

1 Parenting a Young Child with Conduct Problems

New Insights Using Qualitative Methods

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1. Introduction

What is qualitative research? Why should we do it? After all, isn't quantitative research the only "legitimate" method of scientific research—objective, verifiable, and methodologically rigorous? Does qualitative research have scientific integrity? Is it reliable? Valid? Generalizable? Can it add anything new to the findings of quantitative research? Is it publishable? After all, haven't psychology journals adhered almost exclusively to quantitative models of research? Why have they published so little qualitative research?

These are some of the questions that the first author of this paper asked herself when the second author, her doctoral student at the time, suggested that they undertake a qualitative analysis of parents' experiences living with their conduct-problem children. In part, these questions and concerns arose out of the first author's lack of familiarity with qualitative research. She had not studied this approach in her graduate training in psychology, nor had she read many articles using qualitative approaches in the psychological journals. At her student's urging, the professor put aside her discomfort with qualitative methods and reluctantly began the first of what was to become a series of three studies. She was motivated in part by a desire to learn about qualitative methods, particularly procedures grounded in theory.

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This endeavor on the part of two researchers who do not profess to be experts on qualitative research resulted in a firm belief that the assumptions and methods of qualitative research can and should be incorporated with quantitative methods to help advance our understanding of families of children with conduct problems. This new line of research has convinced us that however much we have learned from traditional (quantitative) research about child conduct disorders and their treatment, our understanding of them remains in a sense superficial without the insights to be gained from qualitative research. For while quantitative research can tell us the number and types of behavior problems in children, it cannot tell us the meaning of those problems for the family. While it can tell us the relative effectiveness of treatment programs in behavioral terms (e.g., 30% reduction in parental criticisms or child deviance), quantitative research cannot tell us what actually occurs during treatment from the parents' perspective, namely, the experience of treatment in terms of internal changes and the meaning of treatment in parents' lives.

This chapter, then, has a twofold purpose: to provide an overview of qualitative research, emphasizing the techniques and procedures of grounded theory, and to illustrate the application and usefulness of qualitative research through our findings from three studies of families of children with conduct problems. These studies were based on parents' perspectives at three different points in time: (1) prior to intervention, (2) throughout the 20-week therapy process, and (3) 2 to 3 years after intervention.

2. *Qualitative versus Quantitative Research*

On its simplest level, the term "qualitative research" refers to types of research that produce findings arrived at by nonquantitative methods. It refers to methods of documenting, analyzing, and interpreting attributes, patterns, characteristics, values, and meanings of specific contextual or "gestaltic" features of the phenomenon under study (Leininger, 1985; Clarke, 1992). Typically, it stresses open-ended approaches to data gathering and inductive or intuitive approaches to analysis. But on a more profound level, qualitative research stems from a philosophical position that humans construct their subjective reality and that there are multiple realities as opposed to a single, objective truth. To understand the decisions and actions of individuals, we must understand the complex meanings they give to the reality they perceive (Berger & Luckman, 1966), and to understand a phenomenon, we have to see how it is experienced by the subject. Qualitative research accords a

central role to subjective reality (or, more accurately, subjective realities) and therefore recognizes the importance of understanding contexts such as families, life events, social circumstances, cultures. This approach has its roots in the scientific disciplines of sociology and anthropology. Essentially, the goal is to document and interpret as fully as possible the phenomenon under study *from the subject's point of view and in its particular contexts*.

Qualitative research is considered to be of dubious value by some quantitative researchers, for it seems to defy all the traditional principles of quantitative research. For example, it is seen as overly subjective; its methods of interviews and participant observation are unreliable because they are not standardized, producing results that are of questionable validity and difficult to replicate. Certainly, if qualitative research is pursued without proper understanding of its underlying research principles, or by a researcher who is not sensitive to the phenomenon as it emerges or who is insufficiently analytical in its interpretation, the research may well lack validity. Yet the same accusation could be made of quantitative researchers who misinterpret statistical significance or fail to provide information on the clinical significance of findings. So let us put value judgments aside, and first describe some general contrasts between qualitative and quantitative research.

In many ways, the assumptions and methods of qualitative research may appear to be irreconcilable with those of quantitative research. For example, traditional quantitative researchers emphasize the importance of starting from theory and working deductively via a set of hypotheses using a carefully worked out design, standardized methods of data collection, randomized experiments, and statistics. Qualitative researchers, on the other hand, do not start with a theory or with a set of hypotheses to be tested; rather, they begin with broad, open-ended questions that become more focused in the process of data collection and analysis. Hypotheses are arrived at inductively, and are confirmed or rejected in light of the accumulating data. For these researchers, there are no standardized questions, no statistical analysis. While the quantitative researcher attempts to manipulate the variable of interest, such as how the intervention (the independent variable) influences a particular parent behavior (the dependent variable), the qualitative researcher attempts to assess the overall meaning of the phenomenon in its natural context, as perceived by those who are experiencing it. Theory emerges late in the process, as a result of the researcher's insights and based on induction or intuition. Thus, whereas quantitative research is context-free, emphasizes deterministic or causal explanations, and aspires to objective knowledge via numerical methods and deductive logic, qualitative research is inherently subjective, inductive, and context-sensitive, stress-

ing the importance of describing, interpreting, and understanding the meanings of phenomena.

It is our contention that these types of research should not be in competition; each serves different purposes. Quantitative methodology has a well-deserved role in advancing our knowledge, for quantitative data and statistical analysis help to establish and verify facts. Qualitative research offers the promise of advancing our understanding by giving new dimensions and depth to factual knowledge, embedding fact in culturally relevant meaning, and perhaps providing rich clues for new lines of investigation. By pursuing both approaches to the phenomenon we wish to understand, we stand a better chance of overcoming the deficiencies and biases of each.

3. *Reliability and Validity in Qualitative Research*

Though qualitative research is often criticized as lacking in scientific rigor or integrity, there are criteria for evaluating its scientific integrity. Because the methods and aims of qualitative research are inherently different from those of quantitative research, the criteria for evaluating the scientific integrity of qualitative research must differ accordingly. For example, take the scientific principle of replicability. Applied to quantitative research as is customary, this criterion means that the experiment can be reproduced in successive experiments with identical results. To do this, the investigator must re-create the original conditions and control any extraneous variables that may impinge on the phenomenon under study. The research is credible only if it is reproducible. In qualitative research, however, the social and psychological variables that impinge on the phenomenon under investigation are notoriously difficult to control. Furthermore, these variables are by no means regarded as "extraneous"; rather, they are the vitally important subjective reality that the qualitative researcher seeks to understand. Thus, qualitative research almost by definition defies the criterion of reproducibility. Moreover, because grounded theory depends on the researchers' creative interaction with the data, it is unlikely that two researchers would come up with the same theory. In fact, the question of replicability is not especially relevant to qualitative research, in which the point of theory generation is to offer a new perspective on a phenomenon, a useful way of looking at it.

Nonetheless, the usual canons of "good science" do apply to qualitative research, but simply require modification (for a succinct overview of these canons, see Gortner & Schultz, 1988, p. 204). Foremost among these canons are reliability and validity. Guba (1981) and Lincoln and

Guba (1985) have suggested the term *trustworthiness* in reference to reliability and validity in qualitative research. The trustworthiness of any given qualitative research study can be assessed in terms of four factors: credibility, transferability, dependability, and confirmability.

Credibility refers to having confidence in the truth of the findings. Glaser and Strauss (1967) and Strauss and Corbin (1990) state that the credibility of a qualitative study is a matter of how the investigators derived their conclusions. As a first step in assessing the credibility of the conclusions, the reviewer has to ask whether the subjects are appropriate informants for the investigation and whether the data they offer are true presentations of the area of concern. In our studies, for example, the subjects were parents of conduct-problem children; they were considered reliable informants for research on the experience of parenting a child with conduct problems, the process of parent training intervention, and the long-term subjective results of intervention. The perspectives that these parents provide must be accepted as accurate representations of that realm.

The second factor in trustworthiness, transferability, is concerned with the degree to which the results are context-bound (Sandelowski, 1986). Research is considered trustworthy to the degree to which it adequately represents a particular cultural, social, or economic group. In our studies, our sample consisted of both mothers and fathers of conduct-problem children from different socioeconomic levels (one third welfare, one third lower and middle class, and one third upper class); the children had a variety of behavioral problems, and the parents exhibited different approaches to child-rearing. Therefore, the range of data was considered sufficient to provide the basis for assessing relevancy to a wide cross-section of socioeconomic groups representing primarily Caucasian mothers and fathers.

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

The last dimension of trustworthiness is confirmability. This dimension is defined as the ability of an independent reviewer to conduct a formal audit of the various study procedures (Lincoln & Guba, 1985). In our studies, one of the investigators served as a reviewer by auditing the various study procedures step by step. Validity checks were conducted throughout the stages of data collection and data analysis. A first-order

validity check of the investigator's interpretation was carried out during the collection phase through continuous feedback from the interviewees. Data were repeatedly compared and contrasted. To clarify concepts or validate the investigator's perceptions, parents were often asked to explain their ideas or to comment on other parents' ideas. In a second-order validity check, the importance of the various categories of the experience was validated against a standard question: "How is this for you, and how are you doing now?"

4. *Types of Qualitative Research*

There are many different types of qualitative research: grounded theory; ethnography; phenomenological, historical, philosophical inquiry; and conversational analysis. All have similar purposes, but each has its own rules of evidence, inference, and verification, and all differ in terms of the degree to which the researcher is permitted to interpret the data and the degree of importance given to theory building. For example, ethnography, with its roots in anthropology, has traditionally been used in the study of different ethnic groups to understand their cultural systems, behaviors, and meanings (Sanday, 1983). It uses extensive fieldwork and participant-observation methods (i.e., to become part of the subculture one is studying) to discover how culture shapes people's behavior and their interpretation of their experience. The goal is to produce a factual and rich description and analysis of life in a particular culture or subcultural group. Ethnography contributes explanatory theories of culture, cultural behavior, and cultural meanings. Phenomenological studies examine how people perceive their world and make sense of an experience (C. T. Beck, 1990; Spiegelberg, 1976) with the goal of describing lived experience rather than defining, categorizing, explaining, or interpreting it by means of theories. In contrast to ethnography, phenomenology does not attempt to make interpretations or to generate explanatory theories, but simply to describe experiences as they are lived by people (i.e., without judgment).

Grounded theory is a qualitative method originally developed by sociologists Glaser and Strauss (1967) in a study of dying. Grounded theory research is aimed at initiating new theory and/or reformulating and clarifying existing theory. This method begins with systematic techniques to study the phenomenon and gather data, and moves inductively through data verification and analysis, allowing the researcher to abstract qualitative data into concepts or categories and to generate a theory or conceptual framework (Strauss, 1987). The theory emerges

from the data and remains grounded in the data, hence the term "grounded theory." While this method has systematic and rigorous procedures and techniques designed to provide analytical process precision (described below), it also relies on the researcher's inquiring, analytical mind. The researcher is not expected to be a neutral observer or a tabularasa—rather, the qualitative researcher brings to the interviews the general perspective of her discipline as well as her own theoretical perspectives. This process is perhaps inevitable in all research, but in qualitative research this inevitability is acknowledged and valued. The qualitative researcher starts with a set of experiences he or she wants to explore, rather than a hypothesis to prove or disprove. Thus, the researcher actively forms questions, seeks data, asks new questions based on the data, and interacts with the data by checking out hunches and formulating concepts. It is this process that results in "discovery"—discovering and conceptualizing the essence of complex interactional processes—and a grasp of another's subjective reality. The theory that emerges should present a new way of understanding the observations from which it is generated.

5. *Grounded Theory—Methodology*

For our qualitative studies, we chose the method of grounded theory (Glaser & Strauss, 1967; Strauss, 1987). One of the reasons we chose grounded theory is that by virtue of its emphasis on theory (in contrast to other qualitative methods), and by virtue of the place of theory in its processes (emerging, not a priori), it had the potential to offer new insights into a problem that we had previously studied extensively via quantitative methods. Second, as mentioned earlier, because grounded theory incorporates a systematic set of procedures to help develop an inductively derived theory about the phenomenon under study, it promises greater scientific integrity than other qualitative methods. In this method, the researcher abstracts qualitative data into concepts and categories. Constant comparison of data units is used to find similarities and variations within categories, to link categories in a hierarchical mode, and to form working hypotheses as to the theoretical nature of these links (Lincoln & Guba, 1985). By constantly comparing and contrasting the data, the researcher attempts to guard against premature commitment to a set of analytical categories, a liability in quantitative research as well as in other types of qualitative research.

The data-coding process used in grounded theory involves three stages: (1) open coding, (2) axial coding, and (3) selective coding.

5.1. Step 1. Open Coding

In the first phase of analysis, transcriptions are analyzed separately and subjected to open coding (Strauss, 1987). The initial codes are the result of breaking the data into small, meaningful units. Each discrete incident, idea, event, or name is coded as a concept. Dozens of codes are added as needed throughout the analysis and are entered into the computer. This step represents the most detailed phase of the coding, but is also the most generative because it becomes the basis of future theoretical sampling and tells the researcher what to focus on in the next interview.

5.2. Step 2. Axial Coding (*Hypothesizing and Categorizing*)

Whereas open coding breaks apart the data and allows one to see them in terms of minute categories, axial coding is the first step in putting the data together. To take a humble analogy, consider opening a new jigsaw puzzle: You open the box, separate the pieces, mix them up, then sort them by color, design, and shape and begin to fit the pieces back together. In axial coding, the initial codes arrived at during open coding are compared and contrasted to detect similarities and differences among them (Hutchinson, 1986). When the researcher perceives an overriding category that encompasses two or more codes, these codes are grouped together as dimensions of one axial code. It must be emphasized that this grouping is not determined a priori. For example, after hearing many parents talk in diverse ways about feeling trapped by their children, we generated a category "held hostage" that encompassed a number of specific situations originally coded as separate (e.g., unable to go to the grocery store, unable to socialize). As in open coding, one source of names for categories is the words or phrases used by the parents themselves; these are called "in vivo" codes. For example, one parent's expression "under siege" was used to summarize parents' feelings about living with their children when they first sought help.

Axial coding strengthens the density of the categories by "specifying varieties of conditions, strategies, and consequences that are associated with the appearance of the phenomenon referenced by the category" (Strauss, 1987, p. 64). It is at this point that the researcher's intuition and sensitivity concerning following up on meaningful categories for families become critical. Taking the aforementioned example of the category "held hostage," the researcher develops a hunch about the potential importance of this phenomenon for families and proceeds to analyze this category preintervention, during therapy, and at follow-up. The researcher must continually reflect on the data and the categories, com-

paring one informant to another, comparing each informant to emerging categories, each category to other categories, and categories to the literature. Each axial category is in a sense the result of the researcher's "hunch" about the process; each hunch is then subjected to examination in light of all the data, which validate or invalidate the hunch, that is, the category. In this stage of data analysis, the researcher proceeds with axial coding and at the same time continues open coding. This process is what "grounds" the theory—the categories and the proposed relationships among categories are provisional until they have been verified over and over again in light of the data.

