores of daily child behavior were collected over a 2-week period. During the 14-day follow-up period, child B and D showed continued improvement in the daily behavior measures, child C showed fluctuations in behavior and data were not able to be collected for child A.² (Figures 7, 8, 12, 13, 17 & 18).

Parent Functioning Measures

Parenting Stress Index (PSI).

Parent stress levels were expected to decline following treatment. Two participants (A & C) showed a decline in PSI scores across treatment, and there was overall improvement in stress levels at follow-up for three participants (A, B & D) (Table 3). Participant C continued to have high PSI scores throughout the treatment and remained in the clinically significant range at follow-up.³

Beck Depression Inventory (BDI).

It was expected that depression levels would improve with treatment and this was evident for participants A, B, & D (Table 3). Participant C's level of depression increased across treatment and at follow-up was in the severe depression range (30–63).

Weekly family functioning.

Figures 1, 6, 7 & 14 show the changes in family functioning over the treatment period and at follow-up for each family. Each participant identified three areas of family functioning to target for improvement during the training. Overall, treatment impact was seen across treatment and follow-up intervals.

For participants A and B, all three functions increased steadily during treatment, and at follow-up, all items were at the maximum best score. For Participant C, one function, ('yelling') was unstable and showed no overall improvement. The other two functions had an overall improvement at post-treatment and continued to improve across follow-up. For participant D, all three measures fluctuated during the treatment period with a general trend towards improved family functioning. By follow-up, all functions had improved.

Group goals.

The group identified 17 goals and rated their achievement for each item on a 1-7 likert scale (1 = worst, 7 = best). As seen in Table 4, most goals by mid-treatment were not yet mastered. All participants rated some improvement on all goals by the end of treatment period. By follow-up, all participants reported achieving 10 or more goals.

Attendance and parents' satisfaction questionnaire.

There was a reasonable rate of attendance with all participants attending at least sixteen of the twenty sessions (range = 16-19). The Parent Satisfaction Questionnaire completed at the conclusion of the training program rated items on a 1-7 likert scale (1 = least satisfied, 7 = most satisfied). As seen in Table 5, all items were rated at 4 and above indicating a general level of satisfaction. Items relating to parenting confidence were all above 5 indicating above average levels of satisfaction. All participants scored a high

level of satisfaction with the course with regard to recommending the program to a friend and overall feeling about the treatment program for their child and family.

Discussion

The results of this study provide evidence to support the hypothesis that the Incredible Years Parent Training has a number of beneficial effects on the functioning of families of solo mothers with children diagnosed with ADHD. The improvement in (a) teacher reports of child behaviors, (b) targeted family functioning problems, (c) number of goals achieved related to child behaviors, and (d) the improvement in stress and depression scores for most participants provides some support for the effectiveness of this program as carried out in a public health setting. Importantly, all participants reported (a) high levels of satisfaction with the program, (b) improvement in parent-child relationships, (c) increased confidence in parenting ability, and (d) had reasonable levels of attendance. However, parent reports of child behavior overall did not uniquely reflect generalized improvement across treatment and thus did not provide unqualified support for the impact of the program on child behavior.

Other aspects of family functioning did show improvement across treatment. In particular, targeted family functioning, explicit treatment goals, and general levels of stress and depression improved in most cases. This is consistent with other studies showing that parent functioning can be improved with parent training (Anastopoulos, Shelton, DuPaul & Guevremont, 1993).

A number of factors could account for the equivocal parent report findings: low parent teacher agreement on ratings has been reported in other studies (e.g., Furlong & Wood, 1998); a lack of independent observations of child behaviors in the home; a high number of individual, family, and community risk factors present for each participant; families were all selected from the wait list of referrals to this clinic which, based on referral criteria, puts them in the top 3% of families in terms of dysfunction; and the single case study design magnifies individual cases. In addition, parental psychopathology has been found to moderate ratings of child behavior (Breen & Barkley, 1988; Marsh & Johnston, 1990; Treacy et al., 2005). The fact that Parent C reported increased levels of stress and

depression may have influenced her ratings of child C behavior. Of course, an alternative explanation to the pattern of parent reports is that children may not have improved where indicated.

However, the teacher ratings provide evidence not supportive of this latter explanation. While parents reported feeling better about their parenting skills and more positive about specific features of their child's problems and family factors, their perceptions of overall child behavior, as reflected on standardized instruments was not as positive as teachers. Parents often lack the opportunity to compare their child's behavior with a number of other age related peers, whereas teachers have ready comparisons in the classroom and may have more realistic and perhaps more objective expectations of age appropriate behavior.

The Incredible Years does have evidence supporting its efficacy in modifying behavior of children with conduct problems (Herbert, 1995; Scott, Spender, Jacobs & Aspland, 2001; Webster-Stratton, 1994) in the United Kingdom, Canadian, and USA samples. Given the other supportive findings here, including the teacher report and other findings reported, this research does go some way towards supporting the use of the Incredible Years parent training in a public clinic setting to improve the important aspects of functioning of families of solo mothers with children diagnosed with ADHD.

Limitations of Current Research

Research shows that change occurs more predictably when parents are supported and encouraged by another adult in the home environment (Webster-Stratton, 1998). Only one participant (participant A) reported having a support person in the community to encourage her. This support aspect could be given more emphasis in future training programs and related research. Second, given that this study was aimed at solo mothers, there were no fathers in the research group. Typically, fathers are more verbose in their parenting style and tend to use more physical punishment than fathers of children without this disorder (Treacy et al., 2005; Mash & Johnston, 1990). Recent findings have indicated that there is no significant difference in parenting stress between mothers and fathers of children with ADHD and that fathers have a significantly smaller social support network compared to mothers (Treacy et al., 2005). Targeting fathers or perhaps other male role models, along with other

forms of support, in future studies, would clarify whether the addition of such a component could assist a solo mother. A third limitation was the lack of independent child observations. Including such observations would provide a different perspective on changes in observed child behavior in the home. Finally, there was no educational assessment carried out for the participants' children as part of this research. It is well established that children with ADHD often have associated learning and or social difficulties.

