

A Controlled Clinical Evaluation of the Parents Plus Children's Programme: A Video-based Programme for Parents of Children Aged 6 to 11 with Behavioural and Developmental Problems

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ABSTRACT

This article describes the development and the clinic-based evaluation of the Parents Plus Children's Programme (PPCP), a group-based video-modelling-assisted programme for parents of children aged 6 to 11 referred to a Child Mental Health Service with significant behavioural problems both with and without associated developmental difficulties. In evaluating the programme, a sequential block design was used to assign 74 parents of children referred to the service to the PPCP group ($n = 42$) or the Treatment as Usual (TAU) Comparison Group ($n = 32$). Assessment took place before and immediately following the 8-week intervention for both groups and at 5-month follow-up for the PPCP Group. Compared to the TAU Group postprogramme, the PPCP Group displayed significant reductions in total difficulties and conduct problems as measured by the Strengths and Difficulties Questionnaire, decreased parental stress, increased parental confidence and significant improvements in parent-defined problems and goals. These positive changes were maintained at 5-month follow-up for the PPCP group, in addition to further significant improvements in peer problems and prosocial behaviour. The analysis also suggests that the programme is more effective for parents of children with behavioural problems only, than for those with associated developmental difficulties. The strengths and limitations of the study are discussed, as well as the difficulties of conducting practice-based research.

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KEYWORDS

child behavioural difficulties, developmental difficulties, parent stress, Parents Plus Children's Programme (PPCP)

EMOTIONAL AND BEHAVIOURAL DIFFICULTIES in children range from recurrent disruptive behaviour to mental disturbances such as Oppositional Defiant Disorder or Conduct Disorder (Frederickson & Cline, 2002). Recent research in Ireland reported a prevalence rate of 6.1 per cent for behavioural difficulties in children aged 6 to 11 (Martin & Carr, 2006). It is estimated that children with behavioural problems account for 30–40 per cent of referrals to child mental health services (Kazdin, 1995).

Children with serious conduct problems such as aggression, defiance and tantrums are at risk of a wide range of long-term problems including early school leaving, delinquency, drug and alcohol abuse, and relationship difficulties (Kazdin, 1995; Offord & Bennett, 1994). These difficulties have poor long-term prognosis, with 35–40 per cent of children diagnosed with conduct problems later diagnosed with antisocial personality disorder in adulthood if they do not receive appropriate treatment (Nolen-Hoeksema, 2001). Furthermore, their parents and families often experience considerable stress and are isolated and undersupported (Webster-Stratton & Herbert, 1994). There is also a considerable cost to society in terms of the child's increased involvement in mental health and social services and the Criminal Justice System (Essau, 2003)

Quality of parenting is identified as a factor involved in the development of behavioural problems in children (Shaw & Winslow, 1997) with the recognition that parents

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can act as the primary socialization agent to help children overcome negative patterns of behaviour (Essau, 2003). Therefore, parent-training approaches, based on social learning ideas, have become a commonly used mode of intervention for addressing behavioural problems in children (Carr, 1999). Evidence for the effectiveness of video-modelling-assisted group parent training is especially convincing (Behan & Carr, 2000; Webster-Stratton & Reid, 2003). Video-based approaches are immediate and less dependent on literacy skills. This approach has been shown to significantly decrease conduct problems, increase prosocial behaviour, reduce parental stress and improve parent-child interactions (Kazdin, 1995; Nixon, 2002; Serkeitch & Dumas, 1996; Webster-Stratton & Hammond, 1997). Group parent training has the advantages of being a cost-effective way of providing services to children with behavioural problems (Olchowski, Foster, & Webster-Stratton, 2007) and is almost twice as effective as individual therapy in reducing behavioural problems in children (McCart, Priester, Davies, & Azen, 2006).

However, there are serious doubts about the organization and effectiveness of routine services for children and adolescents in clinical services (Meltzer, Gatward, Goodman, & Ford, 2000). The evidence for the effectiveness of child and adolescent mental health care are often inconsistent and often discordant with efficacy studies (Carr, 1999). Whereas, efficacy refers to the beneficial effects of the programme under optimal conditions of delivery, such as university trials, effectiveness refers to the effects of a programme under more real world conditions (Flay, 1986).

There is evidence for better outcomes in university trials than in clinical settings for child and adolescent mental health difficulties (Weisz, Weiss, & Doneberg, 1992). Reasons include greater staff training, highly specialized research teams who both develop and deliver the intervention, and the inclusion of self-selected and highly motivated referrals (Meltzer et al., 2000). In addition, efficacy studies usually screen referrals and exclude those with comorbid conditions, thus precluding the participation of many families (Sanders, Markie-Dadds, Tully, & Bor, 2000; Scott, Spender, Doolan, Jacobs, & Aspland, 2001; Webster-Stratton & Hammond, 1997). For example, Scott et al. (2001) reported that out of 430 referrals, 124 (28%) were excluded from the investigation of a parent training intervention as the child presented with comorbid difficulties such as developmental delay and other conditions requiring separate treatment. Other factors pertinent to the poorer outcome in clinical settings may include more severe child problems and less empirically supported interventions from staff with intensive caseloads. There is therefore a salient need to develop evidence-based programmes that are responsive to the needs of typical referrals to child and adolescent mental health services and which demonstrate effective outcomes in these clinical settings. This issue is particularly pertinent in Ireland with early intervention and prevention research in its infancy. Currently, there is no health service- or government-funded initiatives involved in the evaluation of parenting programmes, such as the Incredible Years in Wales or Triple P in England.