5.3. Step 3. Selective Coding and Theoretical Integration

The third phase of analysis, selective coding, is a process of focusing selectively on higher-order categories that seem to make sense (and in doing so disregarding or discarding other categories). Open coding is refined as codes identified early in the process either do not hold up under scrutiny or are not generated in successive data and are therefore discarded. As selective coding proceeds, the relationships or connections among the core categories are explored and integrated. This integration is similar to axial coding, but done at a more abstract level of analysis; it is a process of "weaving the fractured data back together again" (Glaser, 1978, p. 116). The goal in this phase of analysis is to reduce the number of categories by creating higher-order categories, to explicate the relationships among these categories, and to develop a theory. It has been called "theoretical integration" (Glaser, 1978).

For example, from our initial study, we developed the core categories of parents "treading water" (denying the problem), problem recognition, self-blame, "nothing works," and mounting anger and loss of control. This process led us to the theory of learned helplessness, which then became the basis for further qualitative analysis as we sought to determine how parents overcame these feelings and began to cope more effectively. In this phase of analysis, the researcher is translating categories into an analytical "story," trying to capture the process in a conceptual framework. It may become apparent that some components of the process are absent or incomplete, which means that the researcher is driven to collect more data, selected on the basis of what is already known about the problem. This is called "theoretical sampling." For example, we learned from our pretreatment interviews how families perceived their experiences with other parents whose children were behaviorally normal and with teachers, but we did not have much information on how their extended family members had reacted to their difficulties. This led us to "theoretical sampling"—that is, conducting

to link categories to causal relationships; for example, the difficult and aggressive child leads to the parents' feeling of being held hostage and to eventual alienation from the community. The phases that had become obvious during axial coding evolved into a description of the sequential process by which parents moved from "treading water," to problem recognition, to learned helplessness, and to eventual effective coping strategies following treatment. This coping theory is the "cement" that integrates all the components of the theory and is the basis for the analysis at 3-year follow-up.

6. Why Do Qualitative Research on Conduct Problems?

Despite the volume of quantitative research showing correlations between child conduct problems and the more coercive styles of parental discipline, it is far from clear whether there is a causal relationship (and, if there is, which factor is cause and which is effect). This question is part of a larger question, namely, what it is like to parent a child with conduct problems. Apart from anecdotal information, we know very little about how parents experience their conduct-problem children, how they perceive and react to the problematic behavior over time, and what difficulties they encounter as they try to cope with the behavior. This is a question ideally suited to the methods of qualitative research, for it is a matter of understanding these parents' subjective reality.

Moreover, the literature contains comparatively little discussion of the impact of child conduct problems on the family system—that is, how the child's conduct problems affect relationships within the family (e.g., relationships between parents, or relationships of parents with other siblings)—or of their impact on relationships between the family system and outside systems or agencies (e.g., relationships with grandparents, with schools, with other families). While there is research to indicate that families of conduct-problem children experience high rates of major and minor life stressors (e.g., Forgatch, Patterson, & Skinner, 1988; Patterson, 1982; Wahler & Dumas, 1984; Webster-Stratton, 1988, 1991), marital stress (e.g., Furey & Forehand, 1985; Schaughency & Lahey, 1985; Webster-Stratton, 1989; Webster-Stratton & Hammond, 1988), and social isolation or lack of social support (Dumas & Wahler, 1985; Wahler & Dumas, 1984; Webster-Stratton, 1985a,b), it is unclear exactly how child conduct problems may contribute to these stresses. We know very little *from the parent's point of view* of the difficulties parents encounter as they try to cope with the child's conduct problems and simultaneously manage the stresses within the family system as well as the accompanying stresses in their relationships with agencies and indi-

additional selective interviews with families to explore and expand this missing link in the theory evolving around lack of family support, increasing isolation, and eventual learned helplessness.

The qualitative research—specifically, grounded theory—presented in this chapter is based on individual interviews of parents of conduct-problem children prior to therapy, group sessions and individual interviews during therapy, and follow-up interviews several years later. Since we had videotaped all interviews and therapy sessions, we had a rich set of longitudinal data on each family. Transcriptions of interviews and therapy sessions were initially entered into a computer and formatted for use with Ethnograph (Seidel, Kjolseth, & Seymour, 1988). Ethnograph is a computer software program that provides the researcher with a convenient means of storing and sorting through the massive amounts of data that accrue in qualitative research interviews. The computer serves as the index cards, scissors, and glue for breaking apart, sorting, and reassembling the data. For example, once the interview is transcribed into the computer, it is formatted into 40-character lines, allowing each line of transcript to be sequentially numbered and providing an empty right side of the page for coding.

In open coding, the data were approached across families at three time periods: before, during, and after treatment. This procedure allowed the investigators to study each family separately across the various intake and therapy sessions, as well as to compare and contrast different families' responses as they moved through the different phases of the intervention program. Parents' own words often supplied the codes for this phase of analysis. The Ethnograph program allowed us to sort through every transcript for every occurrence of a given code—for example, every transcript in which a parent talked about feeling trapped. In axial coding, the categories were analyzed for similarities and differences in parents' behaviors, comparisons from one parent to another, and changing viewpoints as the intervention program advanced. As the categories were examined more closely, it became clear that the parents described their responses in terms of different phases. For example, in the beginning, we were struck by parents' reluctance to admit their child's and their own problems and the length of time it had taken them to seek assistance. We termed this phenomenon "treading water." Once we had coded and developed categories based on the first set of transcripts, we analyzed a second set of randomly chosen transcripts according to the categories we had developed to continue to search for properties of categories, and to compare each category and subcategory for different patterns and recurrent themes; these categories and subcategories were validated and any new codes identified. In the third phase of coding, selective coding and theoretical integration, we sought

viduals outside the family. This lack of insight into the meaning of child conduct problems in the lives of families—the *lived reality* and gestalt of conduct problems—is not surprising, given that the research has been largely quantitative. The first of our qualitative studies is a first step, we hope, in addressing that gap in our understanding of child conduct problems.

The area of child conduct problems has a second gap, namely, in understanding the subjective experience of undergoing treatment. Despite documented effectiveness for various types of parent training programs, the literature contains little discussion of such intervention programs from the parent's point of view. The large body of research to date has been quantitative in nature, focusing on static outcome measures such as reductions in rates of negative parental discipline (e.g., criticisms, physical force) and child deviant behaviors (e.g., hitting, non-compliance). To put it a little differently, while the end product of parent training has been well researched, the process has not. We know little about the actual processes of change brought about by such programs. Yet there are many questions to be answered concerning the intervention process: What happens when parental behaviors, attitudes, and practices are challenged and modified by a parent training program? What emotional, social, and cognitive changes accompany the process of behavioral change (i.e., parenting practices)? What difficulties do parents undergo as they work with the concepts presented in the program? How do these changes affect the family system—that is, what kinds of impact does the program have on different family members and on their relationships and interactions? In fact, our ignorance regarding what happens when parents' attitudes and practices are challenged is profound, particularly with regard to the consequences when the intervention raises cultural, family, or personal lifestyle issues. As these questions are matters of process rather than outcome and subjective rather than objective reality, they are more amenable to qualitative research rather than quantitative.

A third area that we felt qualitative research could help us explore was understanding long-term effects of intervention. While our quantitative follow-up data have enabled us to predict which families would relapse and which would maintain treatment successes at a given follow-up point, they did not provide information on how parents perceived and experienced those relapses and/or successes, nor did the data provide information on what impact intervention had for the children and their families. What was it like to end treatment? How are the families generally coping several years later? What kinds of successes or failures have their children had? How did the parents react to relapses in their children's behavior? What are their perceptions about intervention

in retrospect? In the face of relapses, did they consider treatment to have been useful? How could the intervention program have better prepared them for their experiences following intervention? What do the families feel they still need?

In sum, we felt that qualitative research would complement our quantitative research by allowing us to examine three areas: the impact of the conduct-problem child on her or his parents' lives, the subjective experience of undergoing therapy, and the meaning that the experience of therapy has for parents from a longer-term perspective. The scope of our data allowed us to describe the rich process of cognitive, emotional, and social changes that parents underwent from the initial intake interview to a follow-up point 3 years later. To answer the question posed at the start of this chapter, qualitative research on conduct problems in families is inherently valuable for the new knowledge it yields—what it can reveal that quantitative research cannot. But perhaps the most important reason for doing qualitative research is a practical one: We cannot successfully treat children with conduct problems unless we know more about these families' subjective experiences prior to therapy, in therapy, and afterward.

7. Study 1. *The Meaning of Having a Child with Conduct Problems: "Families under Siege"*

As stated earlier, we had conducted a number of quantitative studies of the families who came to our clinic and had accumulated a large body of data indicating that these parents of conduct-problem children were depressed, stressed, angry, critical, and inclined to use physical forms of discipline (Webster-Stratton, 1994). Our quantitative research had revealed that prior to intervention, over 23% of the mothers and 6% of the fathers were experiencing mild to moderate depression (i.e., a score of over 13 on the Beck Depression Inventory) (A. T. Beck, 1972); 65% of mothers and 36% of fathers were experiencing high levels of stress (i.e., a score above 294, or in the 90th percentile on the Parent Stress Inventory) (Abidin, 1993); 39% of mothers and 11% of fathers had high levels of anger (i.e., a score of above 9 on the Brief Anger-Aggression Questionnaire) (Maiuro, Vitaliano, & Cohn, 1987). Of those parents who were married or had been living with a partner for more than 3 months, nearly half (51%) reported significant distress in their relationship with their partner (scores of less than 100 on the marital adjustment scale and/or experiences with spouse abuse) (Locke & Wallace, 1959). According to our independent observations of family behavior in the home, parents were highly critical in their communication with

their children (i.e., a mean of one critical statement every 2 minutes). In telephone interviews regarding discipline, 48% of mothers reported that they "frequently" yelled, hit, and spanked their children.

We also had accumulated considerable data regarding the children's behavior. Based on parent reports of child misbehaviors, over 99% of the children were more than 1 standard deviation above the norm for conduct problems on the Eyberg Child Behavior Inventory (ECBI) (Eyberg & Ross, 1978), and over 75% of mothers and 67% of fathers reported that their children were highly aggressive, defiant, and/or noncompliant—that is, they exhibited behaviors that translated into externalizing *T*-scores above 90% on the Child Behavior Checklist (CBCL) (Achenbach & Edelbrock, 1991). On home observations, children were observed to exhibit an average of 18 deviant behaviors per half hour.

These quantitative data, however, could take us only so far and no further. It did not help us understand the experiences families had prior to entering our intervention program or how long the behavior problems had been occurring. Neither did it provide insights into the impact their children's problems had on their intra- and extrafamilial relationships. Moreover, such static data on parent and child behavior did not tell us how these parents perceived the relentless process of trying to parent a difficult child. Our first study, carried out prior to families entering treatment, is described in some detail to illustrate our beginning efforts at using grounded theory methods and to show how these qualitative data enriched our understanding of these families and the parents' experiences.

7.1. Participants

One of the major differences between the methods of quantitative and qualitative research concerns sample size. We did not know in advance how many subjects our study would involve, for with grounded theory the researcher keeps interviewing new subjects until he or she has developed a conceptual framework that is integrated and testable and explains the phenomenon to his or her satisfaction. Ultimately, our sample consisted of 57 families (57 mothers and 20 fathers) of young children with conduct problems. Criteria for study entry were: (1) the child was between 3 and 7 years old; (2) the child had no debilitating physical impairment, intellectual deficit, or history of psychosis, and was not in treatment at the time of referral; (3) the primary referral problem was child misconduct (e.g., noncompliance, aggression, oppositional behaviors) that had been occurring for more than 6 months; and (4) parents' reports of their child's behavior problems were clinically significant according to the ECBI.

Of these families, 73% were headed by couples and 26% by single mothers (only a portion of fathers participated in the interviews). The mean age was 34.1 for the mothers and 35.9 for the fathers. Family social class, as determined by the Hollingshead and Redlich (1958) Two Factor Index, varied across a wide range: Class 5 ($N = 6$), Class 4 ($N = 18$), Class 3 ($N = 16$), Class 2 ($N = 20$), Class 1 ($N = 17$). The sample of children included 57 boys and 20 girls, with a mean age of 4 years and 10 months. The mean number of behavior problems reported at pretreatment according to the ECBI was 21.3 ($SD = 5.6$), indicating that the children were clearly in the clinic range according to Eyberg and Ross (1978) (for nonclinic range: mean = 6.8, $SD = 3.9$).

7.2. Analysis

Each couple or single parent underwent an extensive intake interview lasting 3–4 hours. Information was elicited about the effects of the child's antisocial behaviors on the family system as well as the parents' feelings, thoughts, and attitudes toward themselves as parents. Transcriptions from videotapes of these interviews were computer formatted for use with Ethnograph (Seidel et al., 1988).

In the first phase of data analysis, ten transcripts selected at random were analyzed separately and subjected to open coding (Strauss, 1987), resulting in Level 1 codes. Customarily in this type of research, analysis of the first interview would influence further data collection and interviews, but because we already had all the interviews on videotape, we randomly determined a starting point. These codes were the result of breaking the data into small meaningful units; often the informant's words provided the code. For example, the parent was asked, "Tell me what your child is like at home." The parent's description of the child would be coded line by line using such categories as "aggressive to animals" or "violent with sister." Once the ten transcripts had been coded, it became apparent that these Level 1 codes could be grouped into three major domains: the profile of a conduct-problem child, the impact of the child's conduct problems on the family system, and the family's relationships with the broader community.

In the second (axial) phase of analysis, the Level 1 codes were constantly compared and contrasted to detect similarities and differences; codes that represented dimensions of an overriding category were grouped together. Selected categories were then subjected to axial coding (Strauss, 1987) to strengthen the density of these categories (Strauss, 1987). Specifically, these categories were analyzed in regard to the child's profile, certain focal points in the family system, and the characteristics of the developing parental pattern of discipline. Axial

analysis was used to develop and validate the core categories. Next, a second set of 30 randomly chosen transcripts were analyzed according to the categories to validate the existing codes and to develop any additional codes as necessary.