Future Research

The role of this type of intervention in a continuum of stepped case services (e.g., Ronan, Finnis & Johnston, 2005) might be clarified in future research. Given the low cost and increased efficiency compared to more intensive interventions (e.g., intensive, home-based service delivery for individual families, e.g., Curtis, Ronan & Borduin, 2004), such a program might reduce the need for more intensive services for some.

As one example, implementing the Teacher Training Program in combination with Parent Training might very well result in greater change but would also add to the cost. Webster-Stratton (2000) found that teachers and parents from combined interventions reported a significantly higher level of collaboration, stronger home-school connections and children with fewer behavior problems. Despite an increased cost, the effectiveness of the Incredible Years intervention would be expected to be enhanced if both parents and teachers worked together collaboratively (Power et al., 2002) and might be indicated in some cases. Research would help to clarify these issues.

This study made no attempt to monitor medication. A further study could work in close liaison with medical colleagues to track changes in medication over the treatment period. It would be anticipated that children might be able to be managed on lower doses of stimulant medication when behavioral strategies are in place (MTA, 1999).

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Footnotes

¹ Gaps in graph lines meant data was not able to be collected. The daily measures collected during treatment were subject to a Trewess (Trimmed Resistant Weighted Scatterplot Smooth) formula to average responses and eliminate excessive fluctuations in daily scores. Trewess is a smoother developed by Velleman (1997). It accommodates unequally spaced data and is designed to produce comparably useful smooth traces. It is thus suitable for smoothing scatter plots. Trewess offers two parameters; the span of the smoother and the trimming percentage. For this research, a span value of 25% of the data and trimming percentage of 10% trimmed mean was used as the default. Setting the span larger makes the trewess smooth smoother and less willing to follow local fluctuations. Setting the trimming percentage larger makes trewess resistant to longer excursions in the data but can also affect sensitivity and smoothness. The trewess scores for positive child behaviours and negative child behaviours are graphed separately for child A, B, C and D and presented in Figures 2-3, 5-6, 10-11, 15-16, respectively.

² Child A was in the care of his father at follow-up.

³ This mother was referred for continuing services to manage stress, depression, and relationship difficulties.

Table 1

Conners' Parent and Teacher Rating Scale

Measure	Participant	Pre-treatment		Post-treatment		Follow-up	
		Parent	Teacher	Parent	Teacher	Parent	Teacher
Total <i>T</i>	A	87	61	83	61	81 (50) ^a	62
Total <i>T</i>	B	70	77	82	69	66	71
Total <i>T</i>	C	87	74	84	46	85	61
Total <i>T</i>	D	72	66	61	60	64	56

Note. Conner's Total T clinically significant at $T \geq 67$;

()^a = Father's scores for child D

Table 2.

Parent Scores on Strengths and Difficulties Questionnaire

Scores	Participant	Pre-treatment	Post-treatment	Follow-up
Difficulties	A	36	37	29
Strengths		7	7	7
Impact		7	10	5
Difficulties	B	19	27	15
Strengths		7	8	10
Impact		2	8	0
Difficulties	C	23	24	29
Strengths		4	5	6
Impact		6	5	5
Difficulties	D	16	13	16
Strengths		8	9	6
Impact		2	2	0

Note. Total Difficulties Score: 17-40 abnormal; 14-16 borderline; 0-13 normal;

Pro-social Score 0-10; Impact score 0-10: ≥ 2 is abnormal, 1=borderline, 0= normal.

SDQ = Strengths and Difficulties Questionnaire; Total Strengths = Prosocial Behavior Score;

Total Difficulties = Hyperactivity Score+ Emotional Symptom Scale + Conduct Problem

Scale + Peer Problem Score.

Table 3.

Parent Functioning Scores on PSI and BDI

Measure	Participant	Pre-treatment		Post-treatment		Follow-up	
PSI		Score	Percentile	Score	Percentile	Score	Percentile
	A	166	99	139	99	92	90
	B	82	80	98	90	53	10
	C	95	90	94	90	147	99
	D	110	99	121	99	72	55
BDI		Score		Score		Score	
	A	2		7		0	
	B	11		14		7	
	C	14		20		36	
	D	21		1		9	

Note. PSI=Parental Stress Index; Total Stress 15th - 80th percentile = normal range; \geq 90th percentile = clinically significant levels of stress.

BDI-II=Beck Depression Inventory; BDI < 10 = none or minimal depression; 11-18 = mild to moderate depression; 19-29 = moderate to severe; 30-63 = severe depression.

Table 4.