The Parents Plus Programmes

The Parents Plus Programmes are video-based parent training programmes that were developed in partnership with parents and children with the specific aims of reducing behavioural problems, and promoting learning and positive parent-child relationships. The programmes use footage of both actors and of real parents interacting both positively and negatively with their children to illustrate parenting principles, in addition to the use of group discussion, role plays and homework assignments. The programmes can be delivered to small groups of parents in both clinical and community settings. The

original Parents Plus Programme (Sharry & Fitzpatrick, 1998) was a broad-based intervention targeted at children aged 4 to 11. This has now been replaced with three age-specific programmes:

1. Parents Plus Early Years Programme – young children aged 1 to 6 (Sharry, Hampson, & Fanning, 2003).
2. Programme – primary school children aged 6 to 11 (Sharry & Fitzpatrick, 2007).
3. Parents Plus Adolescents' Programme – young adolescents aged 11 to 16 (Sharry & Fitzpatrick, 2001).

The philosophy, content and techniques of the Parents Plus Children's Programme will be discussed in detail later.

The programmes are evidence based and several studies attest to their effectiveness in a variety of settings. Results of a small-scale comparative study indicated that parents completing the original Parents Plus Programme reported fewer child behaviour problems and improved parent-child interaction, when compared to a wait list control group (Behan, Fitzpatrick, Sharry, Carr, & Waldron, 2001). In an evaluation of the effectiveness of the programme with preschool children with developmental disabilities and behavioural problems, Quinn, Carr, Carroll, and O'Sullivan (2007) found that the treated group reported fewer behavioral difficulties when compared to a waiting list control group and that these gains were maintained at a 10-month follow-up. Furthermore, a related study showed that the programme could be effective for children with behavioural difficulties – with or without developmental disabilities (Quinn, Carr, Carroll, & O'Sullivan, 2006).

In a large scale multisite controlled outcome study ($N = 97$) of children aged 1 to 6, it was found that for families attending the Early Years programme, there were significant decreases in child problem behaviour, parental stress and a reduction in commands and an increase in positive attends in the parent-child interaction as measured by independent before and after video observation (Griffin, Guerin, Sharry, & Drumm, 2006). Another interesting result is the fact that no significant difference in benefit was noticed between children with developmental delays and children with primarily behaviour problems, suggesting that the PPEY is equally beneficial to both groups and can be used as broad-based intervention in child mental health services. (Griffin et al., 2006). Similarly the Parents Plus Adolescent Programme is currently being evaluated in a controlled study. Preliminary results indicate that following completion of the programme, parents report greater goal attainment, an improved relationship with their child and a reduction in behavioural difficulties when compared to waiting-list control group (Beattie, Fitzpatrick, Guerin, & O' Donohoe, 2007).

The Parents Plus Children's Programme

The focus of the current study is the evaluation of the new Parents Plus Children's Programme (Sharry & Fitzpatrick, 2007) for parents of children aged 6 to 11 with emotional and behavioural problems both with and without developmental problems. The Parents Plus Children's Programme (PPCP) is a positive and practical video-modelling-assisted group-based course which aims to help parents build a positive relationship with their child, equip parent with skills to promote prosocial behaviour, assist with their children's learning and teaching noncoercive approaches to discipline. The programme generally builds a group discussion around the principles illustrated by the actors or nonactor families on the video and parents are asked to role-play positive

parenting techniques during the session and reflect on how these can be applied in the home situation.

The Parents Plus Children's Programme was developed over a period of 4 years in collaboration with parents and children who attended groups at the Mater Hospital, Child and Adolescent Mental Health Service. The target groups were generic, involving parents and children with the full range of presentations referred to a child mental health service. This included children with emotional and behavioural problems, ADHD-type difficulties, mild autistic difficulties, speech and language disorders, learning delays, as well as children with relatively developmentally normal presentations whose parents were seeking extra support.

Programme materials

The programme material includes two DVDs containing 2.5 hours of footage, a facilitator's manual and an accompanying text book for parents. The manual contains directions on running the programme, session plans, group exercises and handouts for parents. The video input provides both acted and real scenes of nonactor parents interacting both positively and negatively with their children, and responses to preventing and handling misbehaviour. The scripted acted scenes are presented in 'right and wrong' pairs, where the 'wrong way' to respond to a behavioural situation is placed in contrast to the 'right way'. The real footage of actual families is used to illustrate some of the subtle and complex issues of the parenting principles in action in real, home-based situations (such as homework, problem solving and play). The real footage was collected from families who had previously participated in the parenting programme. Positive comments and stories by parents who have used these parenting practices at home and from their children who have experienced them are also presented in the video input to show how these ideas apply in real-life settings at home. These comments give special validation to the ideas.

Course content

The central philosophy in each group session is balance. The aim is, each week, to introduce one positive parenting idea (e.g. play, special time, encouragement, listening) and one discipline/behaviour-management idea (e.g. clear instructions, routines, consequences, assertive parenting etc.). This give parents two new ideas to reflect on and practice each week. It addresses both the need to make the course positive and preventative, while also tackling the behaviour problems that parents are concerned about (and thus their specific goals early on in the course).