In the third (selective) phase of coding, the relationships among the core categories were explored. Codes that did not hold up under analysis were discarded. Selected interviews were conducted to fill in any gaps in the data. The analysis indicated that the relationship of child conduct problems to parenting styles took the form of a complex, multi-level process in which parents felt increasingly ineffective or helpless at parenting their conduct-problem children. The transcripts and videotapes of over 50 intake interviews with mothers and fathers were subjected to this third phase of analysis.

7.3. *The Child's Profile*

In order to understand the meaning of living with a conduct-problem child, it was crucial to understand first how these children are perceived by their parents. We had a wealth of data on these children's behavior, as reported by their parents and teachers as well as by independent observers. But what did their parents *think* and *feel* about that behavior and, more generally, about their child? Certainly there are a variety of emotional and psychological reactions one can have to problematic behavior, such as anger, guilt, embarrassment, empathy, apathy, sympathy, rage, indifference, and sadness, and a variety of cognitive responses (or nonresponses), such as denial, rationalization, projection, and distortion. We wanted to know whether there are certain emotional, psychological, and cognitive reactions that are typical of parents of children with conduct problems. Insight into their perspective, or at the very least awareness of it, is crucial for those of us who are working with these parents, because it is parents' perceptions of their child, the meanings they attribute to the child's behavior, and the feelings they have as a consequence of those attributions that shape their reactions to the child in general and to conduct problems in particular, not to mention their attitudes toward parenting and toward intervention.

7.3.1. *Child as Tyrant, Parent as Victim*

When asked to name their child's dominant characteristic, these parents specified *aggression*. Children with conduct problems were described by their parents as both verbally and physically aggressive toward family members and abusive of pets. Parents reported that their children intentionally harmed these targets with no evidence of remorse or regret.

Mother: I don't know if you have suffered the physical abuses—I have. Just a few weeks ago, he threw his booster seat in my face and hit my jaw. And he thought it was funny! . . . He was acting up, and I think he had already had one Time Out for yelling and screaming and interrupting us at the table. And I said, "Fine, you are going upstairs now. You are not having dessert." And he just flew into a rage. He picked up a metal fork and threw it with all his force, and hit me—barely missed my eyes. There was blood on my forehead. I was screaming. I was hysterical. And I was terrified, I mean, to see that type of behavior, that type of rage.

Mother: She tells me she is going to run away from home and that she wants to leave. She told her father she wished he was dead so that way he won't wake up . . .

Frequently, parents recounted incidents in which their children had been destructive to the house or household objects. This aggression extended outside the family as well. Parents reported that their children were aggressive toward other children in day care settings, at friends' homes, and toward strangers in public places. Sometimes this aggression was sexual in nature: pulling down other children's underwear, touching children in their genital areas, using sexually provocative language, and so on. Parents described having to be always on guard, for their own sake and to ensure the other children's emotional and physical safety.

Mother: He is so violent with his sister. He split her lip a couple of times. And he almost knocked her out once when he hit her over the head with a five-pound brass pitcher. He's put plastic bags over her head. Even things that you wouldn't think could be dangerous, you have to make sure and keep out of his reach.

They were also concerned that younger siblings would develop similar patterns of aggressive behaviors by watching their older brother or sister. In the face of this verbal, emotional, and physical aggression, parents reported feeling victimized and tyrannized. The ever-present possibility of abuse left them feeling deeply insecure when around their children. Clearly, they experienced their child as the one in charge, the family member who "called the shots."

A second well-known characteristic of children with conduct problems is their noncompliance and defiance. Parents in our study gave vivid descriptions of the arguments that they would get into with their children, which usually ended up in screaming fights. Parents could get their children to comply only by expending an enormous amount of energy.

Mother: He just digs his heels in: "That's it, I am not wearing these socks! Forget it, I'm not going!" And he is right. He's gone to school in his pajamas, without lunch, in the pouring rain without any coat. "I've made up my mind, Mom, that's it!" he'll say to me. He will explain to me, "Mom, we

are done with this discussion" He doesn't have any easygoing bone in his body. He is not ever going to say, "Okay, I'll put that turtle-neck on." It's going to be, "I will do something but only on my terms . . . I will do nothing that you want me to do and furthermore I'll throw such a tantrum and throw this cereal bowl all over the wall, so you will be late, and mad at me when you clean it up" He enjoys that power.

Perpetually faced with these continually defiant reactions, these parents typically felt exhausted. In short, these children controlled the entire family by virtue of the power they commanded through their resistance.

7.3.2. *Hyperactivity and Distractibility*

A third well-known trait of conduct problem children is their hyperactivity and distractibility. Many of these parents talked about their children's high-intensity temperaments. They described their children as highly active, easily "wound up," overexcited, loud, wild, and out of control since birth.

Father: He's mentally fine, but his emotions are twisted in some ways—he doesn't seem to have the normalities that a lot of kids have. I look at my nieces and nephews and, while they have their moments, most of the time they can listen and talk. But with Keith he goes off into outer space and won't come back—he's not even on this planet! He's crazy, running around the house screaming, jumping on the bed, and goes into a fit of hyperactivity trying to accumulate as many things wrong as possible in that time. To get him under control we have to restrain him until he's so worn out, he's exhausted.

Moreover, they felt that their children had trouble listening and concentrating even for brief periods of time. They reported that when they made requests of their children, their children often "tuned them out" or got so distracted by their surroundings that they forgot what the parents had requested. They described their children as unable to sit still to play on their own and constantly demanding attention. The consequences for the parents were twofold: exhaustion and anxiety. These parents never get a break or quiet moment during the day. And, because their children's activity level is so high, their safety and even their survival is a major parenting issue.

Mother: From 15 months he started running and destroying everything in sight and has not stopped since then. Keeping him alive became paramount. Once he crawled out of his car seat and over the seat when I was going 50 miles an hour and he hit the door and it flew open. He was so reckless that I could not shower unless he was in his crib asleep. I could not have him out of my sight for a minute. Life with him was a nightmare. One time I put him in his room for a nap, and turned on the shower. And I hear this frantic banging on my door, and it was my neighbor telling me that his second floor window was open—he had thrown a book on the roof and was going to get it. And so from 25 months to 3, it was this incredible desire to keep him alive. We couldn't afford one mistake.

Many parents were concerned about their child's inability to learn from experience. Too often, they had seen their child suffer the negative consequences of a particular behavior, yet go on to repeat the same self-defeating behavior later.

Father: I am concerned because he is so experimental. If you tell him (or explain to him) not to do something, that guarantees he will try it at least one more time. He's so impulsive he doesn't think out the consequences of what he does. He has a kind of destructive curiosity which will get him into big trouble if he is still doing that as a teenager.

Mother: I'm concerned because he makes a mistake and we talk about it, but there is no carryover to the next situation. He still makes the same mistake. Then when I try to talk about it with him, he has this blank face with rolling eyes and I get scared that a kid this young is tuning me out.

Similarly, they would describe having tried to help the child understand a problem, only to be met with either a blank expression or a deliberately defiant continuation of the troublesome behavior. This led parents to worry about their child's future.

7.3.3. *Developmental Problems*

Aside from the characteristics unique to children with conduct problems, parents reported various developmental problems that are common among children between 3 and 8 years of age. However, the intensity with which their children experienced these problems made their parents' experiences far from normal. For example, sleeping and eating problems are typical of children at this age. Yet one parent reported:

Mother: One day we tried just to wait him out. At 6:00 I said, "We've got to go to bed." Six A.M.! We waited all night and he never did go to sleep.

Parents described how, when they tried to get their children to bed at a certain time, which is a normal area of conflict for parents and children at this age, their children would become noncompliant and defiant.

Father: You have to follow them every step of the way to get them to go to bed. And then, once they are in bed, they're either turning on the light and getting up and playing with their toys, or else sneaking around the house. They won't stay put. I found the only thing that I can do to really control that is: I take a chair down at the end of the hall, part it in front of their door, and sit and read a book. Then they'll settle down and go to sleep.

Normal eating problems were exacerbated by the conduct-problem child's high activity level, lack of concentration, and inability to sit in the same place for a long period of time.

Father: A meal at our house is like a circus. It's like two rats out of a sack. One goes one way and one goes the other. He'll run around the table. He'll take a bite of food, he'll sit down half on the chair, take another bite of food, and then run off and chew it and run around.

They also described resorting to various extreme measures in order to achieve some semblance of family mealtimes.

Mother: He is so hyperactive at meals that even at age 4 we keep him in a high chair to get him to eat. We joke about how we have to break his legs to get him in the high chair. We are just so determined to have a family meal where he is not running around and causing havoc.

Transitions are difficult for many children between the ages of 3 and 7 years. Yet for these conduct-problem children, this common developmental problem was extreme; almost any change in routine was reported by the parents to result in defiant behavior. At the root of this problem is the child's inability to adapt.

Mother: Transitions are really hard for him. We try to give him warnings, like bedtime is in 10 minutes. And then sometimes you get a temper tantrum getting his teeth brushed. Because even though he's had warnings, it hasn't assimilated that we mean, you are going to bed, we're going to turn the light off. He thinks he can still play.

A fourth developmental problem reported by these parents concerned fears. Whereas it is commonly believed that conduct-problem children exhibit externalizing but not internalizing behaviors, interview with parents indicated that these children also exhibited many internalizing problems such as fears and suicidal thoughts.

Father: He has night fears. It's been awful. It started about a year ago, but it got really bad about 4 months ago. The toys started moving their heads, and the stuffed animals . . . and then I had this long conversation with him in the bathtub the other day, and he is scared of thunder and lightning and it comes every night. He thinks that the thunder and lightning can throw bowling balls down from the roof and they can come and get him . . . it took about 20 minutes to get through that conversation. He has anxiety in his room—he lays awake for hours. We give him flashlights—sometimes he'll be awake at 2 or 3 in the morning from anxieties.

Father: He often talks about wanting to die and how he wants to kill himself. Like the other day he was angry because he got pulled out of swim lessons for not keeping his hands to himself and he said, "It's so terrible, I should just die."

7.3.4. *Unpredictability: Child as "Jekyll and Hyde"*

Along with reporting the negative aspects of their children's behaviors, most parents talked about their children's personalities as having positive aspects. For instance, parents often portrayed their children as particularly sensitive and reactive to others' moods.

Mother: He doesn't like to see anybody upset. It really bothers him. He just becomes very emotional. Say if I'm upset, he really catches on to it. Or if my husband and I are having a disagreement, he'll immediately start hollering at my husband to side with me, to get him to stop screaming.

While this sensitivity presented a challenge for the parents, it was also seen as a positive characteristic, a special gift as it were. Many parents described their children as having unique cognitive abilities and being more developmentally advanced than other children in their age group. One parent characterized her child as a "Jekyll and Hyde," an apt label for the child who is at times highly tyrannical, destructive, and defiant, and at other times loving, intelligent, understanding, and sensitive to others' emotions.

Mother: He is like a "Jekyll and Hyde." Sometimes he can be sweet, charming, loving, easy to get along with, he's a very good-natured child. But then there's the other side of him which emerges—an angry, hostile, aggressive, hurting child, who will do violent things to try to get his way. He is rough with animals and mean with little children, and he is very noncompliant. By the time he is ready to be loving again, you are fed up.

Although the personality profile of the conduct-problem child that emerged from our interviews with parents was a mixture of negative and positive characteristics, certainly the negative predominated. It was the unpredictability of these negative behaviors that seemed to cause parents so much stress. Behavior problems might arise any time, any place; parents had to be always on their guard. Thus, ironically, the child's positive characteristics contributed to the parents' stress, since without a positive side there would have been no unpredictability. A "Jekyll and Hyde" child was harder to cope with than a mere "monster" child would have been.

Father: We have these stressful times where he is very defiant and argumentative, we all lose our temper and perhaps he finally gets a swat. Then there is this emotional breakdown followed by big make-up sessions where he tells us he loves us. It is an emotional roller coaster.

In summary, it is evident from these descriptions that conduct-disordered children are not only nonreinforcing to their parents, but actually physically and emotionally punishing. Parents' feelings of victimization were amplified by their uncertainty about how their children might respond at any moment.

7.4. *Impact of the Child on the Family System: "The Ripple Effect"*

Our quantitative research had informed us about the high level of family stress, particularly marital distress. Because quantitative measures do not reveal anything about causality, however, we did not know how these parents' stress was related to their experience of living with a conduct-problem child. Our qualitative data revealed that the conduct-problem child's behavior introduces significant stresses into her or his family system and, moreover, that these stresses have a cumulative

effect on the parents. Parents' descriptions of the impact on their lives of their child's conduct problems suggested an image of ripples in a pond that widen until eventually the entire pond is affected. The child's behavior has consequences that radiate outward from the child in ever-widening circles, affecting first the parents, then the marital relationship, then other siblings, then the extended family, and then the family's relationships with the community.

7.4.1. *Impact on Parents' Relationship*

We have already described the impact of the child's behavior on his or her parents individually—namely, the experience of being tyrannized or victimized. But the couple's relationship also is affected. The relationship between the parents is dominated by the need to continually monitor and discipline the child. Very little time and energy are left for parents to devote to themselves or to each other.

Mother: One of the things that is so frustrating is that he has consumed our lives. Since he's been born, 99% of our conversation is about Matthew and what we are going to do to deal with his behavior problems. We don't have a life—everything revolves around Matthew.

Except in the unusual situations in which the father was the primary caretaker, the mother was the one who spent the most hours "under siege" with the conduct-problem child. Furthermore, mothers often took on a disproportionate sense of responsibility for the child. Typically, this imbalance created a situation in which mothers were exhausted and beleaguered, desperate for some time alone, with little energy to spare for husbands. And yet at the end of a long day with a conduct-problem child, mothers needed to share these feelings with their partners, especially when they blamed themselves for the day's problems.

The father, on the other hand, typically spent less time with the child and therefore had a less intense, somewhat easier relationship with the child. This difference between the mother-child and father-child relationships was potentially a source of relief and perspective and typically created conflict in the parents' own relationship. Observing their partner engaged in long episodes of cajoling and yelling at the child, fathers often questioned these approaches and were critical of the mothers' discipline or any inconsistency.

Father: On a micro level if my son gets my wife upset, she doesn't distinguish between him and me. If it's a weekday and I've had a hard day at work I have limited resources when I get home at night. I may try to smooth the waters a little, but I'm often not successful and sometimes I get concerned about the way he is treated. I feel real angry about it, but I haven't done anything.

We commonly heard fathers express the belief that their wives were "too easy" and "not tough enough." These criticisms were bolstered by their awareness that they did not have the same kinds of problems with their children that their partners experienced. Mothers, in turn, felt resentful if fathers had an easier time with the child. Fathers often reported feeling left out and unsure how to contribute. Their subsequent guilt and confusion discouraged rather than encouraged communication between the couple. Frequently, fathers' distress was so great that they withdrew from the situation or avoided discussions with their partners about the children. Of course, these kinds of responses from fathers exacerbated the mothers' anger and frustration, thereby undermining the support system potential in the couple's relationship.