Participant Scores on Group Goals

Participant	Mid-Treatment	Post-Treatment	Follow-up
Number of items scored >5			
A	7	8	16
B	13	14	17
C	9	13	10
D	1	5	13

Note. There were 17 goals in total

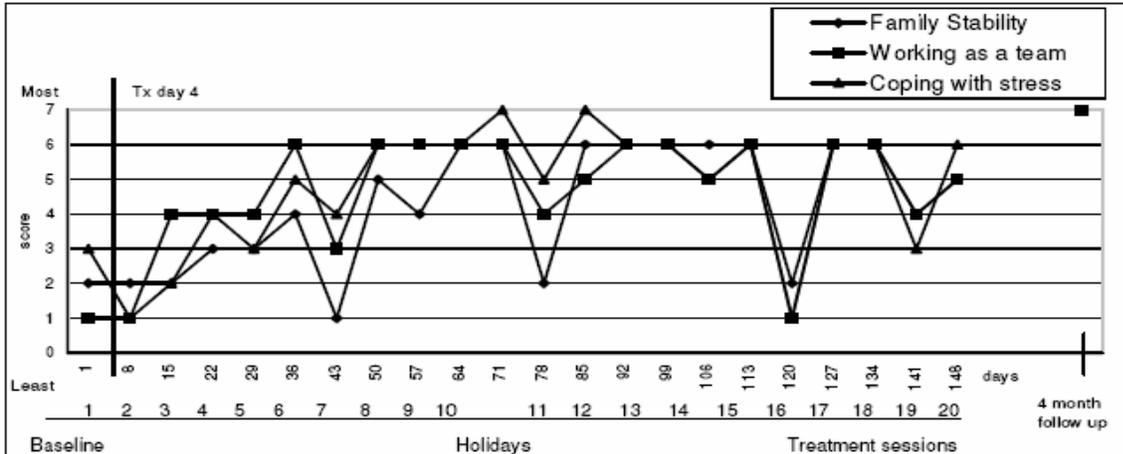


Figure 1. Child A Family Functioning

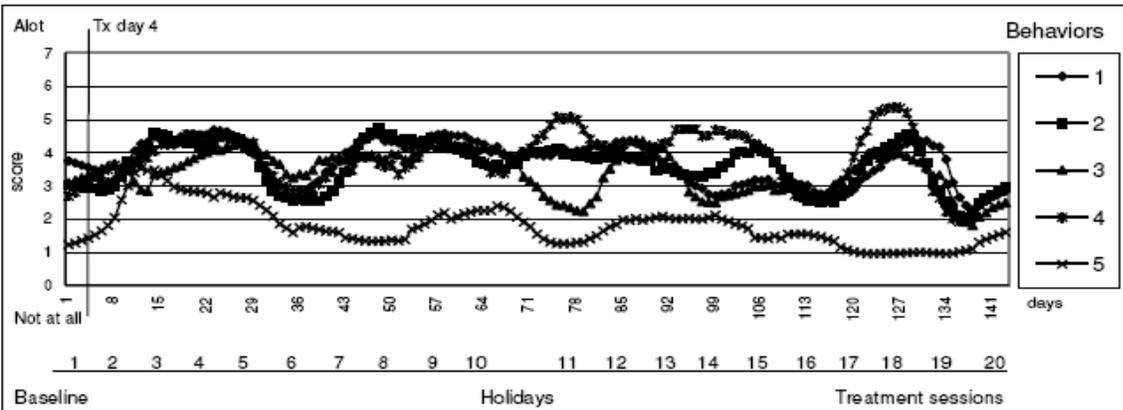


Figure 2. Child A Positive Behaviors