The idea source for the PPCP is eclectic. The main focus is on the parent-child relationship, whereby parents are encouraged to communicate positively to their children and to build positive connections through play, special time, listening to one another and so on. The behaviour-management part of the course draws mainly on cognitive-behavioural and social learning principles focusing on how parents can encourage positive behaviour and use consequences and choices as a means of reducing misbehaviour. Throughout the course, parents are invited to 'pause' and to become self-aware of their own responses to their children, particularly during problems and to thus be able to make more effective discipline choices. In approaching problems, parents are invited to both come up with a discipline plan (a plan of action for when the problem happens) and a prevention plan (a plan to stop the problem happening in the first place).

Programme delivery

The PPCP is designed for delivery both in specialist clinical settings such as child mental health services where children have been referred due to identified difficulties (such as behavioural or learning problems) and also for delivery in frontline community settings such as schools, primary care community settings where the emphasis is largely preventative. Delivery in community settings is usually shorter – over six to eight group sessions, while delivery in specialist settings is longer – eight to ten group sessions, and includes targeted individual sessions for some families. The study described in this article centred on the delivery of the programme in a specialist child mental health setting so this is the format we will describe in detail here

There is some flexibility in the exact content to be covered (and plenty of video scenes and manual exercises to draw upon) depending on the needs of the group, and facilitators are encouraged to actively plan and review each session. A strengths-based collaborative facilitation style is at the heart of the programme. Facilitators are encouraged to centre the group content on the goals and needs of the parents, to focus mainly on building on the parents' strengths, their successes and what they are doing right (and thus modelling an encouraging style of parenting). See Table 1 for a sample course plan, incorporating nine group and two individual sessions.

Group sessions

The group programme involves weekly sessions of 2 hours each. During each session one Positive Parenting and one Positive Discipline topic is introduced from the videos and parents, backed up by discussion, role-play/practice and weekly planning

Session structure involves:

1. Introduction.
2. Weekly review from the participants of how they have put into practice the new ideas from the previous week's session.
3. Positive Parenting Topic (including introduction, video input, discussion, role-play and practice).
4. Break.
5. Positive Discipline Topic (including introduction, video input, discussion, role-play and practice).

Table 1. Parents Plus Children's Programme plan

<i>Group session</i>	<i>Positive parenting</i>	<i>Positive discipline</i>
1	Providing positive attention	Pressing the pause button
2	Setting aside play and special time	Using dos rather than don'ts
3	Child-centred Play	Establishing routines
<i>Individual session – practice play/establish routine chart</i>		
4	Encouragement and praise	Using consequences
5	Encouraging homework and learning	Using sanction systems
<i>Individual session – problem solve/establish discipline</i>		
6	Prevention plans	Assertive parenting/dealing with disrespect
7	Problem solving with children	Step-by-step discipline
8	Active listening and problem solving	Dealing with special needs
9	Family listening/family problem solving	Parent self-care

6. Planning for the next week.
7. Concluding comments.

Individual sessions

One or two individual sessions are offered to families in order to provide extra support and to assist them in applying the ideas at home. Parents who are vulnerable or struggling with the material are particularly encouraged to take up these sessions. Depending on the needs of the families, the sessions can involve the children and can focus on areas such as supporting the family to establish good routines (using a chart), setting up rules, problem solving as well as giving them time to practise child-centered play with the support of a therapist. Some individual sessions are offered to parents alone particularly when they need extra support in thinking through their discipline system and in working together (in the case of two parents). Individual support can also be provided to parents in the form of a weekly telephone call

Evaluation of the Parents Plus Children's Programme

The focus of the current study is the evaluation of the new Parents Plus Children's Programme (Sharry & Fitzpatrick, 2007) for parents of those aged 6 to 11 in a child mental health service. The aims of the study reported in this article are to (a) examine the effectiveness of the new Parents Plus Children's Programme for parents of children aged 6–11 with emotional and behavioural problems; (b) to determine whether improvements are maintained over a 5-month period; and (c) to determine whether the programme is equally effective for those with associated developmental difficulties. This is the first study to evaluate the new Parents Plus Children's Programme.

Methods

Participants

The current study took place in the Child and Adolescent Mental Health Service at the Mater Hospital in Dublin. Recruitment took place at four different clinics, one on the Mater Hospital Site in central Dublin, and three others in community settings on the north side of Dublin. The programme was open to all parents of children aged 6–11 who were referred to the service with significant behavioural problems and no families were excluded on account of associated developmental difficulties.

Participants recruited at the baseline stage were parents of 99 children who had been referred to the clinic with significant behavioural and emotional difficulties. All parents availing of the PPCP agreed to participate in the research study. The demographic characteristic of the parents and their children in the PPCP and Comparison Groups are presented in Table 2. The data collected are mainly mothers' assessment as the majority of single parents taking part without a marital spouse or partners were mothers.