The result of this dynamic was a polarization of the couple:

Mother: I always feel that if you [looking at husband] took a bigger role in parenting we could do it together and share the role. I feel it is you against "us" [mom and the children]. I want it to be "us" and "them."

Father: Since our son was born, you [looking at his wife] have become really obsessed with parenting. Even during the pregnancy, you were always reading really big books about how to parent and trying to be supermom. I am not willing to put my mind, body, and soul into parenting all day and night. I'm going to have walls and boundaries. You are constantly attached—even when we go out for time alone, what do you talk about? Nothing but the kids! I finally made it a rule when we are out with friends not to talk about the children. The separation in our relationship began when he was born.

In this last example, the father's experience of parenting a conduct-problem child has distorted his thinking about the relationship. The normal estrangement a husband feels at birth (feeling outside the mother-child bond) becomes, upon reflection, a permanent condition. He projects onto the past what he feels now, a "rewriting" of the couple's history that only increases the emotional estrangement. Consequently, this couple experiences a loss of intimacy due not only to the practical constraints of too little time and too little privacy for a sex life, but also to the intense feelings of guilt, anger, frustration, and resentment that result from perceiving the relationship in terms of estrangement.

The sense of loss of control that parents felt in their parenting role seemed to spill over into their own relationship, resulting in a paralyzing depression and a sense of hopelessness. Instead of the relationship being a protective factor, a zone of relief from the stress of parenting a conduct-problem child, it was permeated by that stress and developed its own stressful dynamics.

Mother: She [child] doesn't allow us to talk together—with the kids we don't get enough time together. As far as a romantic sexual-type relationship, for the past 4 years, it's been shot to hell! We don't have time to talk, we don't have time to pull in together, and, you know, just have a relationship.

7.4.2. *Impact on Siblings*

As described by these parents, living with a conduct-problem child has both a direct and an indirect impact on siblings. The direct impact lies in the child's aggressive behavior, which is often directed toward siblings, as discussed earlier. The indirect impact lies in siblings' relationships with their parents, especially their parents' expectations for them. Most parents felt that the constant, extraordinary degree of attentiveness required to manage the conduct-problem child's behavior left them with very little time or energy to attend to siblings. Stretched to the limits, they felt unable to tolerate misbehavior from more than one child. They expected siblings to be model children who always act responsibly and under control.

Mother: What happens in our family dynamic is that our non-problem child always has to be responsible. Wrongly, but you know, because life with his brother is so incredibly complicated, he is expected to act like a 40-year-old and think like a 40-year-old. The consequences for him are great. I expect too much of him, I expect him to act, to use his head every minute of every day about dangers for his brother—that's more than an 8-year-old should have to contend with. Because life with his brother is so dangerous for everybody and because we try to control his brother's behavior, we are constantly on him to control his. And that is hard . . . he never gets to have a bad day; he never gets to throw a tantrum, he never gets to do anything because we are so maxed out on his brother, there's nothing left for him. He has to shut up, behave, and not talk to us about any of his concerns and problems.

Or because these parents felt so beleaguered, they placed the siblings in a shared parenting role, expecting them to care for the conduct-problem child. With siblings expected to act as adults and sometimes as parents, normal familial roles are distorted. The shift in the normal balance of power that occurs when a child becomes a tyrant and parents become victims is extended further; the family system is turned on its head.

It is obvious that these parental expectations place an unfair burden on the sibling in terms of age-inappropriate responsibilities. Moreover, these expectations are likely to create a sense of resentment on the part of the sibling toward the misbehaving child. In many families, the "good sibling" was becoming as difficult as the conduct-problem child by mimicking the problematic behaviors, a predictable result of the excessive parental attention given to the problem child.

Mother: He definitely requires a lot of attention. And basically what we are feeling now is a backlash from giving him so much attention, that my older one, who used to be my "great kid," is now acting up and being sneaky and starting to get that way.

7.4.3. *Impact on Extended Family*

These parents also reported that their children's conduct problems had become a source of tension between themselves and *their* parents and/or siblings (i.e., between the parents and grandparents or between the parents and aunts and uncles). It seems that grandparents often attributed the child's misbehaviors to a lack of good parenting. Many parents reported that their parents (the child's grandparents) were always giving advice about how they "should" handle the problems. Typically, they advocated a stricter approach to misbehavior.

Mother: When Grandma comes to visit about once a month, he [child] just goes ape. He starts terrorizing the cats, he starts throwing his toys, he starts going ape. And he has a real hard time when Grandpa is there. And Grandpa likes him, but Grandma thinks we should "nail the little sucker a good plant a couple of times on the rear end."

On the other hand, sometimes the children did not behave as badly with grandparents as they did at home with their parents, a fact that these parents interpreted as further evidence of their own failure as parents.

7.5. *Impact of the Child on the Family's Relationships with the Community*

Eventually, the child's conduct problems "rippled outward" to affect the family's relationships with professionals, teachers, and other parents in their community. In general, these relationships become characterized by negative feedback to the parents: stigmatization, social isolation, and rejection.

Parents felt rejected and isolated by teachers' and day-care providers' reactions to their children's misbehaviors. The children's aggression and defiance created problems with their peer group at school, causing other children to cry or misbehave and generally increasing the level of aggression in the classroom. Understandably, teachers became more disapproving and punishing toward these children. Parents frequently reported that they had been asked by teachers to find another day care or school for their child because their child was unmanageable and consumed too much of the teacher's time. Some families had been asked to leave half a dozen day care centers by the time their child was 5 years old.

Mother: It started when he was 18 months old. He was always the most aggressive, the most outgoing, the loudest child in every group he's ever been in. And I remember after his first day at day care—I picked him up and I got a phone call. It was on my answering machine—I mean the teacher

never confronted me in person and she just said she didn't think it was going to work—he was terrorizing other children and really being a disruptive force to her preschool. And I had to drop that day care. So you know, a notice—and it's just been like that from that point. I remember getting a phone call on my answering machine, and with it one of the teachers asking me to call back—I was just holding my breath, wondering if she was going to tell me to take him out . . . I would come back after 3 hours and just the expression on her face—it was this horrified, painful expression.

Mother: He's 3 years old and he's always on probation. The teacher just greeted me with one of those really painful expressions I'm so familiar with: "Your son did this." Then you would hear stories of how your son had to have two people release him from a choke hold on another child or how he was pouring water on someone's head. They told me not to bring him back. I was just so embarrassed.

Moreover, as children's antisocial identity was established, they frequently became targets of other children's ridicule and rejection.

A further "ripple effect" was that the disproportionate amount of teacher time devoted to the child's behavior problems resulted in resentment by parents of other children in the school or day care and complaints to teachers and principals.

Mother: I've never been to a school meeting when I haven't been trashed. I can't stand to go to one more meeting and have them tell us what they are not going to do for us. After they got rid of us—well it was like we were disposable and we never heard from them again.

This intense negative feedback compounded the parents' feelings of isolation and lack of support.

Mother: The principal came up to me and said your boy is a very sick boy and is going to need many years of psychoanalytic counseling—I feel all the teachers knew this and set us up in the school so we couldn't win. I felt everyone else in this kindergarten were on this raft while we were swimming around trying to clutch to get on. We said we'll pay for books and I'm helping out twice a week in class and I'm offering to be a personal aide and we'll pay for a social skills teacher—and everywhere we'd go around the raft and try to get on someone would step on our fingers.

Yes, and we even sent away for literature to provide ADD handbooks for the teachers which were never read. By the end of the school year, we started realizing that the kindergarten raft was sailing away, and when they told us not to come back, we felt we were left drowning in the water.

Faced with this stigmatization and confused by their child's behavior, these parents had sought help from a variety of professionals, such as pediatricians, psychologists, counselors, and psychiatrists. In general, they were frustrated in this quest. Parents had received conflicting opinions regarding the seriousness of their child's problems and conflicting advice about how to deal with them. Many parents reported being told that their child was "normal," that she or he would soon

"outgrow" the problems, and that they should just "loosen up" and "be patient." Far from being reassuring, this advice caused parents to blame themselves for overreacting to the problem behaviors or confused them, since in their experience the behavior was not normal.

Mother: I've talked to our pediatrician about it. I went and saw a counselor, and I've talked to him about it. And everyone basically told me, "Oh, he's just a normal kid." Well, I mean our life at home is not normal . . . and they say, "he is just like a normal 4-year-old . . . nothing is wrong with your child." And he goes, "I wouldn't worry about it." And he kept telling me, "I wouldn't worry about your kid, I would worry about the ones that are quiet and compliant and do everything they're told." So you know I was just pulling my hair out—while they are trying to make you happy and realize that you don't have a weird child—but that's not what I wanted to hear. I wanted to hear step one, two, three, four . . . and I really don't know what to do.

Other professionals would tell them to "be more consistent and get stricter control" of their children's problems. The net result, regardless of the type of advice given, was to make the parents feel at fault and confused about how to cope with the situation.

As the "ripples" spread, these parents experienced increasing isolation from other parents in their neighborhoods and in their schools. Parents felt a lack of connection with and support from parents of "normal" children. They thought that if they were honest about their difficulties, they would encounter indifference.

Mother: Basically I feel I am really in a minority. Because of all the other mothers I've talked to . . . they've never been hit. I mean to me it's unimaginable not to be slapped and kicked. And I have a friend. I was telling her about it and she says, "What? Your son hits you? My daughters never hit me." I mean other parents look at me like I just walked off another planet. So I feel very isolated. I feel like no one is like me! No one has my situation.

Mother: There's always the fear that if you share with somebody what your child is like, somebody will assume it's your fault, and think you screwed up as a parent. Or they'll reject you and say, "God, I don't want to hear about this!"

Or, worse yet, the parents feared reprisals in terms of the impact this information could have on others' perceptions of them or their child. The tremendous amount of negative feedback these parents received from other parents bred feelings of stigmatization. This lack of empathy was often perceived as rejection or condemnation. When they invited other children to come over to their house to play with their child, they were turned down. Their children seldom received invitations to birthday parties or to play at another child's house. Typically, after one experience with their child, a babysitter would not want to come back.

Mother: She has run off three babysitters. No one wants to babysit her. I mean, one day she was jumping on the bed, pulled down the curtains, threw pillows all over the place, wouldn't mind the babysitter. We came home, everything was trashed. And the babysitter said, "Look what this child did."

Parents even felt rejection from strangers in grocery stores, parks, and restaurants.

Mother: There have been times when he has been aggressive enough that I've seen a look in other people's eyes that just makes me feel horrible to the core. One day I took him to the children's museum by myself, and by the time we left, maybe 45 minutes later, I was really an emotional wreck because I'd seen a look and posture in the other parents there that showed repulsion on their part. And I felt that as a couple, we were really being rejected. And I literally saw other people come into a play area and, seeing we were there, just turn their own child away.

As a result, parents reported becoming more and more insular. Frequently, they reported having stopped taking their children to grocery stores and restaurants in order to avoid having to deal with possible tantrums and negative behavior in these public places.

Mother: I won't take him shopping with me because he throws temper tantrums, and with child abuse laws the way they are now you can't discipline him in public any more. So I won't take him. I won't even take him to a restaurant.

This apprehension of blame and rejection from extended family members and from the community led parents to feel more and more isolated.

Mother: There is huge isolation. My mother doesn't understand, my stepfather is hypercritical, and other parents think it's awful—rarely do we get support. Other parents walk in our house and look at the holes and think, "My God, what kind of children live here, obviously these parents are letting things run amok." Isolation has been a huge issue for me, I don't think anyone else understands. Nobody has a child like him.

In sum, they felt stuck with a child who was noncompliant and aggressive—a tyrant at home, a terror at school and in the community—with no support or understanding from others.

7.6. *Theoretical Integration—Living with a Conduct-Problem Child: An Experience of Learned Helplessness*

When professionals and lay people alike look at families of conduct-problem children, certain judgments are commonplace: The parents are at fault for their child's misbehaviors, the parents might resolve their child's problems if only they were more committed as parents or used more effective discipline strategies. But these judgments are off base.

Persons outside these families usually have only a superficial view of what these parents have experienced and of the cumulative effects of the child's behaviors—we see the situation within the context of our own generally positive experiences of child-rearing. Such an approach is insensitive to the disrupting process that parents go through while raising a child with conduct problems. We haven't experienced what it is like to feel "held hostage" by a tyrannical child. Nor have we experienced the complexities of the "ripple effect."

Unfortunately, research has done little to correct these misperceptions. Quantitative data such as mean scores of parental critical statements toward their children, number of spankings per day, and mean depression or marital scores do not help us understand subjective realities or the context of the phenomenon. Such data may even bolster common misperceptions of these parents as incompetent and blameworthy.

Qualitative data, on the other hand, allow us to understand the phenomenon within its context and to explore links between phenomena. In the third step of grounded theory analysis, theoretical integration, the researcher is permitted to have "hunches" about the data and to make "intuitive leaps." Findings from this qualitative study led us from the open and axial coding of interviews with parents (as described earlier) to integrating the recurring themes into a theory, namely, that of learned helplessness (Seligman, 1975). Although this theory was not original with us, this study did for the first time reveal how the theory applies to the phenomenon of parents living with a conduct-problem child. For example, the recurring themes of unpredictability, isolation, victimization, self-blame, and despair over not being able to change the situation that we found in our data are also the hallmarks of learned helplessness. We have described the three phases of the process that parents went through (treading water, problem recognition, and learned helplessness) in a longer version of this paper published elsewhere (Webster-Stratton, 1994).

The basic premise of the learned helplessness theory (Seligman, 1975) is that during contact with an uncontrollable situation, an organism learns that outcomes and responses are noncontingent (Abramson, Seligman, & Teasdale, 1978; Maier & Seligman, 1976; Seligman, 1975). As parents realized that their child's behavior problems were not going to disappear, they coped with their feelings of self-blame by launching into a variety of discipline approaches with their child. Parents reported seeking help from books, from courses, and from various professionals. They reported trying a range of discipline strategies such as teaching, yelling, criticism, spanking, Time Out, taking away privileges, and positive reinforcement. After several years of struggling to control the child's

behavior problems with only limited success, if any, they began to believe they were doomed to be ineffective in changing their children's behaviors. In fact, typically, the children's misbehaviors were often gradually escalating under what parents perceived as their own best efforts. Parents reported reaching a point at which they believed that "nothing works."

Father: I get agitated easily, I mean, this has been 4 years of this. And I am 42 years old, and I've just about had it. So now I'm kind of at my wit's end, like what to do. Because nothing is working.