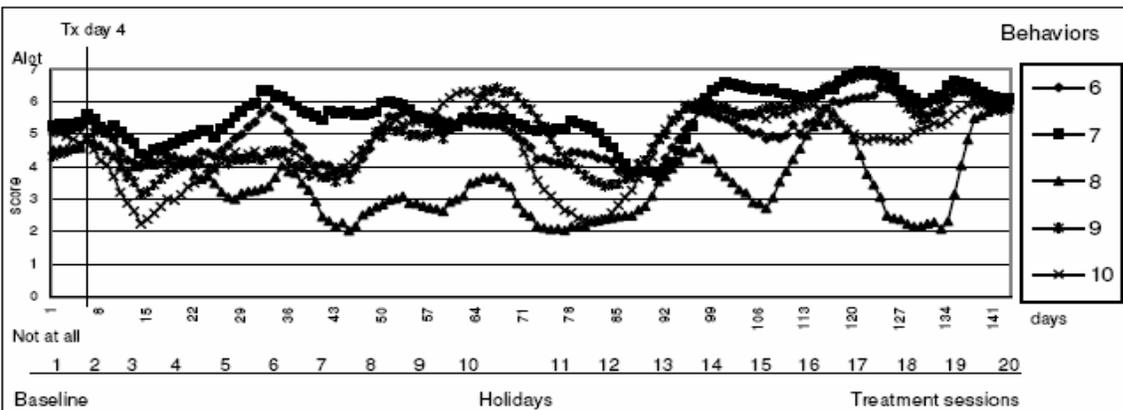


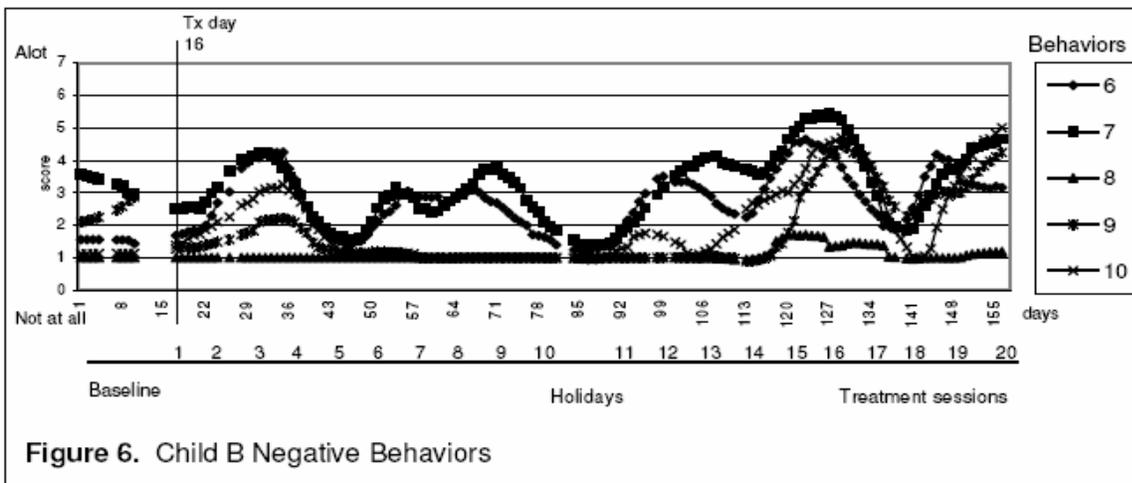
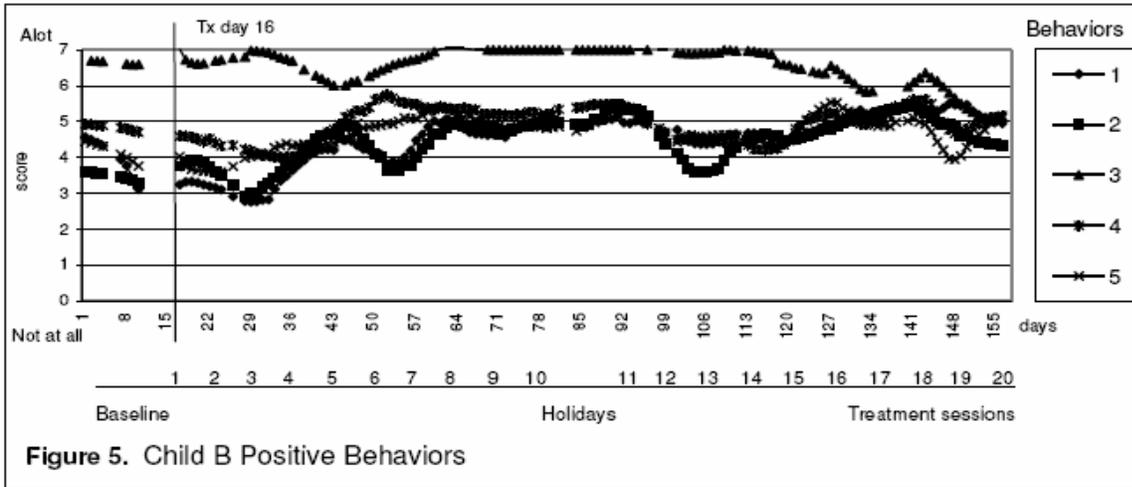
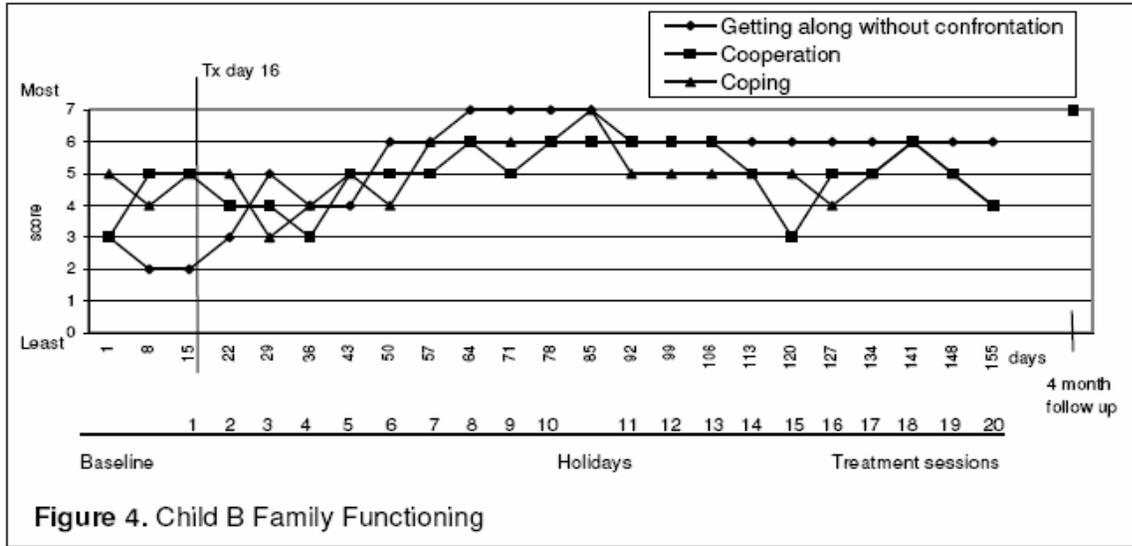
Figure 3. Child A Negative Behaviors

Positive Behaviors:

- 1=Completes tasks on time
- 2=Complies with requests
- 3=Plays nicely with siblings
- 4=Respects feelings for others
- 5=Waits his turn to speak