Design

A sequential block design was used to assign parents to the PPCP Group or the Treatment as Usual (TAU) Comparison Group depending on the date of referral. Sequential block design involved recruiting a block of 12–15 for a group, and placing further referrals for the programme on a waiting list – the TAU group. These families were then offered a place on the next available parenting programme. Families were assessed Time 1, before, and at Time 2, after the treatment group's participation in the Parents Plus Children's Programme. Data was collected for the PPCP group at Time 3,

Table 2. Demographic information

Measure	PPCP Group (n = 42)		TAU Group (n = 32)	
	Mean	SD	Mean	SD
Age of Parent	38.97	7.16	34.52	5.87
Age of Child	8.54	1.76	8.84	1.62
	N	%	N	%
Gender of Child				
Male	34	81	25	78.1
Female	8	19	7	21.9
Presenting concern(s)	N	%	N	%
Developmental delay	10	23.8	6	18.8
Autism/PDD ⁺	3	7.1	0	0
Speech and language	7	16.7	6	18.8
Overactivity/inattention	16	38.1	12	37.5
Behaviour problems	41	97.6	31	96.9
Emotional problems	18	42.9	12	37.5
Neurodevelopmental/medical	0	0	2	6.3
Type of Difficulty	N	%	N	%
Behavioural*	29	69	21	65.6
Developmental**	13	31	11	34.4

Behavioural* = presenting difficulties involved at least one of the following: Overactivity/inattention, behavioural and/or emotional; Developmental** = presenting difficulty included at least one of the following: Developmental delay, autism/PDD, speech and language delay; ⁺PDD = Pervasive Developmental Disorder

5 months after the end of the programme. Time 3 data were not collected from the TAU group because they had been taken off the waiting list and had completed the parent training programme during the follow-up period. Throughout the study, participants in both groups continued to receive routine clinical care services from the clinic, such as family therapy, social work, and speech and language services, and the TAU comparison group were offered a place on the next available parenting programme.

Measures

The Strengths and Difficulties Questionnaire

This 25 item inventory (SDQ; Goodman, 1997, 2001) contains descriptions of children's positive and negative behaviours. The questionnaire was completed by the primary carer and, in some families the second parent also completed the measure. Only the primary carer's results are included in the current study. Three-point response formats are used for each item and are scored from 0 to 2. The instrument yields scores on 5 subscales: Hyperactivity, emotional symptoms, conduct problems, peer problems and prosocial behaviour. Subscales scores range from 0 to 10 and are obtained by summing scores for each of the 5 items. Scores from the four difficulties subscales are combined to yield a total difficulties score, which ranges from 0 to 40. The psychometric properties of the SDQ are well established with a high internal consistency and test-retest reliability (Goodman, 2001). The measure also has strong criterion validity for predicting psychological disorders (Goodman, 2001). The alpha in the current study was .81 for the Total Difficulties and > .7 for the Hyperactivity, Emotional Symptoms and prosocial behaviour

subscales and the Impact Score at Time 1. The reliability coefficient for Conduct Problems was .61, while Peer Problems yielded an alpha of .67 at Time 1.

Parental Stress Scale

The Parental Stress Scale (PSS; Berry & Jones, 1995) is an 18-item self-report measure assessing perceptions of the difficulties and stress experienced as a parent. Each item is scored on a 5-point response format with the instrument yielding a total score of parental stress. The instrument authors report a high internal reliability and good convergent and divergent validity (Berry & Jones, 1995). In the current study, the measure demonstrated an acceptable internal reliability of .83 at Time 1.

Parent-defined (PD) problems

At Time 1, parents were asked to identify the most difficult problems at home relating to their child's behaviour, up to a maximum of three problems. Parents then identified the intensity of the problem by placing a mark on a line between 0 and 10 where 0 is not a problem and 10 is couldn't be worse. Examples of problems identified by parents were: 'He can't concentrate doing homework' and 'She won't dress herself in the morning'. A mean problem score is calculated, ranging from 0 to 10. At subsequent data collection points, parents indicated the approximate intensity of the same problems. The alpha coefficient in the current study was .65 at Time 1.

Parent-defined (PD) goals

At the initial assessment, parents set three individual goals for what they hoped to achieve from coming to the course. They were helped by the interviewer to frame these goals in clear and positive terms. For each goal, parents were invited to indicate by marking on a line from 0 to 10 how close they were to achieving their goal, where 0 is very far way from the goal and 10 is have reached this goal. Typical goals identified by parents included, 'I want my child to follow instructions' and 'I want to feel more calm and confident as a parent'. A mean goal attainment score is calculated, ranging from 0 to 10. Attainment of the identified goals was assessed at later time points. The measure yielded an alpha coefficient .78 at Time 1.

Parental confidence

Two items assessed parental confidence in managing their child's difficult behaviour and helping their child learn and develop to the best of their abilities. Parents indicated level of confidence by placing a mark on a line between 0 and 10 where 0 is *not at all confident* and 10 is *couldn't be more confident*. A mean score of the two items was calculated at each time point. The alpha coefficient in the current study was .57 at Time 1.

Procedure

The research study was approved by the Mater Hospital Ethics Committee. Referrals were received from the multidisciplinary team in the Mater Child and Adolescent Mental Health Service. All participants were given an information sheet outlining the purpose of the study and signed an informed consent form. Parents in both the PPCP and TAU Groups completed the SDQ, Parent-defined Problems and Goals and the PSS at the relevant time points. The MSPSS was administered to both groups at Time 1 only.