Mother: Both of us are professionals and we work with people a lot and we've had a lot of resources. We've been in counseling since he was 3 years old and seen several psychologists and psychiatrists and we've worked very hard, but haven't gotten very far. He's still got the same traits and that's scary.

Mother: I'm stuck here—it will never get any better, this child is going to be a delinquent, I know it. I'm going crazy and I need help. Maybe I should give up because I'm going down in a sinking ship.

They felt helpless and inadequate in their parenting roles and, more generally, as human beings. Moreover, their extended family members, teachers, professionals, and other parents seemed to confirm these feelings of ineptness.

The transition from intense feelings of inadequacy to learned helplessness was evident in parents' reports of feeling overwhelmed, even paralyzed, by their children's behavior problems. Parents talked at times as though they believed their children were "out to get them." As the embattled parents felt increasingly helpless, they began seeing their children as the powerful ones. In an inversion of the usual power structure, the children were controlling their parents' lives. Thus, the parents became victims and the children oppressors. In response to their sense of victimization, the parents' anger increased, as if in an effort to regain control and power in the relationship. Additionally, however, these powerful feelings of anger were coupled with fears of losing control of their own behavior with their children and control of their sanity.

Mother: I was ready to just walk away from everybody. It was just too much—his screaming, the temper tantrums all day. And I thought I was completely loony bins. I felt like a real failure as a human being . . . There are times when he just drives me to destruction. . . .

Sometimes parents reported that they did lose control of themselves and used excessive physical punishment. Such out-of-control reactions further inflamed their self-blame, setting in motion a vicious cycle of anger, loss of control (ineffective parenting), and guilt. These reactions and feelings, in turn, further aggravated the child's aggressive responses. Eventually, the fear of their own angry responses led parents to give up

even trying to discipline their child and to withdraw, which in turn brought on depression.

Mother: It's like he pushes, and pushes, and pushes me . . . I feel real helpless . . . and what I do is, rather than react appropriately, I shut down. I mean it's like I'm in shock. That's when I feel really incompetent. . . . I have truly never questioned my own sanity, as I have with the kind of episodes I told you. It really overwhelms me—it scares me.

Another characteristic of the learned helplessness experienced by these parents, and one that was very difficult for them to accept, was a sense of having invested for so long in their child with little or no "return" for their investment in terms of joy and pleasure in their parent-child relationship. This situation, in which parents experienced few rewards for the difficult work of parenting, created a sense of paradox and despair for parents in that the discrepancy between what they were "putting in" and what they were "getting out" was just too great.

Mother: I've noticed other mothers and families, and they really enjoy their little girls and their little boys, because it's a real different situation for them. And it's not like that for me. I don't have that real enjoyment.

7.7. Discussion

As mentioned earlier, learned helplessness theory posits that when people undergo experiences in which they have no control over what happens to them, they develop certain motivational, cognitive, and emotional deficits. The motivational deficit is characterized by retarded initiation of voluntary responses, the cognitive deficit by a belief or expectation that outcomes are uncontrollable, and the emotional deficit by depressed affect (Abramson et al., 1978; Maier & Seligman, 1976; Seligman, 1975). Parents of conduct-problem children learn through repeated experience that regardless of what parenting strategy they use (e.g., Time Out, spanking, explanation, positive reinforcement), the child's aversive behavior remains constant. In other words, the outcome is not affected by their actions. Moreover, on those rare occasions when they were able to influence their child's behavior, these parents came to feel that there was no predicting which parenting strategy would produce a particular outcome. For example, Time Out might be effective at one time, but not at a different time—even in response to the identical problem behavior. Thus, they feel there is no discernible relationship between their actions and the outcome.

Abramson et al. (1978) distinguish between universal and personal helplessness. In universal helplessness, the person believes that neither he nor she nor anyone can solve the problem, whereas in personal helplessness the person believes that while the problem is solvable, he

or she lacks the skills to solve it (i.e., low self-efficacy expectations). Analysis of the attributions of the parents of conduct-problem children in our study revealed that these parents had developed a sense of personal helplessness. Parents constantly compared their child-rearing skills to those of other parents and came to believe that unlike other parents, they were incapable of controlling their child's behavior. These internal comparisons were reinforced by feedback from family members, teachers, and other professionals, who also attributed the child's behavior or problems to their lack of parenting skills—thereby increasing their sense of personal helplessness.

Our qualitative data amplified our quantitative findings concerning depression among this population of parents, revealing very low levels of self-esteem or high levels of depression or both. This finding is explained by learned helplessness theory, which asserts that people who feel personally helpless show lower self-esteem than do those who experience their helplessness as universal (Abramson et al., 1978). A related hypothesis advanced by Bandura (1982, 1985, 1989) may also help explain this finding. He proposes that self-efficacy beliefs are central to an individual's transactions with the environment. For example, in his view, a parent may understand how to do Time Out with an aggressive child, but be unable to do it because of self-doubts. In addition, Bandura (1989) has suggested that the relationship between self-efficacy and performance is bidirectional. Self-efficacy beliefs are enhanced or decreased, respectively, by success or failure experiences. The parents in our study reported feeling ineffective due to their repeated failure experiences trying to parent their difficult conduct-problem children. Thus, they stopped trying.

According to the theory, learned helplessness varies in terms of generality, chronicity, and intensity of the problem (Abramson et al., 1978; Kofta & Sedek, 1989; Mikulincer & Casopy, 1986; Miller & Norman, 1979). The helplessness felt by these parents was extreme in all three respects. With regard to generality, these parents of conduct-problem children felt inadequate in other areas of their lives beyond child-rearing, such as in their marital relationship and relationships with teachers, other parents, and professionals in the community. Many felt isolated, stigmatized, and even rejected. Thus, their sense of helplessness had become somewhat globalized rather than remaining specific to the child. With regard to chronicity, these parents reported waiting endlessly for their child's problems to disappear before they even began to try to control them—and when they did try to handle them, they were usually unsuccessful. Most had therefore experienced chronic helplessness for several years. With regard to intensity, the high intensity at which these parents experienced these problems evolves from the im-

portance our society places on successful child-rearing and a harmonious family. Abramson et al. (1978) have suggested that intensity of helplessness will be higher to the extent that the event about which the person feels himself helpless is highly preferred or valued. It is not difficult to understand the intense feelings of helplessness that can occur when parents develop the conviction that they lack the skills for rearing behaviorally normal children.

As discussed earlier, we knew from our quantitative studies that parents were stressed, depressed, angry, out of control, and critical with their children. We had not information, however, about the interaction of these factors, their relation to the child's behavior problems, and their subjective meaning for the parents. It is one thing, for example, to know that parents are angry or depressed as measured on a standardized scale, and quite another thing to hear how they feel "held hostage" by their children and to know that their attitudes and feelings are similar to those of a prisoner of war (i.e., learned helplessness). It is one thing to know that they are more critical in their communication than parents of "normal" children, but when we also know that they blame themselves and have low self-esteem, we interpret their critical behavior in a light different from, say, that in which we interpret the behavior of parents with strong self-images who are critical of their children. Thus, our qualitative findings, and especially the theory that arose from our findings, add meaning to our quantitative findings by helping us to see the gestalt of these families. Understanding parents' sense of victimization and their feelings of isolation and stigmatization as the ripple effect spreads from the family to community puts the quantitative data "in context." Understanding how the unpredictability of their children's conduct problems contributes to their feelings of helplessness and their difficulty with providing consistent parenting gives us new insights into these parents.

This qualitative analysis has important implications for treatment. Not only does this theoretical formulation contribute a new viewpoint regarding the development of conduct problems in families, but also the description itself should help sensitize therapists to the long history that these parents have already experienced prior to seeking help for their problems. Moreover, learned helplessness and low self-efficacy beliefs can be reversed by experiences of success. Teaching effective parenting skills undoubtedly starts a reversal process; it begins to give parents some expectation that they will eventually be able to control outcomes (i.e., their children's behaviors). These findings also reveal the importance of enhancing social support (reversing these parents' experience of isolation and stigmatization) by involving partners and, if possible, teachers in the intervention. Indeed, these findings suggest that group-

reality of intervention, the process of change as experienced by parents in our intervention program.

8.1. Participants

Subjects were parents of conduct-problem children (ages 3-7). In the study, 20-24 weekly meetings of five different groups of parents (totaling 40 mothers and 30 fathers) were videotaped, and 16 therapist consultations with 37 mothers and 30 fathers were audiotaped half-way through the parent intervention program and upon termination of the program. Transcriptions of these videotapes and audiotapes provided the data for this study.

The data suggest that in learning to cope more effectively with life as the parent of a conduct-problem child, parents went through several phases. First, their attitude seemed to oscillate between despair and irrational hope. Next, as they gradually came to realize that their child's problems were chronic, their anger, guilt, and resistance gradually decreased. In this phase, most families were able to change their expectations and settle for a less than total recovery of the family and the child; we called this phase "tempering the dream." This phase was followed by a third phase in which the parents worked at "fine-tuning" or tailoring the program to their own particular needs; we called this phase "making the shoe fit." Finally, by the end of the intervention, many parents had reached a phase of "coping effectively." As these phases (and the prior phase of "acknowledging the problem") have been described in detail in an earlier paper (Spitzer, Webster-Stratton, & Hollinsworth, 1991), we will describe them only briefly here in order to illustrate the type of findings that arose from our qualitative data.

8.2. Phase 1. Alternating Despair and Hope

8.2.1. Reexamining the Blame and Guilt

As parents participated in the parent training program and learned new parenting strategies such as play skills, effective reinforcement, and nonviolent discipline approaches, their guilt over their previous use of punitive discipline approaches, their regret about their earlier lack of parenting knowledge, and their failure to use these new approaches more consistently with their children (unfortunately, new sources of guilt) were recurring themes.

Session 6

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

based therapeutic approaches would be particularly helpful for these parents in that the group experience counteracts their isolation, normalizes some of their experiences, and can provide support.

8. Study 2. Parents Undergoing Therapy: An Experience of Gaining Knowledge and Control

From our first qualitative study, we learned a great deal about what parents of conduct-problem children experience within their families and communities. What about their experience in therapy? Our quantitative research had shown that compared to waiting-list controls, families in our parent training program showed significant decreases in parental anger, stress, and depressive symptoms immediately posttreatment; only 20% of mothers and 10% of fathers still reported depression or stress in the abnormal range (i.e., about the 90th percentile). Moreover, home observations of parent-child interactions indicated a significant decrease in parental critical statements, an increase in praise statements and a significant reduction in child deviant behaviors. In this study (Webster-Stratton, 1994), over 70% of mothers and 75% of fathers perceived their children to be in the normal range as measured by the CBCL, that is, a T-score below 63 (Achenbach & Edelbrock, 1991).

These results attest to the value of the intervention, in terms of parents' emotional states (anger, stress, depression) and behavior (criticisms, praise). But this is very limited information indeed about the impact of therapy, particularly about the therapeutic process. We wanted to know more than the outcome of the intervention; we wanted to know what parents experienced during the intervention, the broad range of interwoven emotional, cognitive, and interpersonal effects not necessarily captured by our usual quantitative measures and not necessarily reflected in behavioral outcomes. In part, this need to know more about parents' subjective experience of therapy was a matter of good practice; that is, we wanted to understand what difficulties parents experienced as they worked with the concepts presented in the program so that we might improve our intervention. But also, in light of our first qualitative study, we wanted to know the extent to which their attempts to change their parenting practices affected the family system and their relationships and with those outside the family. And, knowing what we now know about the isolation, anger, guilt, despair, and helplessness experienced by these parents, we wanted to know how the process of undergoing our intervention affected these feelings and perceptions. Consequently, our second qualitative study was an analysis of the subjective

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

The guilt arose, of course, from a desire to attribute blame. Initially, parents were preoccupied with identifying who should be blamed for the child's problems. While some externalized the child's problems and blamed the child's personality on an absent parent, teachers, or society in general, other parents internalized the child's problems and attributed them to their own personal inadequacies or lack of parenting skills. During treatment, as parents viewed the videotaped examples of other parents interacting in different ways with children of different temperaments, and as they listened in group to other parents' accounts of their family's interactions, they began to reexamine the blame. Their guilt began to give way to a realization that children with difficult temperaments demand higher degrees of parental supervision. They began to reframe their parenting goal as successful socialization of whatever type of child one had been given. Children with conduct problems simply required different parenting skills. With this new mind-set, parents were able to think more constructively about their child, focusing on which parenting techniques would work best to bring out her or his prosocial behaviors and personality strengths and which strategies would decrease his or her aggression and noncompliance. Thus, the focus of parents' attitudes gradually shifted from assigning blame for their child's problem (and feeling guilt) to attempting to understand and manage the behavior problems.

8.2.2. Finding "Magic Moon Dust"

While parents initially expressed guilt over their failure to control their child's misbehaviors, as they began to learn new parenting strategies they reported feelings of excitement, even exhilaration, over the prospect of improving their interactions with their children.

Session 3

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

Most parents, after completing the first four programs (Play, Learning, Praise, and Tangible Rewards), experienced a major shift in their perception of their children's behaviors. They began to notice and appreciate their child's positive behaviors and deemphasize the negative.

Session 6

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

Session 6

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

On reflection, it became obvious to us that the parenting techniques that we were teaching were all too often perceived by parents as "magic moon dust" that could cure all their child's problems. The immediate relief that they experienced as their child made initial improvements led them to believe that their child's problems would be easily solved. Moreover, they sometimes seemed to believe that these changes in their children's behavior would alleviate other family problems. They anticipated a "total cure." In this phase, parents did not consider the possibility that their child's behavior might regress or that improvement might cease at some point. Moreover, parents did not comprehend the long-term commitment and the sheer amount of work that would be necessary to sustain these initial improvements.

8.3. Phase II. *Tempering the Dream*

In the next phase, parents faced the fact that there are no magical solutions and realized that they would need to "temper the dream" by adjusting their hopes and expectations. Three categories were identified in the data as part of tempering the dream: "apparent setbacks," resistance, and "no quick fix."

8.3.1. *Apparent Setbacks*

Soon after parents started to apply what they were learning in the program, unexpected changes started to take place in the child's conduct problems, in the parents themselves, and in the family system. Some of these changes were in conflict with the parents' expectations for the program, resulting in anxiety and anger in some cases. Three common themes characterized these apparent setbacks: role reversal within sib-

ling relationships, conflicted parenting, and child's regression despite parents' hard work.

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

Session 8

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

As parents put into practice with the target child the strategies taught in the program, they observed that the other children in the family began demanding the same degree of attention, thus further taxing these parents' already depleted resources and energy. Often, the other children's demands took the form of noncompliance and deviance, with the result that parents felt more discouraged because they had made headway on one child's conduct problems only to have them surge elsewhere.