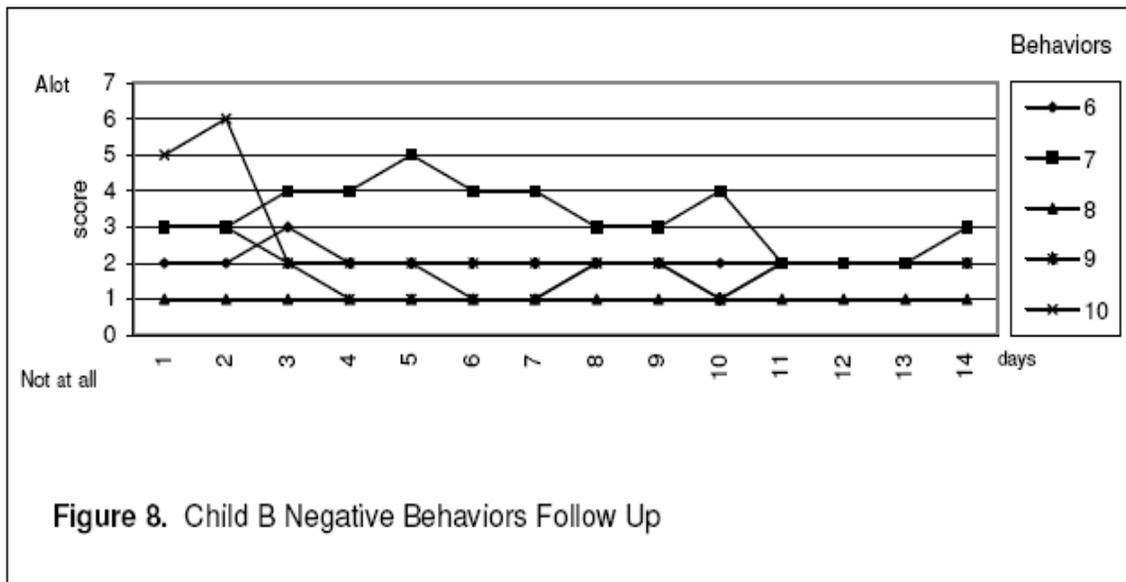
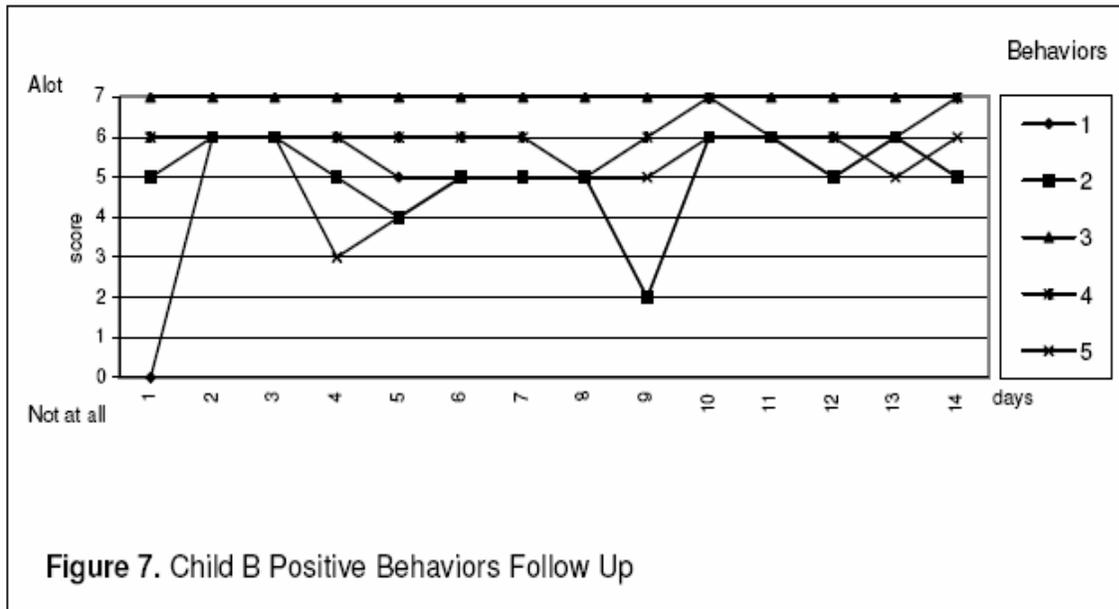
Negative Behaviors:

- 6=Interrupting demanding attention
- 7=Argues; Talks back to adults
- 8=Hitting kicking biting
- 9=Being hyperactive, running around
- 10=Yelling & temper tantrums