For the PPCP group at Times 1 and 2, assessments were conducted in the clinics and at Time 3, assessment packs were mailed to participants. Assessment of TAU group participants took place in the clinic at Time 1 and either in the clinic or by mailed

assessment at Time 2. Telephone assessments took place if the mailed questionnaires were not returned within 2 weeks.

Results

Preliminary analysis

The statistical package SPSS (V11) was used to analyse the data. Sample size was based on power calculations to achieve a medium effect size on the SDQ Total Difficulties at an alpha level of .05. Ninety-nine parents were assigned to the PPCP Group or the Treatment as Usual Group and at Time 2, 74 (74%) completed postassessment, 42 from the PPCP group and 32 from the Comparison Group. A series of independent *t*-tests found the PPCP and TAU Group did not differ significantly in terms of child's age or baseline scores on study variables, while a chi-square analysis found no difference in the gender of the child in the two groups.

Of the 25 (25%) parents who did not complete Time 2 assessments, 16 were from the PPCP Group and 9 were from the TAU Group. Forty-two families (72%) out of the 58 initially assigned to the PPCP Group successfully completed treatment. In the PPCP group, a series of independent *t*-tests revealed that the baseline level of conduct problems was the only significant difference between completers ($M = 5.16, SD = 2.18$) and noncompleters ($M = 6.6, SD = 2.47; t(55) = 2.1, p = .02$) at Time 2. There was no significant difference between completers and noncompleters at the 5-month follow-up.

In the Comparison Group, the children of noncompleters at Time 2 were significantly younger ($M = 7.55, SD = 1.10$) than completers ($M = 8.84, SD = 1.65$). This was the only significant different between completers and noncompleters in the TAU Group.

Comparison of the PPCP and TAU groups

The first set of analysis examines the effects observed for the PPCP Group ($n = 42$) compared with the TAU Group ($n = 32$) on the parent report measures postprogramme. As there were no data collected for the TAU group at Time 3, only Time 1 and Time 2 are considered. A series of 2×2 one between one-within mixed model ANOVA were used to explore Time effects and Interaction effects. Table 3 displays the means and standard deviations of the variables, while Table 4 indicates the main effects for Time and the Group \times Time interaction effects.

Table 3. Means and standard deviations (in parentheses) at Time 1 and Time 2

	PPCP Group ($n = 42$)		TAU group ($n = 32$)	
	Time 1	Time 2	Time 1	Time 2
Total Difficulties	21.19 (6.15)	18.12 (6.23)	22.34 (7.33)	22.15 (8.30)
Hyperactivity	7.19 (2.81)	6.70 (2.75)	7.93 (2.25)	7.34 (2.78)
Conduct Problems	5.07 (2.06)	3.92 (1.61)	5.28 (2.12)	5.53 (2.46)
Emotional Symptoms	5.04 (2.61)	3.92 (2.70)	5.12 (3.05)	5.09 (2.95)
Peer Problems	3.87 (2.37)	3.56 (2.41)	4.00 (2.89)	4.18 (2.75)
Prosocial Behaviour	6.65 (2.78)	7.13 (2.15)	6.46 (2.56)	6.35 (2.68)
Impact Score	5.12 (2.88)	3.02 (2.46)	4.09 (2.39)	3.58 (2.20)
Parental Stress	47.76 (10.14)	43.07 (8.53)	44.51 (9.47)	44.20 (11.94)
Parent-Defined Problems	7.69 (1.39)	4.64 (2.39)	7.51 (1.49)	6.78 (1.69)
Parent Defined Goals	2.4 (1.5)	6.38 (1.56)	2.88 (1.82)	4.02 (1.66)
Parental Confidence	4.14 (2.09)	6.48 (1.69)	4.15 (2.22)	5.10 (1.95)

Table 4. Time main effects and interaction effects for PPCP and TAU Groups

	Time Effect		Interaction Effect		
	F	Partial η^2	F	Partial η^2	Cohen's d
SDQ Total Difficulties	6.06*	.08	4.75*	.06	.57
Emotional Symptoms	4.16*	.06	2.08	.04	
Hyperactivity	6.22*	.08	.06	.00	
Conduct Problems	3.59*	.05	8.72**	.11	.81
Peer Problems	.08	.00	0.98	.01	
Prosocial Behaviour	.80	.01	2.02	.03	
Impact Score	14.71**	.18	5.4**	.07	.24
Parental Stress	7.16**	.10	5.5*	.07	.11
PD Problems	40.7**	.40	15.39**	.19	1.02
PD Goals	41.17**	.57	27.46**	.29	1.49
Parental Confidence	4.98*	.30	4.98*	.06	.77

* $p < .05$; ** $p < .01$.

Strengths and difficulties As can be seen in Table 4, there were significant Time \times Group interaction effects observed for the SDQ Total Difficulties and Conduct Problems subscale. Using tests of simple effects, significant changes were found for the PPCP group over time for Total Difficulties and the Conduct problems subscale. The analysis also revealed significant Time main effects for Total Difficulties and Conduct Problems with parent reports of these difficulties being higher at Time 1 than Time 2. A significant interaction effect was also observed for the Impact of these difficulties with a greater decrease in the impact score for parents in the PPCP group at Time 2 when compared to the TAU Group. However, there was also a statistically significant main effect for Time with parents in both groups reporting reduced impact of difficulties at Time 2. Tests of simple effects revealed no significant group differences at Time 1 for these three variables or for Impact Score at Time 2. However, there were significant group differences at Time 2 for Total Difficulties ($F(1, 71) = 5.62, p < .01$) and for Conduct problems ($F(1, 71) = 11.22, p < .01$) with mean scores being lower for the PPCP Group than for the TAU Group. Nonsignificant findings for the SDQ subscales are also displayed in Table 4.