Conflicted parenting occurred when one partner participated actively in the program while the other parent did not participate, was critical of the program, or was invested in maintaining the status quo. These differences in level of participation led not only to debate as to the best way to handle the child's misbehavior, but also to conflicts within the couple's relationship. Thus, at this stage, the intervention seemed to some parents to increase marital stress. Conflicted parenting also operated in some cases in which a single parent had a former spouse, a boyfriend, or a grandparent involved in raising the child but not participating in the program.

Session 8

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

Regression, the third type of setback, occurred when the child's behavior seemed to regress despite the parents' hard work. Their hopes raised as a result of initial improvements, anticipating success and desparate for some relief, parents made no allowances for limited progress or for actual regression in the children's behavior. Therefore, when parents encountered regressions, their reaction was one of disbelief, depression, and even anger.

Session 9

Mother: In the last two weeks, we've had a 75 to 85% regression. Complete—well, almost complete—reversal to where she was before this class began.

I'm not certain why. I was really sick; maybe that had something to do with it. All of a sudden, out of the blue, she's had some real bad episodes, and last week it was every day. It's like we've never been in this class. And the time before that—up through Christmas—was wonderful. I mean both of us had to hold him down to get him dressed on Saturday, amidst screaming and kicking and spanking.

Session 9

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

These emotions arose from a perceived lack of congruence between the parent's hard work at implementing the program's strategies and the child's failure to improve—so much work, so little progress. In some cases, as shown in the next example, the parents felt that the children actively resisted their efforts to change the family dynamics.

Session 6

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

8.3.2. Resistance

In general, parents did not have realistic expectations concerning the demands the program would impose on them and their family life. They wanted and expected the program to lighten their burden, to decrease the amount of effort involved in parenting a child with conduct problems; instead, it was putting more demands on them, adding to the burden they felt. This was only for the short term, of course, but that was how most of them were focused. Along with anger at these setbacks, they expressed resistance when they discovered that favorable changes in their child's behavior could be brought about and maintained only to the extent that they were willing to continue investing time and energy in implementing the program; to some, this investment was excessive. Although most parents accepted the rationale of the program, during this phase many exhibited resistance to parts of the program, especially those parts that demanded extra effort. Frequently, this resistance was manifested in parents' failure to complete the weekly homework assignment. When asked about the homework, parents would give excuses such as lack of time, forgetting the assignment, too much

stress at home and at work, procrastination, and difficulty being motivated.

Sometimes parents resisted homework assignments involving interactions with their children because they perceived their children as controlling. It was as though the parent did not want to do anything that would cede further control to the child. In cases in which the child was verbally abusive of the parent, parents were even less inclined to spend time with their child. There was no reinforcement for doing so.

Session 5

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

8.3.3. No Quick Fix

The combined effect of the setbacks and resistance was apparent in a deterioration of the "total cure" myth and a dissipation of the "magic moon dust" phase. Parents gradually came to understand that there was no quick fix or cure for their child's problems or for their family as a whole. It was not a matter of a "flaw" in their child that could be "fixed" like a broken arm or a faulty heart valve.

Session 13

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

Parents realized that although their child's behavior would improve, as would their overall parent-child interaction, the child's temperament and associated problems were long-term. The chronic nature of the problems would continue to exact a heavy toll from parents, requiring them to monitor the child continuously. This acknowledgment of the duration of the child's problems constituted a change in parental perceptions, and it was necessary in order for them to make a long-term commitment both to the intervention and to the principles taught in the program.

Session 8

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

8.4. Phase III. "Making the Shoe Fit"

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

8.4.1. Understanding Parenting Techniques

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

For example, reinforcement menus were developed by some parents with inappropriate expectations and without concern for the child's developmental stage or the frequency and type of misbehavior. More specifically, parents demonstrated difficulties around the timing of the reward (i.e., how long the child should wait before getting the reward), the type of behaviors to choose for reinforcement, and the cost for each behavior (e.g., 2 points = sharing, 5 points = extra reading time, 25 points = visit to the zoo).

Another parenting technique that posed difficulties for many of these parents was reducing the number of commands and giving the child adequate opportunity to comply with a command. Having come to expect noncompliance, parents had compensated with frequent repetitions of their commands (chain commands). This had become a habit, almost a reflex, which they found difficult to stop.

Session 7

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

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

8.4.2. Generalizing Parenting Techniques

Data indicated that some parents, in the process of "making the shoe fit," had difficulties generalizing the particular parenting techniques shown in the videotape scenarios to other children, other problems, and other settings. They did not readily see how a given parenting strategy could be used with different behaviors across different age groups. For example, without help from the therapist, some parents could not take the concept of the Ignore technique, which is demonstrated on the videotape as a response to tantrums, and generalize its use to a response to whining and swearing.

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

Session 10

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

Interestingly, parents had less difficulty generalizing the techniques when their training involved group discussions. Presumably, the parent group sharing and problem solving provided a rich array of examples of parents applying the concepts in different situations, which helped enhance parents' ability to generalize the concepts—that is, to learn the skills.

8.5. Phase IV. Coping Effectively

In this phase of treatment, parents began to exhibit effective cognitive and emotional coping strategies: They could express empathy for their children's problems, understand their children's developmental

needs, experience their own vulnerability without feeling victimized, and laugh at their own responses. As they discovered that they could cope successfully with the daily hassles of having a conduct-problem child, they gained confidence in themselves and in their ability to cope with future problems. In this phase, parents expressed the conviction that they would survive their children's and their own relapses. Having reframed their child's behavior problems in terms of temperament rather than malevolence or their own failure as parents, they became experts at managing and responding to their children's special needs, which allowed them to act as their children's advocates in the larger community. Four categories of coping effectively were identified in the data: coming to terms with the hard work, accepting and respecting their child and themselves, self-refueling, and getting support.

8.5.1. Coming to Terms with the Hard Work of Parenting

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

Session 15

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

Session 15

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

8.5.2. Accepting and Respecting Their Child and Themselves

In this phase, parents indicated empathy, understanding, and acceptance of their child's particular temperament and sensitivity to the child's developmental struggles. Part of gaining this empathy for the

child was parents being able to see beyond their own frustration and anger, to understand the child's feelings and perspective.

Session 20

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

They accepted their child's need for independence and realized their child needed to have opportunities to learn from mistakes. They also understood the importance of their patience and support in the child's developmental process.

Session 20

Mother: In the last three weeks I've noticed a synthesis of all the sessions we've had, and me basically changing the way I interact with Hannah in a dramatic way—spontaneously. Now when I interact with her I tend to look at her eyes and I realize I can't remember my parents ever doing that. I'm giving her more space and time—more room to make mistakes, screw up, and make messes. I'm trying to give her more independence, when she wants to do something let her do it, rather than saying you're going to spill the milk all over the floor. It's fine if she spills the milk, she'll learn what happens and we've actually been getting on really well.

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

Session 20

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

I said, "You're right, and I'm sorry. I'm real tired and it's wet in here." I felt saved by her.

8.5.3. Self-Refueling

Along with becoming more knowledgeable and confident in their parenting skills and more accepting of and able to manage their own

emotions, coping parents also realized the importance of caring for themselves as individuals and couples. As the blame, guilt, fear, and anger subsided and the child's behavior improved, parents were able to get babysitters so that they could spend time away from the children. Parents expressed the view that taking time for themselves and being with their partners was a "refueling" process that allowed them to gain a more positive perspective and to maintain the energy they needed for coping with their child's problems.

Session 13

Mother: If I'm grading my kids for controlling their aggression and for compliance and good behavior, I need to ask myself, "How many times do I lose it?" "How am I doing in keeping my temper and my anger, and how well am I doing in rerouting my thinking when I'm short-circuiting?" I need to keep track of that and reward myself. Hey, it's okay to get an ice cream cone or treat yourself to a babysitter for an hour or buy a new blouse. Hey, it dawned on me that my behavior needs to be measured, too, since that's what we're really all discussing, how we can change to effect change in our children. Well, I even mentioned that to the kids and David was really cute, and said, "Well, Mom, we can move our sticker charts over on the refrigerator and make room for you too."

Gradually, parents also experienced some "refueling" through their children. As their efforts began to pay off, parents began to experience their children as reinforcing.

Session 14

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

8.5.4. Getting Support

During this phase, parents no longer felt isolated and stigmatized because of their child's problems and their own parenting, but rather had found support. The parents indicated that the parent group provided a safe place where they could be honest about their difficulties and allow themselves to be vulnerable. Often, to their surprise, they found that the other parents all had had similar experiences and felt similar emotions. Thus, the parent group provided a much-needed sense of connection with other parents.

Session 14

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

group of people that has really enlightened and enriched my life. And, ah, it's going to make me a better person from knowing everyone here.

Session 24

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

Session 18

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

8.6. Discussion

We had known from our quantitative research that generally families would show significant posttreatment reductions in depression, stress, and anger and more positive parenting interactions with their children. In this qualitative research, we were interested not in treatment *outcome* but in treatment *processes*. The process experienced by the parents who were enrolled in this videotape parent training program was one of gradually gaining the knowledge and control to effectively cope with the stresses resulting from having a conduct-problem child. But this overview of the process as seen in terms of its end point—an overview that might have been inferred after all, from our earlier quantitative data—does not adequately reflect the nature of the process. As this study revealed, on their trajectory toward effective coping, parents went through considerable struggles and setbacks. Far from being a linear process, it involved many up and downs, surges and reversals, and although the outcome was indeed positive, the same was not always true of the process at any given moment.

This study revealed that the process parents undergo while in treatment involves radically different phases. This understanding of the process is vital for those of us involved in intervention with these families, for if we can anticipate these phases, we can not only prepare ourselves to deal with them, but also prepare our clients for them. For example, we can help temper their expectations, help them understand and cope with resistance, and provide them with strategies for countering their self-blame or discouragement when setbacks occur. Moreover, it is important to remember that from *within* the process, that is, from the standpoint of those who are undergoing therapy, a positive trajectory may not be evident. In fact, at many points, parents could see only that

the behavior had not substantially changed and their own role was as difficult as ever. If anything, in light of the raised expectations that are the natural result of being in a treatment program, their situation seemed to them worse and they felt more discouraged.

As hoped, we learned a great deal from this qualitative study about the particular emotional experiences and cognitive restructuring during treatment that are responsible for parents' new ability to cope by the end of the program. Experiencing new hope, having those hopes dashed by setbacks and regression, then experiencing anger at the child, at oneself, and at the therapists; experiencing empathy and support, moving from discouragement, even despair, to recommitment—these were key emotional steps in the process. Reframing the child's behavior problems as a matter of temperament and developmental phase; abandoning blame and guilt as a model and substituting the need for special parenting skills; incorporating the ideas of self-care and ongoing support as elements in one's own stability and well-being; arriving at a view of oneself as competent, though imperfect, rather than a victim or a failure—these are the cognitive shifts that we discovered. We found that in general, these emotional and cognitive changes occurred in a certain sequence and were interwoven in complex ways, which suggests that they cannot be rushed—for instance, parents were not ready to empathize with and respect their child until they had first gone through the "tempering the dream" phase; they were not motivated to generalize the techniques ("making the shoe fit") until they had first gone through the stages of unrealistic hopes and disillusionment. Those of us involved in parent training need to be attuned to these stages in the treatment process. Our empathy and our effectiveness depend upon it.

9. *Three-Year Follow-Up: Moving beyond the Intervention—"The Work Continues"*

The purpose of this third qualitative study was to explore through interviews the subjective experience of parents in the 3 years following completion of the parent training program. Our quantitative data obtained 3 years posttreatment indicated sustained improvements in parenting behaviors and child behaviors (within normal limits) for two thirds of the sample; however, 25% of children were reported by their parents and teachers as continuing to have behavior problems that put them in the clinic range for aggressive behaviors. But these numerical data did not help us understand what meaning these parents assigned to their own parenting efforts and their child's successes or failures. It did not tell us how families had coped with any child relapses that had

occurred since completing the intervention, how they felt about their child's successes or problem behaviors and their progress in managing them, how they were coping with school-related difficulties. It told us nothing about how they perceived their experience in the treatment program in retrospect, and what it was like to end treatment. We were interested in the relationships within the family and the family's relationships with the community: Did these parents continue to experience a sense of isolation or stigma because of having a difficult child? We were especially anxious to learn whether the cognitive restructuring and emotional adjustments that had occurred over the process of treatment had been maintained. These questions led us to our third qualitative study, which is currently in progress.

9.1. *Participants*

We randomly selected for interview a subset of 10 parents who represented both single-parent and married families. We plan to continue to interview more families at longer intervals posttreatment. In these interviews, parents talked about their fears regarding the ending of the parent group program 3 years earlier.

Mother: My immediate feeling was being cut loose. I felt very vulnerable. It was scary because it had been so wonderful to be with the other parents. Because that was the first time I had ever been around parents that had kids like mine. That was so reinforcing. I remember feeling terribly vulnerable when I left and being afraid that I wouldn't be able to continue . . . I wouldn't remember what to do. I was nervous. Over time I realized I had incorporated a lot of the basic stuff.

Parents feared that once the program was over they would not be able to maintain their efforts or would not know what to do when a new behavior problem came up. Their feelings of vulnerability returned. They felt worried about relapses and were uncertain of their own skills. Parents who had not seen the dramatic changes in behavior that others had seen were worried that their child's behavior would not continue to improve without the help of the group sessions.

Mother: I was afraid we couldn't maintain the changes without the support of the group and having to go in and report each week. I felt a sense of loss of the group, because we had developed really good relationships and I knew that I would miss those people.

The ending of the parenting groups represented a loss of support, not just from the therapists who had provided assistance in troubleshooting behavior problems but also from the parent group who had provided so much moral support. How did these parents cope with the loss of support, the challenges posed by their children's behavior, the sense of

vulnerability? The qualitative data gathered in these interviews revealed a number of common themes in parents' subjective experience posttreatment, themes that fell into three categories: parenting attitudes and behavior, relationships with other parents, and parents' sense of self.

9.2. *Parenting Attitudes and Behavior*

9.2.1. *Taking It Moment by Moment*

All the parents told stories of the successes and improvements that had been made in their children's social skills over the subsequent years. In many cases, improvements were slow in coming.

Mother: It took a long time for the principles in the program to really have an effect. The first year afterwards, things were still very hard—to travel, to go somewhere else, the level of aggression was still very high for her. It takes a long time to get results—like three years. Now you can see the results.

Yet rather than feeling frustrated at the slow pace of change, these parents felt proud and confident of their own and their children's accomplishments. Their newfound pride has, it appears, two sources: First, they had learned to look for and celebrate the positive in their children's behavior.

Mother: I have learned with these kids to take each moment by moment. I used to look at the day as a 24-hour unit—now I celebrate the wonderful moments with him when they come. And we have more wonderful moments all the time.