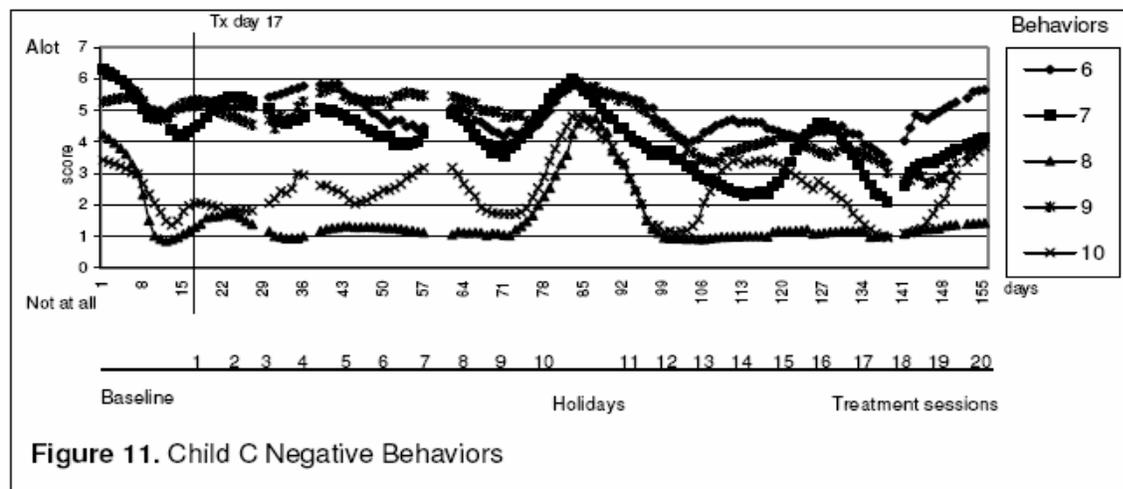
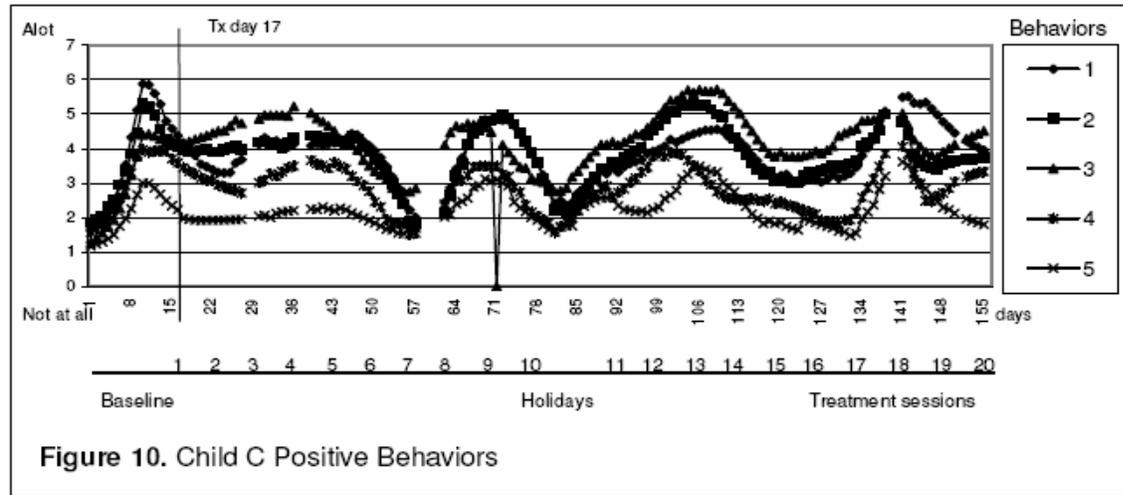
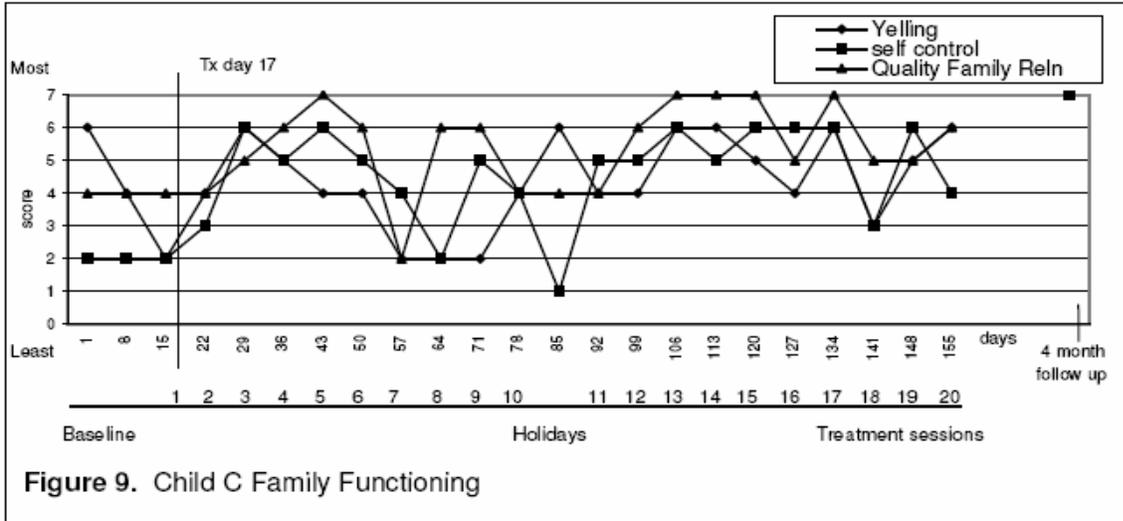
Positive Behaviors:
 1=Completes tasks on time
 2=Complies with requests
 3=Plays nicely with siblings
 4=Respects feelings for others
 5=Waits his turn to speak

Negative Behaviors:
 6=Interrupting, demanding attention
 7=Argues; Talks back to adults
 8=Hitting kicking biting
 9=Being hyperactive, running around
 10=Yelling & temper tantrums

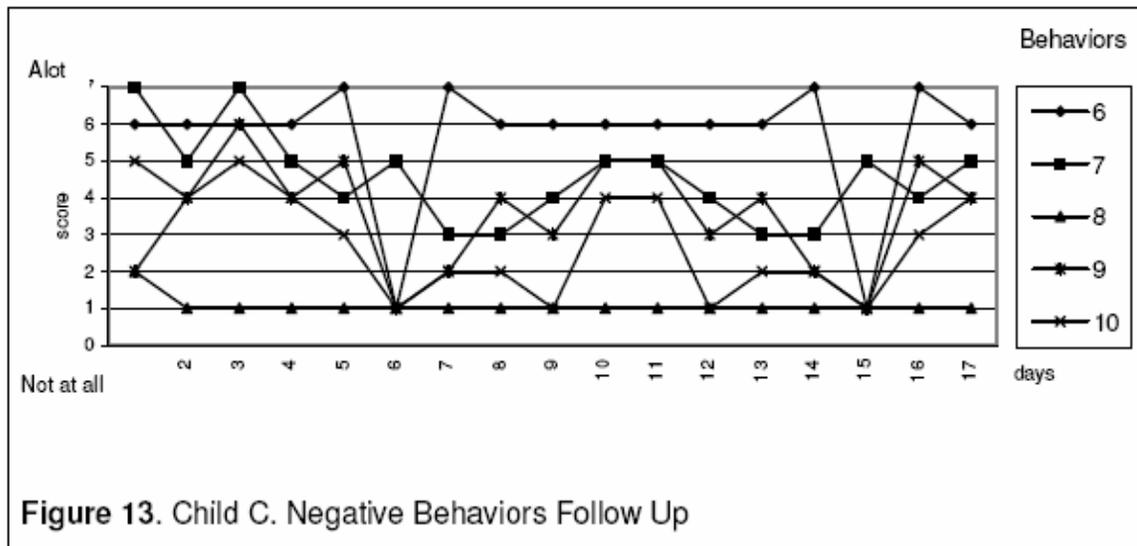


Positive Behaviors:
 1=Completes tasks on time
 2=Complies with requests
 3=Plays nicely with siblings
 4=Respects feelings for others
 5=Waits his turn to speak