Parent-defined problems and goals Significant interaction effects were observed for parent-defined (PD) problems and goals, as can be seen in Table 4 above indicating a significantly greater reduction in problem behaviour and greater goal attainment for the PPCP Group than for the TAU Group at Time 2. Time main effects were also observed for both PD problems and PD goals with parents in both groups reporting reduced problems and greater goal attainment at Time 2. Tests of simple effects revealed no group effect at Time 1 but significant group effects at Time 2 for both PD Problems ($F(1, 63) = 15.97, p < .01$) and PD Goals ($F(1, 69) = 38.48, p < .01$) with greater improvements for the PPCP Group than for the TAU Group.

Parental stress A significant Group \times Time interaction effect was observed for parental stress with parents in the PPCP group displaying a greater decrease in stress from Time 1 to Time 2 when compared to the TAU Group. There was also a significant main effect for Time with parents in both groups reporting reduced stress at Time 2. Tests of simple effects indicated no Group difference at Time 1 or at Time 2.

Parental confidence As can be seen in Table 4, there was a significant interaction effect for parental confidence indicating that parents in the PPCP Group displayed greater gains in confidence postprogramme when compared to the TAU Group. A significant main effect for Time was also observed with a significant increase in confidence from Time 1 to Time 2 for both groups. There was no Group difference as revealed by a test of simple effects at Time 1 but there was a Group difference evident at Time 2 ($F(1, 69) = 10.56, p < .01$) with a greater confidence mean score for the PPCP Group than for the TAU Group.

Changes in the PPCP Group over time

The second set of analysis used a series of one-way repeated measures ANOVAs to compare scores on parent measures at Time 1 (prior to the PPCP programme), Time 2 (following completion of the programme) and Time 3 (at 5-month follow-up) within the PPCP group. These analyses involve 27 parents who completed assessments at the three time points. Fifteen parents who completed Time 1 and Time 2 assessments did not complete Time 3 assessments as they were no longer attending the child mental health service or their contact details had changed. Therefore, the Time 3 retention rate was 64 per cent. The means, standard deviations and main effects for time are displayed in Table 5. Sixty-four per cent of parents who completed Time 1 and Time 2 assessment also completed Time 3 assessments.

Strengths and difficulties As can be seen in Table 4, there were significant time effects for SDQ Total Difficulties and Emotional Symptoms, Conduct Problems, Peer Problems and Prosocial Behaviour subscales. There was also a significant time effect for the Impact Score. Posthoc analyses identified that significant differences in the mean score for Total Difficulties, Conduct Problems, Emotional Symptoms and the Impact Score occurred between Time 1 and Time 2, and that the positive changes were maintained at Time 3.

Posthoc analysis also indicated that the significant change for Prosocial Behaviour occurred between Time 2 and Time 3, while the significant change for Peer Problems occurred between Time 1 and Time 3.

Parent-defined problems and goals One-way repeated measures ANOVA revealed significant time effects for both parent-defined problems and for parent-defined goals. Posthoc analysis identified significant differences between the mean for Time 1 and Time 2 and between Time 1 and Time 3, indicating that at postprogramme and at follow-up, parents

Table 5. Means, standard deviations (in parentheses) and time effects for PPCP Group ($n = 27$)

	Time 1	Time 2	Time 3	F	Partial η^2
SDQ Total Difficulties	20.51 (6.02)	17.22 (6.55)	16.37 (7.37)	7.85**	.39
Conduct Problems	5.00 (2.2)	3.85 (1.72)	4.37 (2.27)	3.61*	.23
Emotional Symptoms	4.85 (2.55)	3.77 (2.45)	3.44 (2.76)	6.14**	.33
Hyperactivity	6.81 (2.82)	6.18 (2.68)	5.92 (2.78)	1.97	.14
Peer Problems	3.85 (2.55)	3.4 (2.37)	2.62 (2.38)	5.31*	.3
Prosocial Behaviour	7.11 (2.28)	7.11 (2.21)	8.19 (1.78)	5.49*	.31
Impact Score	4.64 (2.98)	2.76 (2.55)	2.88 (2.72)	5.5*	.32
Parental Stress	46.03 (9.62)	42.11 (9.2)	38.88 (10.78)	8.48**	.41
PD Problems	7.4 (1.47)	4.52 (2.5)	4.81 (2.07)	16.59**	.6
PD Goals	2.63 (1.55)	6.63 (1.55)	6.43 (2.87)	41.17**	.77
Parental Confidence	4.62 (1.98)	6.5 (1.89)	6.7 (1.5)	10.37**	.47

* $p < .05$; ** $p < .01$.

rated their child problem behaviour as less intense and were closer to achieving their parenting goals than preprogramme.

Parental stress A significant Time effect was also observed for parental stress in the PPCP Group over time. Posthoc analysis detected a significant reduction in stress at Time 2 and a further significant reduction at Time 3.