Mother: Someone gave me a journal, but I hate to write because I do so much of it at work. Instead I record the neat things that happen with my children, and there are times I'll go and read it. For example, times when my kids are really insightful or funny or when they do something I feel good about, I record it. I've been doing that for three years now and it's wonderful.

They noted the contrast between this perspective on their children and their perspective before treatment.

Mother: I think what can happen is you could be so overwhelmed with the intensity of the difficult times that you don't see the good times. I know that was happening when I went to the parenting clinic.

A second and more complex source of pride in their children's successes arose from their own newfound sensitivity to their children's temperament and emotional state. The interviews reflected parents who had learned to read the cues in a situation and to decide what the optimal approach would be. To use a metaphor, over time they had become sensitive barometers to their children's reactions and had decided to adapt to the weather, rather than disregard the weather or act as though it were different.

Mother: I don't make as many plans. I sort of wait and see how the day is going.

Mother: We really try to look at the right time for doing something. He's supposed to read to me every night, but I can sense if it's not going to be successful and he needs to be doing something else. At one time I might have forced him—but now my motto is "seize the moment."

9.2.2. *Becoming a Strategist: See the Big Picture*

Related to their new determination and ability to adapt to their child's state-of-the-moment, these parents had maintained their grasp on the principles behind behavior management and had refined their sense of how to apply the skills within their family. In short, they had become "expert strategists."

Mother: It's the ability to first analyze, then internalize some of those parenting coping skills that make life easier.

Mother: We're more skilled, which helps a lot. I think skills with high-maintenance kids are worth their weight in gold because it's still tough with skills. I can pull out things such as charts and I know ways of distancing the battle. Things are better in that respect.

They were able to anticipate potential problems with their children and to head them off with preventive approaches; they had parental "radar" constantly on the alert. As one parent put it, they had become "constantly vigilant" so as to help their children stay out of trouble. They had learned how to structure each day so as to increase the likelihood that their children would behave positively and to decrease the potential for misbehavior.

This did not mean they let their children do whatever they wanted—quite the contrary. Most parents found that they needed to structure their children's time, to establish clear expectations of what was expected and clear descriptions of the consequences for not complying. Attending to their children's need for behavioral guidance required not only vigilance but also steadfastness and rigor.

Mother: He is such a volatile kid, I have found that I have to be incredibly structured. Everything is: "If you do this, then you can do this." You know, "When you follow the rules this week, then on Friday you get to rent a tape," which is a big reward for him. It's constant: "When you get your shoes on in the morning then you can watch TV." It works. For example, to get him into bed at night, I had to develop a set of structured steps, and now he's incorporated them so it's not an issue.

Mother: I have to be constantly vigilant, keep ahead of him because he acts before he thinks.

Like the long-range planner, parents seemed to have developed a wide-angle view—to be cognizant of their long-range goals and to

choose the most effective parenting strategy in accordance with not only the desired behavior but also the larger goal.

Mother: I try to take more time for him now. My housekeeping suffers because I'm a single parent and I can't do everything. But in the big picture, you know, the messy house doesn't matter that much.

This ability to be a strategist requires that parents see the big picture as well as be attuned to the moment-by-moment interactions. As one parent put it, she now had a blueprint for decision making that helped her feel in control, on track.

Mother: I can head off probably 80% of the problems with the parenting techniques I learned. I have a set of principles now that I work from—a blueprint.

9.2.3. *Coping with Relapses*

All the parents talked about times when their children had relapses in their behavior. It was common for them to feel a sense of panic and even fear that all their prior efforts had been useless. Yet they described a variety of ways of coping with these relapses.

Mother: I remember this time my son got into this horrible cycle—worse than before we went to the parenting clinic. I was afraid all the gains we had made were lost—we were in a negative cycle and I was panicked. I was resentful because I had done so much for him, like taking him to miniature golf and McDonald's, and then when we got home he went crazy because there was something he didn't like. He was very destructive—throwing things everywhere because he couldn't get what he wanted. But then I realized he can only focus on the feeling of the moment. Later I also realized he had been good all day—that it was only one night.

In this example, the parent dealt with her reaction to her son's relapse by reflecting on his temperament and recognizing that he is an impulsive child who cannot focus on his earlier pleasure at the positive experiences with her. Once she reminded herself that her child can deal only with the feeling of the moment, in this instance anger, she was able to diffuse some of her feelings of anger toward him for his ungratefulness. Second, she placed the event in context, objectified the situation, realizing that for most of the day his behavior had been good. Many of the parents talked about their conscious cognitive work at deemphasizing the negative moments with their children and focusing on the positive times.

Third, parents coped with relapses by reframing them as normal or natural. By understanding that relapses were to be expected, they were better able to prepare themselves to deal with them as well as to decrease their panic and fear. They also reframed the way they perceived these regressions by treating them as "learning experiences."

Mother: I remember that learning is a process of making mistakes, and a little kid doesn't know everything you do as an adult. Sometimes this is so obvious, but when you live every day with a little character that's running around it is easy to forget.

Yet another coping strategy was reframing the relapses as challenges that, with their newfound sense of competence as parents, they felt prepared to meet.

Mother: My life is more stressed now because of working full time and the step kids moving in. But the way I feel about parenting is that I know what to do, whereas before I'd be so frustrated and discouraged and think nothing would ever change.

Having learned new skills and behavioral principles, they began to feel optimistic and competent with their parenting approaches, especially as they saw improvements in their children's behavior problems. They felt confident that they had the skills to do what was necessary to help teach their child some new social behavior.

Mother: Now when he relapses, I just assume there will be a way to problem-solve it. And I have ideas instead of going around finding books everywhere. Like I'll go to the teacher and say, "Okay we need to work out a plan," and I feel like it's manageable.

Some parents turned to the parenting clinic for support when their children relapsed. Paradoxically, this revived and strengthened their sense of competence, for they perceived it as a resource they knew how to utilize—one of their strategies for coping.

Mother: His behavior went downhill really fast when we separated. So I went to the parenting clinic, as it felt like a place to go for resources and support, and it's really worked. I've had to eat all my words about my fears—I guess we have more skills and my child has more skills now.

Involvement in school activities was another skill that parents mentioned.

Mother: There is no doubt that my being active in PTSA helped our kid, and you don't have to be working in the classroom, but if you're working outside the home it does behoove you to find a way to be active in school activities so that they recognize you're going to be there. I call up if he gets a demerit slip and his story isn't consistent with the writing on the slip. I call up and find out the teacher's perspective, and I write a note. One time I wrote a note to the principal that resulted in a meeting of the recess teachers. That in the long run supports my son and other kids. You need to know what is happening in school.

Sometimes parents even talked about their own relapses and how they were able to get themselves back on the program.

Mother: My husband and I used to fight over how to handle our daughter. In the group, we agreed on how to handle her behavior. I had to learn to

stop interrupting and correcting my husband even if I disagreed. Well, yesterday I didn't support him, and he was really upset with me. So this goes deeper than parenting, more about loyalty and remembering to be supportive to the other.

Other parents talked about how they had attempted to slow down the pace of life for themselves and build in restful times so that they are "refueled" and ready for the relapses when they happen.

Mother: I've been divorced for six years now, and I used to think I had to be doing all these social things when I didn't have the kids. Now at least one night a week I come home, read the paper, do laundry, and rest—I try to use that time so that when my kids are with me I have the energy for them and can give them attention. I wouldn't be able to give them the attention they need if I didn't take time for myself. So that's one means of support for me.

9.3. *Relationships with Other Parents*

9.3.1. *Moving Forward: Building Networks and Finding Support*

All the parents we interviewed talked about the importance of their parent training group and the tremendous support that the group had given them. Just knowing that other parents had children who were also challenging and difficult to manage helped to "normalize" their problems, to take away the stigma. Hearing those parents' week-by-week struggles with their children's behavior helped defuse their guilt, anger, and frustration. Over the subsequent years, these memories of the other families in their group provided a kind of mental relationship that helped them to survive the tough moments of self-doubt and the isolation.

Because of this positive experience in the parent training group, all the parents we interviewed had attempted to get involved in or even set up other parent support groups in subsequent years. Several parents had become involved in CHAD, an organization for parents of attention-deficit disorder children; others had joined school parent organizations; one had started her own parent support group in her community; another joined the adoptive parents support group; another had joined a Parents' Corps of Little League; several others continued to meet with parents from their group and to call them on the phone for support.

Mother: My husband talks about missing the group. More than me because I keep in touch with more people that give me feedback. But now that we are going to ADD group, that's nice for my husband.

In general, parents seemed to derive the most support from other parents who openly acknowledged the difficulties of parenting and were nonjudgmental.

Mother: I've hooked up with other parents that have children like mine and it's been incredibly helpful. One friend of mine has kids just like mine and we have our club, "The Dark Side of Erma Bombeck," because you have to have humor in this. We have one rule that you can call any time. She and I have really gotten ourselves through this. And she's the one I talk to most often. But some other parents who have adopted kids, I talk to them too.

In addition, many parents had kept up their connections with the therapists by periodically calling about a concern. In some cases, this was only once or twice a year; in others, it was more often. Regardless of the frequency of contact, knowing that the parenting clinic was available appeared to provide important psychological and emotional support.

Mother: I keep in touch with the therapist at the clinic by phone. So I'm not really feeling the loss. That's been positive. I feel like there's continuity and I still see it as a resource. I've stayed close to the people in the class.

Mother: When I've been frustrated and not able to solve problems, I call up the parenting clinic, and I felt like there's this forever, underlying support there.

Almost all the families requested follow-up sessions or a refresher course. They saw this supplementary training as a helpful way to troubleshoot new issues as the children grew older.

Mother: I think for these type of kids and bumbling parents trying to deal with this it would be nice to have follow-ups or refresher classes. I think we hit the same issues as the children get older, only at an upgraded level.

9.3.2. *Dealing with Isolation and Stigma*

One of the few negative notes in these parents' accounts of the years since the intervention was the rejection they felt from parents of well-behaved children.

Mother: The hardest thing for me is the judgment of other people. I grew up being well liked, and now all these people are passing judgment on me as a bad person because of my kids' behavior.

All had continued to experience the pain of other parents refusing to let their children play together. All still felt judged by other parents even though their children were behaving much better at home and at school.

Mother: Our neighbors won't let their kids play with my children because they think we're horrible people. One thing for me that has been particularly hard is the messages I've gotten from other parents at school, much more than neighbors and stuff. I mean the neighbors come over to my house and realize I'm an okay person, that I'm not one of those dysfunctional single mothers. But at school those parents really don't want their children playing with my children.

Even worse, these parents continued to experience alienation from their extended family members. They felt misunderstood and unsupported, which led to anger; at the same time, they felt embarrassed about their children's behavior. These complex feelings led them to avoid contact with other family members.

Mother: The messages I get today are that I am a bad parent because of the way my kids act. And I know deep down I'm not. But when you get these messages, I get them from my family, my extended family! I have given up going to family reunions because my kids are always the ones in trouble and it's not worth it. It's too hard.

Their anger about their family's lack of support seemed to have lessened, however, as they realized it was due to a lack of understanding. They seemed to have moved beyond their anger, having learned not to position themselves in vulnerable situations and to look for their support elsewhere.

Mother: I get no support from my family with this issue. They just don't get it. It's like if you haven't had cancer you don't know what it's really like. I'm convinced some of my closest friends think it's my fault—they could do better. I've wanted to say so many times, "You walk in my shoes and then make a judgment." I think the big thing is having friends who have kids like mine.

9.4. *Parents' Sense of Self*

9.4.1. *Maintaining and Building Self-Esteem*

As they reflected on their experience in the parenting program, these parents talked about their experience as a kind of "crossroads" or watershed, a time when they moved from feeling victimized and helpless to realizing that there were ways of coping more effectively with their child's problems.

Mother: I look back on my experience with the parenting clinic as a crossroads. I have told people, "I shudder to think where we would be now without having gone through that." I felt such a profound sense of failure as a parent. I didn't know what to do. I was going to let him go and live with his dad forever. I couldn't handle it.

Mother: In the beginning we didn't have the skills. And that isn't to say we aren't intelligent. We are both highly educated, hard-working people; it's just that we didn't have the skills, and now we know how to use them.

One of the themes from these interviews 3 years after treatment that was markedly different from our earlier interviews while the parents were still in the program was the parents' emphasis on conscious efforts to maintain and build their self-esteem. In the face of the feelings of blame and stigma from extended family and other parents, these parents had to work hard at reaffirming their own worth.

Mother: My friend and I who have children who are more challenging, we laugh at other parents who think they're such good parents when they're in fact the ones who have really easy kids. I think one of the biggest challenges when you have this kind of child is to feel okay as a parent—because you do not get those messages from other people. That's just the reality.

For these mothers, a key strategy for maintaining a strong sense of self was periodically distancing themselves literally and figuratively from their conduct-problem child.

Mother: I'm not a natural mother—so I needed help to learn the skills, and it's still a lot of work. Getting some space and time for myself helps immensely. Talking to friends and getting away from the children helps me regroup.

Mother: I think he needs other adults in his life besides me. I think he needs time away as much as I need time away.

This theme is distinct from the "refueling" discussed earlier. Whereas the purpose of refueling was to renew one's resources as a parent (i.e., so as to be able to give more to the child), here the emphasis was on time apart as a means of maintaining and strengthening the parent's sense of identity as something other than a parent. These parents recognized the importance of having a strong sense of self apart from parenthood in order to function well as a parent.

Mother: I still feel ownership and get embarrassed by him. That's one place I'd like to work at. I need a little more separateness . . . Even though I know it isn't true, I still feel that if I was a better parent he would be better. I know that isn't true, but my gut still says it is, so I wish I could have a little bit more gut distance from him so I could feel a little happier myself. If I got that distance I'd deal with him better and it would all work better, but I haven't been able to make that jump yet.

Mother: I have to create my own reward system. I realized I have to establish an identity other than parenthood. I mean I very much identify myself as a single parent, but I take great pride in my work. I go off with other women when I don't have the kids.

This literal and figurative distancing, a form of establishing boundaries, allowed these mothers to depersonalize their child's behavior problems and to put them in a wider developmental context.

Mother: When he misbehaves, I am able to keep it in the context of a learning experience for him, a need for me to be consistent and to think. I ask myself, "What does this really mean? Is this something I should just let ride? How significant is it?" I don't blame myself now.

3.4.2. *Grieving, Accepting, and Changing Expectations*

Three years after treatment, while these children's behavior problems had improved (according to teacher and parent reports they were

within normal range) on standardized measures, they were still very much a challenge to manage.