Negative Behaviors:
 6=Interrupting, demanding attention
 7=Argues; Talks back to adults
 8=Hitting kicking biting
 9=Being hyperactive, running around
 10=Yelling & temper tantrums

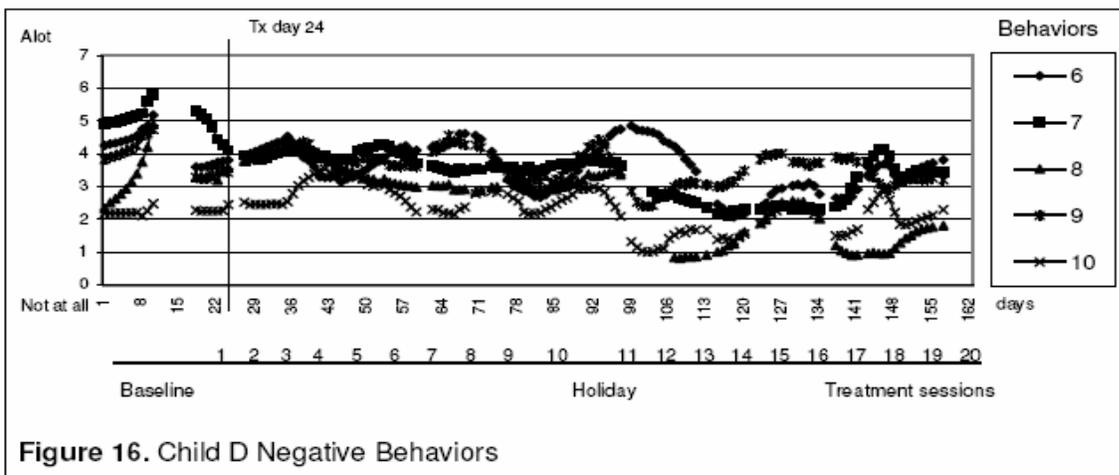
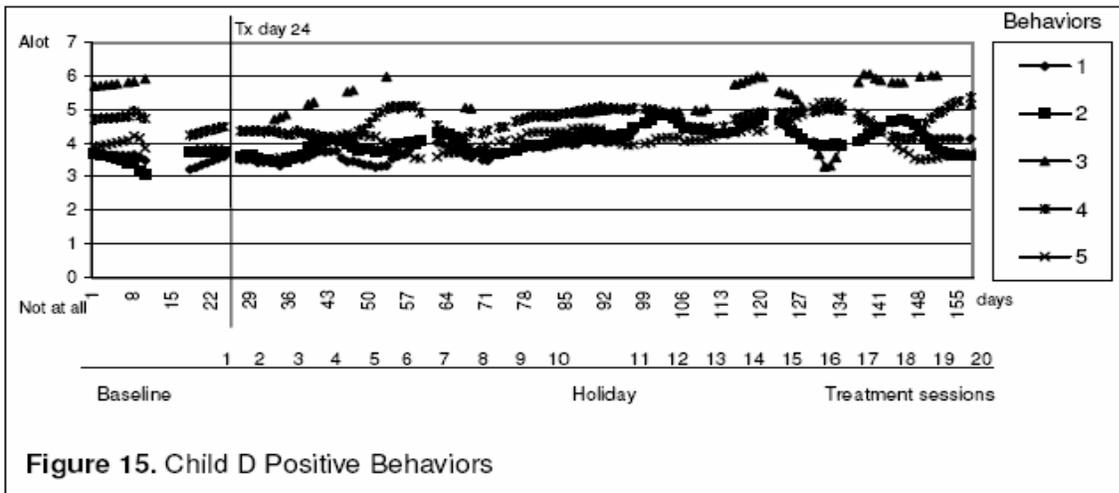
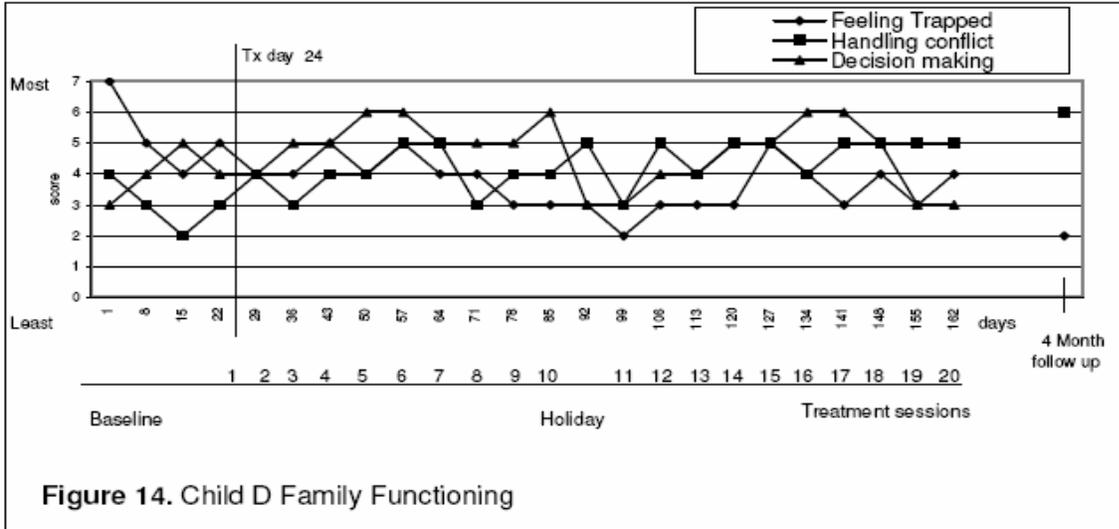