Parental confidence Repeated measures ANOVA indicated a significant time effect for parental confidence in the PPCP Group. Posthoc analysis indicated that the significant difference in mean scores was between Time 1 and Time 2 only with a postprogramme increase in parental confidence.

Treatment effects for children with and without developmental delay

This set of analysis focuses on the 42 parents in the PPCP Group who completed Time 2 assessments only as there were insufficient children with developmental difficulties at Time 3 to conduct a meaningful analysis across type of difficulty. The means and standard deviations of the study variables at Time 1 and Time 2 across type of difficulty are displayed in Table 6. Using two-way ANOVAs (Time \times Type of Difficulty), differential effects for children with exclusively behavioural problems ($n = 29$) and children whose difficulties included a developmental delay ($n = 13$) were explored.

As can be seen in Table 6, significant interaction effects were observed for SDQ Total Difficulties and the Peer Problems Subscale, and for Parent-defined Goals, indicating that participation in the PPCP was more beneficial for children with behavioural problems only on these outcome measures. Tests of simple effects revealed no significant differences between the two groups at Time 1. There were significant group differences at Time 2 for Peer Problems ($F(1, 40) = 7.89, p < .01$) and for Total Difficulties ($F(1, 40) = 6.8, p < .05$) demonstrating a lower mean score for the group with behavioural difficulties only than for the group with associated developmental difficulties. There was no group effect for PD Goals. There were no significant interaction effects for Parent-defined Problems, Parental Confidence, SDQ Impact score, Hyperactivity, Prosocial Behaviour, Conduct Problems or Parental Stress suggesting the PPCP was equally effective for both groups on these variables. The Time and Group \times Time effects are also reported in Table 6.

Table 6. Mean scores and standard deviations across type of difficulty and ANOVA effects

	Behavioural ($n = 29$)		Developmental ($n = 13$)		Time Effect F	Interaction Effect F
	Time 1	Time 2	Time 1	Time 2		
Total Difficulties	20.78 (6.8)	16.5 (6.42)	22.07 (4.36)	21.61 (4.19)	6.02*	3.91*
Hyperactivity	6.82 (2.8)	6.32 (2.9)	8 (2.76)	7.53 (2.14)	2.45	.004
Conduct Problems	5.32 (2.2)	3.78 (1.57)	4.53 (1.6)	4.23 (1.73)	7.55**	3.53
Emotional Symptoms	4.85 (2.88)	3.5 (2.82)	5.46 (1.94)	4.84 (2.26)	5.39**	.76
Peer Problems	3.78 (2.55)	2.89 (1.95)	4.07 (2.01)	5 (2.76)	.002	7.95**
Prosocial Behaviour	7.03 (2.59)	7.34 (1.99)	5.83 (3.09)	6.66 (2.49)	3.22	.68
Impact Score	4.77 (3.02)	2.66 (2.51)	5.91 (2.46)	3.83 (2.24)	13.33**	.001
Parental Stress	46.8 (10.4)	42.5 (9.01)	49.9 (9.66)	44.33 (7.53)	15.22**	.25
Parent-Defined Problems	7.64 (1.42)	4.73 (2.48)	7.82 (1.38)	4.41 (2.25)	40.97**	.25
Parent-Defined Goals	2.12 (1.06)	6.62 (1.49)	2.96 (2.1)	5.89 (1.66)	12.22**	5.52*
Parental Confidence	4.32 (1.96)	6.56 (1.38)	3.77 (6.3)	6.3 (2.04)	23.71**	0.08

Discussion

The PPCP is designed to be relevant for parents of children in both clinical and community contexts. This study explored the utility of a programme for parents of children with emotional and behavioural difficulties referred to a child mental health service. The aims of the current investigation were to evaluate the effectiveness of the Parents Plus Children's Programme for children aged 6 to 11 with behavioural difficulties, to assess whether changes were maintained over time and whether the programme was equally effective for children with behavioural difficulties and only and for those with associated developmental difficulties.

The results suggest that the programme was effective, with participants in the PPCP group overall displaying greater improvements in child problem behaviour, stress, confidence and goal attainment when compared to the Treatment as Usual (TAU) group following the intervention. There were positive significant changes on the SDQ Conduct Problems subscale as well as Total Difficulties. Moreover, the effect sizes for the significant postprogramme changes were moderate to large, indicating clinical relevance for the findings. These gains were maintained at 5-month follow-up, suggesting the changes were enduring rather than short-term fluctuations. Interestingly, there were also significant improvements in peer relations and prosocial behaviour at the 5-month follow-up, which were not evident immediately postprogramme. A possible explanation is that during the programme parents initially prioritized reducing disruptive behaviour in the home, as this was the primary reason for referral to the clinic for most families. Following the reduction in negative behaviour, parents might then have attended to promoting prosocial and appropriate peer-directed behaviour. Alternatively, a reduction in disruptive behaviour may have made these children more likeable to their peers and created greater opportunities for the enactment of prosocial behaviours.