Mother: He's still volatile. He can escalate from zero to hundred in the snap of a finger and be that way for hours. He will throw furniture and take the room apart and totally wipe me out. Because I came from a mellow, laid-back family—and he's got a different temperament. He cannot wait one minute for dinner or anything.

Parents still talked about what they had thought their parenting experiences would be like in comparison with the reality. As had been true in our earlier interviews, there was a sense of parents grieving over the hoped-for child, the harmonious home life, the easy road.

Mother: You know, you grow up thinking you are going to be a certain type of parent—and I had wonderful parents. Well, you know I've had to learn that in our family we're not going to sit around the table and have wonderful discussions—they cannot sit still for more than five minutes.

Mother: Parenting is work. I wish it would be more fun and less work.

Mother: I still put a lot of time into parenting and probably a lot more than I have the energy for or a lot more than most people, but now I'm enjoying it a lot more, that's the difference. But it takes a lot of time.

Mother: I still want to be a sweet, nice mom—like Donna Reed. Why do I have to speak sharply—unless I go to him and say his name and get his attention he won't have heard me.

As these examples reveal, grieving over the hoped-for child and hoped-for home life also implies the loss of a certain hoped-for sense of self as parent. The conduct-problem child challenges a parent's sense of competence; these parents had to adjust their expectations of themselves as well as their child.

But balancing this theme of loss was a strong theme of acceptance. As mentioned earlier, parents had come to accept their children's temperament and therefore viewed their behavior differently.

Mother: He used to be out of control all the time, almost daily with him. Well, now it happened maybe twice a year, or three times. Other people would come in and say he was totally outrageous, but I don't consider it totally outrageous. I have a different standard of what outrageous is than if I had my nieces and nephews as children.

With this acceptance of their child came greater acceptance of themselves as parents—self-respect and, at times, celebration of self for having made the necessary accommodations.

Mother: I think I have had to do a lot of grieving about these children not being the kids I thought I would have. But I feel a bit better about me as a parent today. I don't feel great, because, you know, this culture measures parenting in terms of how your child behaves and my kids do not get high scores in that area . . . but it's so much better now.

Mother: I have the handles I need to help him, but I think we're going to

have a hard life along the road. I don't see it ever being easy. I don't think he is going to have an easy life. He just doesn't have the temperament to have an easy life. Yes, I wished for that and I still wish for that, and I wish there was a cure but I don't think there is. It is better now than it was.

Mother: This indicates how far I've come. Last summer another woman and myself took eight kids camping, and five of them were on Ritalin. That was so empowering for me. First of all, as women to be able to go camping . . . second, that we're taking eight kids and five of them challenging kids, and we did great. So I guess that's a real measure that I'm feeling a lot better about being a parent.

9.5. Discussion

Our third qualitative study indicated that generally parents are coping well, are maintaining their parenting skills, and are feeling optimistic and in control of the situation. This is in contrast to our interviews 3 years earlier, which were full of themes of blame, loss of control, and helplessness. Parents no longer felt "under siege" by their children; they had taken charge. Nonetheless, the interviews indicated that children's behavior was still problematic and that parents were having to devote a great deal of mental, physical, and emotional energy providing an optimal environment for their temperamentally difficult children and in maintaining their self-esteem.

Mother: I hope that we one day can start operating from automatic and it doesn't take so much time and effort. I know parenting is always going to take a lot of effort, but I wish it didn't have to be such focus. But I have an idea for what to do—that's probably a real important thing.

Largely, this work was being done without the support of extended family, parents of older children in their children's classrooms, or their teachers.

The theory that emerged from our qualitative research on these ten families is that despite continuing stigmatization and stresses in managing ongoing child behavior problems at home and school, parents were still coping and had maintained a sense of competence—in fact, more so than immediately posttreatment. They had developed emotional and cognitive coping strategies to manage problem situations. Such coping strategies involved "seeing the big picture" and focusing on the long-range goals and overall positive improvements in the child rather than the moment-to-moment, specific negative behaviors; reading their children's behavioral cues and anticipating their reactions; reframing child behavior relapses as normal; organizing their daily routines so as to bring out the best in their child; building supportive parent networks; and promoting their own self-acceptance. These data imply that one of the most powerful ways to help these parents is not to focus exclusively

on child behavior improvements, but to focus as well on their ability to normalize their experience, to adjust their expectations, and to self-refuel. We are currently continuing this study with a larger representation of families 3–5 years posttreatment in order to determine whether these patterns hold true. It is important that we interview families whose children are doing well at home and school as well as those whose parents and teachers are still reporting child-conduct problems that have reverted to pretreatment levels. By continuing this study, we hope to learn more about the meaning of coping for these families—that is, how some families were able to move from feeling helpless to believing in their ability to cope with their difficult children and stressful lives while others were not coping well.

10. Conclusion

What have we learned from these three studies that we did not know from our quantitative research? In each of the three studies, we have seen the importance of understanding parents' subjective realities (e.g., feeling victimized or helpless) as well as understanding context (e.g., ripple effects involving teachers and community responses) in order to give enhanced meaning to parents' decisions and actions. Each of the three studies has shown us a different advantage of qualitative research. For example, the first study helped us grasp the gestalt of the child's conduct problems—namely, the child as tyrant, the sense of victimization experienced by parents, the isolation and stigmatization of the family. From this study there emerged the theory of learned helplessness regarding families with conduct-problem children. The second study helped us understand the processes families experience during treatment as they gain knowledge and control, resist new ideas, cope with setbacks, experience a support network of parents, and arrive at a new view of themselves as competent. Here, we found a conceptual framework of four phases that families will experience while engaged in treatment. Our third study is helping us to refine this theory regarding parents' coping strategies as we examine how they maintain their sense of competence in the face of relapses (in some cases, to pretreatment levels) and continuing stigmatization. This qualitative research using grounded theory methods has fleshed out our quantitative studies with meaning by providing a theoretical framework through which we can interpret and, in turn, test our quantitative data.

These qualitative studies not only enhance our understanding but also have important implications for treatment. The first study suggests the importance of treatment programs that enhance social support by

involving fathers and teachers and that reduce stigmatization by creating new supportive networks of parents with similar children. The second study helps therapists not only to anticipate phases that parents will be likely to experience during parent training, but also to prepare families for them. The third study suggests possible ways to broaden our interventions so that our support extends beyond training parents in parenting skills—for example, by preparing families for what lies ahead with their children, by encouraging their efforts to share the burden of responsibility through supportive groups and friendships, and by emphasizing aspects of the intervention that promote self-care, self-acceptance, and empowerment. Short-term efforts are clearly insufficient: We need to educate society at large in order to reduce the stigmatization and isolation that these families face in their day-to-day encounters.

Mother: The challenges keep changing and with different kids, but now I know ways to attack each one as it comes up. I don't think anymore when old things come up again, "God! we failed," or, "I thought we had taken care of that, it didn't work." I don't look at it that way; rather, it's just going to be challenges all the way, and we'll just keep applying what we have learned.

The challenges certainly continue for them and for the therapeutic community.

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11. References

- Abidin, R. R. (1993). *Parenting stress manual*. Virginia: Pediatric Psychology Press.
- Abramson, L. Y., Seligman, M. E. P., & Teasdale, J. D. (1978). Learned helplessness in humans: Critique and reformulation. *Journal of Abnormal Psychology*, 87, 49-74.
- Achenbach, T. M., & Edelbrock, C. S. (1991). *Manual for Child Behavior Checklist and Revised Child Behavior Profile*. Burlington, VT: University Associates in Psychiatry.
- Bandura, A. (1982). Self-efficacy mechanism in human agency. *American Psychologist*, 37, 122-147.

- Bandura, A. (1985). *Social foundations of thought and action: A social cognitive theory*. Englewood Cliffs, NJ: Prentice-Hall.
- Bandura, A. (1989). Human agency in social cognitive theory. *American Psychologist*, 44, 1175-1184.
- Beck, A. T. (1972). *Depression: Causes and treatment*. Philadelphia: University of Pennsylvania Press.
- Beck, C. T. (1990). Qualitative research: Methodologies and use in pediatric nursing. *Issues in Comprehensive Pediatric Nursing*, 13, 193-201.
- Berger, P. L., & Luckman, T. (1966). *The social construction of reality: A treatise in the sociology of knowledge*. Garden City, NY: Doubleday.
- Clarke, L. (1992). Qualitative research: Meaning and language. *Journal of Advanced Nursing*, 17, 243-252.
- Dumas, J. E., & Wahler, R. G. (1985). Indiscriminate mothering and contextual factors in aggressive-oppositional child behavior: "Damned if you do and damned if you don't." *Journal of Abnormal Child Psychology*, 13, 1-17.
- Eyberg, S., & Ross, A. (1978). Assessment of child behavior problems: The validation of a new inventory. *Journal of Clinical Psychology*, 16, 113-116.
- Folkman, S., & Lazarus, R. S. (1988). Coping as a mediator of emotion. *Journal of Personality and Social Psychology*, 54(3), 466-475.
- Folkman, S., Lazarus, R. S., Dunkel-Schetter, C., DeLongis, A., & Gruen, R. J. (1986). Dynamics of stressful encounter: Cognitive appraisal, coping, and encounter outcomes. *Journal of Personality and Social Psychology*, 50, 992-1003.
- Forgatch, M. S., Patterson, G. R., & Skinner, M. (1988). A mediational model for the effect of divorce on antisocial behavior in boys. In E. M. Hetherington & J. D. Aresteh (Eds.), *Impact of divorce, single parenting, and step-parenting on children* (pp. 135-154). Hillsdale, NJ: Erlbaum Associates.
- Furey, W. H., & Forehand, R. (1985). What factors are associated with mothers being more subjective and less objective in evaluating their clinic-referred child's behavior? Unpublished manuscript.
- Glaser, B. (1978). *Advances in the methodology of grounded theory: Theoretical sensitivity*. Mill Valley: Sociological Press.
- Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research*. New York: Aldine.
- Gortner, S., & Schultz, P. (1988). Approaches to nursing science methods. *Image*, 20, 22-23.
- Guba, E. G. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. *Educational and Technology Journal*, 29, 75-92.
- Hollingshead, A. B., & Redlich, F. C. (1958). *Social class and mental illness*. New York: John Wiley.
- Hutchinson, S. (1986). Grounded theory: The method. In P. L. Munhall & C. J. Oiler (Eds.), *Nursing research—A qualitative perspective* (pp. 11-130). Norwalk CT: Appleton-Century-Crofts.
- Kofta, M., & Sedek, G. (1989). Repeated failure: A source of helplessness or a factor irrelevant to its emergence? *Journal of Experimental Psychology: General*, 118, 3-12.
- Leininger, M. (1985). Nature, rationale, and importance of qualitative research methods in nursing. In M. M. Leininger (Ed.), *Qualitative research methods in nursing*. Toronto: Grune & Stratton; Harcourt, Brace, Jovanovich.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills: Sage Publications.
- Locke, H. J., & Wallace, K. M. (1959). Short marital adjustment and prediction tests: Their reliability and validity. *Marriage and Family Living*, 21, 251-255.
- Maier, S. F., & Seligman, M. E. P. (1976). Learned helplessness: Theory and evidence. *Journal of Experimental Psychology*, 105, 3-46.

- Maiuro, R. D., Vitaliano, P. P., & Cohn, T. S. (1987). A brief measure for the assessment of anger and aggression. *Journal of Interpersonal Violence*, 2, 251-255.
- Mikulincer, M., & Casopy, T. (1986). The conceptualization of helplessness: A phenomenological structural analysis. *Motivation and Emotion*, 10, 263-277.
- Miller, I., & Norman, W. (1979). Learned helplessness in humans: A review and attribution-theory model. *Psychological Bulletin*, 86, 93-118.
- Patterson, G. R. (1982). *Coercive family process*. Eugene, OR: Castalia Press.
- Sanday, P. (1983). The ethnographic paradigm(s). In J. Van Maanen (Ed.), *Qualitative methodology* (pp. 19-35). Beverly Hills: Sage Publications.
- Sandelowski, M. (1986). The problem of rigor in qualitative research. *Advances in Nursing Science*, 8(3), 27-37.
- Schaughency, E. A., & Lahey, B. B. (1985). Mothers' and fathers' perceptions of child deviance: Roles of child behavior, parental depression, and marital satisfaction. *Journal of Consulting and Clinical Psychology*, 53, 718-723.
- Seidel, J. V., Kjolseth, R., & Seymour, E. (1988). *The Ethnograph*. Littleton, CO: Qualis Research Associates.
- Seligman, M. E. P. (1975). *Helplessness: On depression, development, and death*. San Francisco: Freeman.
- Spiegelberg, H. (1976). *The phenomenological movement*, Vols. I & II. The Hague: Martinus Nijhoff.
- Spitzer, A., Webster-Stratton, C., & Hollinsworth, T. (1991). Coping with conduct-problem children: Parents gaining knowledge and control. *Journal of Clinical Child Psychology*, 20(4), 413-427.
- Strauss, A. L. (1987). *Qualitative analysis for social scientists*. Cambridge: Cambridge University Press.
- Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. London: Sage Publications.
- Wahler, R. G., & Dumas, J. E. (1984). Changing the observational coding styles of insular and nonsingular mothers: A step toward maintenance of parent training effects. In R. F. Dangel & R. A. Polster (Eds.), *Parent training: Foundations of research and practice* (pp. 379-416). New York: Guilford Press.
- Webster-Stratton, C. (1985a). Comparison of abusive and nonabusive families with conduct-disordered children. *American Journal of Orthopsychiatry*, 55(1), 59-69.
- Webster-Stratton, C. (1985b). Predictors of treatment outcome in parent training for conduct-disordered children. *Behavior Therapy*, 16, 223-243.
- Webster-Stratton, C. (1988). Mothers' and fathers' perceptions of child deviance: Roles of parent and child behaviors and parent adjustment. *Journal of Consulting and Clinical Psychology*, 56(6), 909-915.
- Webster-Stratton, C. (1989). The relationship of marital support, conflict and divorce to parent perceptions, behaviors, and childhood conduct problems. *Journal of Marriage and the Family*, 51, 417-430.
- Webster-Stratton, C. (1991). Stress: A potential disruptor of parent perceptions and family interactions. *Journal of Clinical Child Psychology*, 19, 302-312.
- Webster-Stratton, C. (1994). Advancing videotape parent training: A comparison study. *Journal of Consulting and Clinical Psychology*, 62, 583-593.
- Webster-Stratton, C., & Hammond, M. (1988). Maternal depression and its relationship to life stress, perceptions of child behavior problems, parenting behaviors, and child conduct problems. *Journal of Abnormal Child Psychology*, 16(3), 299-315.
- Webster-Stratton, C., & Herbert, M. (1994). *Troubled families—Problem children*. Chichester: Wiley.