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|--|--|
| <p>Positive Behaviors:</p> <ul style="list-style-type: none"> 1=Completes tasks on time 2=Complies with requests 3=Plays nicely with siblings 4=Respects feelings for others 5=Waits his turn to speak | <p>Negative Behaviors:</p> <ul style="list-style-type: none"> 6=Interrupting, demanding attention 7=Argues; Talks back to adults 8=Hitting kicking biting 9=Being hyperactive, running around 10=Yelling & temper tantrums |
|--|--|



Positive Behaviors:
 1=Completes tasks on time
 2=Complies with requests
 3=Plays nicely with siblings
 4=Respects feelings for others
 5=Waits his turn to speak.

Negative Behaviors:
 6=Interrupting, demanding attention;
 7=Argues, Talks back to adults
 8=Hitting kicking biting
 9=Being hyperactive, running around
 10=Yelling & temper tantrums



- | | |
|--|---|
| <p>Positive Behaviors:</p> <ul style="list-style-type: none"> 1=Completes tasks on time 2=Complies with requests 3=Plays nicely with siblings 4=Respects feelings for others 5=Waits his turn to speak | <p>Negative Behaviors:</p> <ul style="list-style-type: none"> 6=Interrupting, demanding attention 7=Argues; Talks back to adults; 8=Hitting kicking biting 9=Being hyperactive, running around 10=Yelling & temper tantrums |
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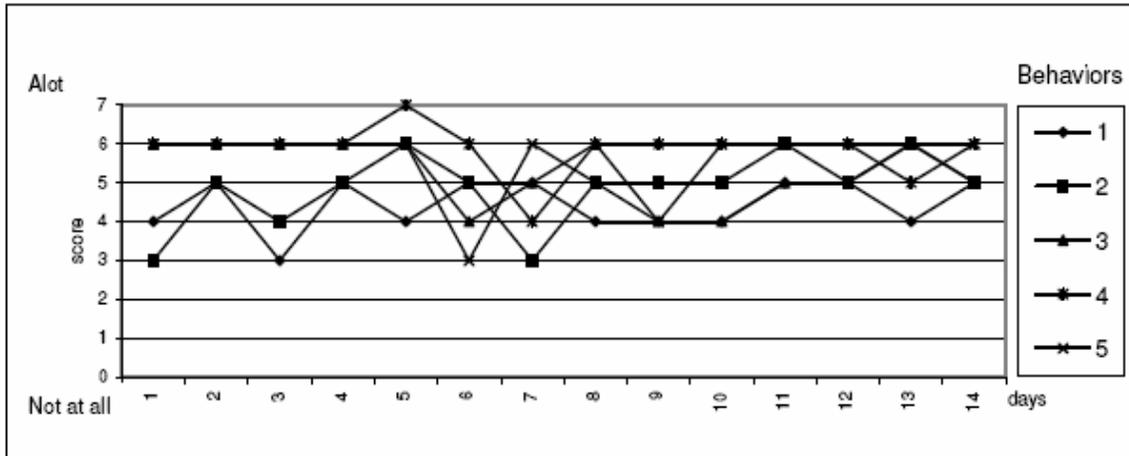


Figure 17. Child D Positive Behaviors Follow Up

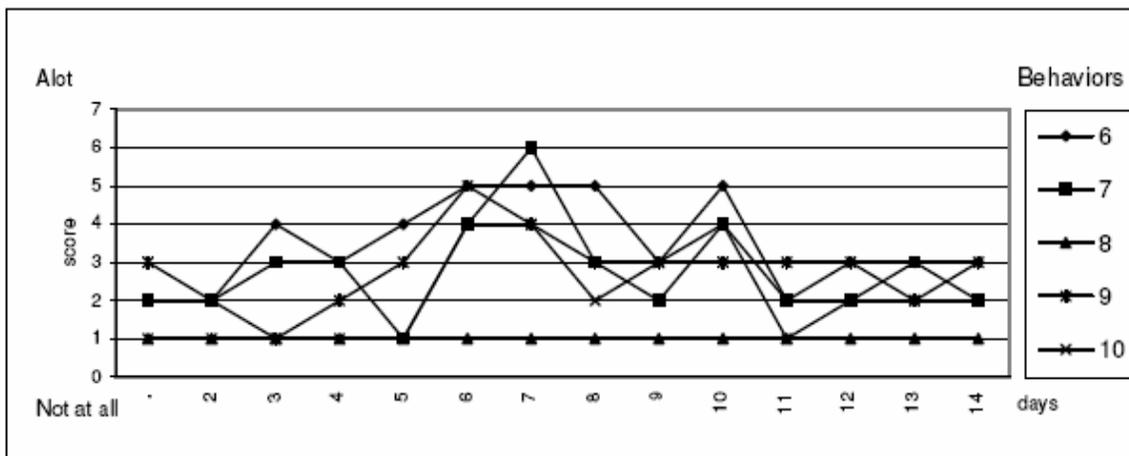


Figure 18. Child D Negative Behaviors Follow Up

Positive Behaviors:
 1=Completes tasks on time
 2=Complies with requests
 3=Plays nicely with siblings
 4=Respects feelings for others
 5=Waits his turn to speak.

Negative Behaviors:
 6=Interrupting, demanding attention
 7=Argues; Talks back to adults
 8=Hitting kicking biting
 9=Being hyperactive, running around
 10=Yelling & temper tantrums