The results of the study are broadly consistent with previous research on the original Parents Plus Programme (Behan et al., 2001; Quinn et al., 2007) and the Early Years version (Griffin et al., 2006; Sharry et al., 2005) which showed a reduction in child problem behaviour and increases in parent goal attainment following participation in the programme. Similar to the current investigation, previous studies (Griffin et al., 2006; Quinn et al., 2007) have demonstrated the effectiveness of the programme with children with behavioural problems and comorbid difficulties. The results of the current study also compare favourably to investigations of other parent training programmes in clinic-based settings (e.g. Scott et al., 2001). The current study is the first with this age group in a child mental health service that did not employ exclusionary criteria on the basis of developmental difficulties, suggesting the current programme has clinical relevance for practitioners.

The finding that the 16 parents in the PPCP Group who did not complete treatment had a child with a higher level of conduct problems than those who successfully completed the programme suggests that such families require extra support from the clinician to maintain their engagement with the programme.

The results indicated no differential effects emerged for children with behavioural difficulties exclusively and for those with associated developmental delay families for parent-defined problem, conduct problems, parental stress and confidence. However, the programme was more effective for families with exclusive behavioural difficulties on several outcomes. This is interesting considering that studies evaluating the effectiveness of the Original Parents Plus and the Early Years found the programmes equally effective for those with behavioural difficulties, both with and without developmental difficulties (Griffin et al., 2006; Quinn et al., 2006, 2007). However, the children in these investigations

were younger, under 7 years of age, than in the current study. Parents of children with developmental difficulties might find it easier to shape new behaviour in younger children and find that maladaptive behaviour patterns require greater effort for older children. These families might benefit from an additional number of group and individual sessions of the PPCP. Several other factors may account for the differential outcome for children with and without developmental delay in the current study. First, the SDQ may not have been sensitive enough to capture change within the developmental group. Second, some of the developmental difficulties may not be amenable to parent training or may be so entrenched that they require a more intensive and broader intervention than parent training alone. For example, these children might benefit from social skills training to promote positive peer relations. Third, parents might have had unrealistic expectations of what could be achieved from the parenting programme and accordingly identified unachievable child-centred goals. As there were only 13 cases in the PPCP Group with developmental difficulties, and insufficient cases in the TAU Group to allow for comparison, firm conclusions cannot be drawn.

The current study has a number of strengths that deserve mention. First, unlike some other studies, this current study took place in the real-world setting of a frontline child mental health service and entry to the study did not employ exclusion criteria based on the presence of developmental difficulties. As such, cases were representative of typical referrals to the service. These were difficult cases that had not responded to routine clinical care but had showed significant improvement following participation in the programme. This suggests that the PPCP could be a suitable first line of intervention for the majority of children referred to child mental health services. Second, the comparison group were not pure controls as the evaluation took place within a real-world clinical setting, and therefore they continued to receive routine clinical care. The results might possibly be more impressive if the treatment group were compared to a pure no-treatment control group. A third strength of the study is the maintenance of the gains to 5-month follow-up. Fourth, the programme was delivered by trained therapists, including the developer of the programme, using a detailed manual and videos, ensuring a high level of programme integrity.

Nonetheless, the study has a number of limitations which should be addressed. In the first instance, participants were sequentially rather than randomly assigned to the PPCP or Comparison Group conditions. Random allocation cannot always be feasibly applied to evaluate psychological programmes in real-world settings. For example, the use of randomization is constrained by legal and ethical issues, in that children or adolescents in need of psychological services cannot be randomly assigned to a 'no-treatment' comparison group (Weisz et al., 1992). In the current study, most families required immediate treatment due to their high level of difficulty. The time involved in recruiting the required number of families for the study and randomly allocating to groups would be difficult to justify to service users and would negate the utility of the programme as a frontline mental health intervention in real-world clinical contexts. Nonetheless, both the PPCP and Comparison Group were remarkably similar in terms of initial level of behavioural difficulties, distribution of developmental problems and demographic profiles. Ethical considerations also prevented the maintenance of the Comparison Group at Time 3. However, for the PPCP group the majority of significant changes occurred between pre and post programme and the gains were simply maintained at follow-up. Therefore, one could reasonably state that the changes were due to the intervention and not simply maturation. A final limitation concerns the absence of follow-up assessments of those who failed to complete the programme. This again reflects the practical constraints on the clinician involved in practice-based research

Future research should examine the differential effectiveness of the programme for children with both behavioural problems and discrete categories of developmental problems. It would also be useful to follow up the parents who did not complete treatment to explore what alternate means could be employed to engage them in services. Finally, it would be useful to evaluate the effectiveness of the programme in community-based settings and to explore whether positive changes are maintained long term at 2 to 2 years post treatment in both clinical and community samples.

The Parents Plus Children's Programme is an evidence-based treatment for children with difficulties typical of referrals in real-world child mental health contexts and can be used as an add-on to routine services. The programme was developed in a practice-based setting to be responsive to the needs of service users. Previous research indicated poorer outcomes in effectiveness trials (in clinical settings) than in efficacy trials, for example, in university-led research for child and adolescent mental health interventions (Weisz et al., 2002). In contrast, this article describes an effective clinic-based programme that displays outcomes that are comparable to efficacy studies. The research demonstrates both the efficacy and effectiveness of the Parents Plus Children's Programme. Considering it is a broad based intervention, it also helps improve health equality (O'Hara, 2006). This suggests that the Parents Plus Children's Programme could be a suitable first line of intervention for the majority of children referred to child mental health services and could be incorporated into routine child intervention clinics in the public health service.

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