Abusive parenting attitudes in parent training subgroups

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Abusive parenting attitudes in parent training subgroups

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University of Nevada, Las Vegas, 1991
ABUSIVE PARENTING ATTITUDES
IN PARENT TRAINING SUBGROUPS

By
Jacqueline Ann Harris

A thesis submitted in partial fulfillment of the
requirements for the degree of
Master of Arts
in
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Department of Psychology
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ABSTRACT

The present study examines the abusive parenting attitudes of three subject populations (self-referred, abusive, and custody) in a parent training group. All subjects were administered the Adult-Adolescent Parenting Inventory (AAPI) before and after the parenting group. The hypothesis that all groups would make gains on the AAPI following the parent training intervention was not supported, with the exception of one AAPI construct (family roles) for the abusive subjects. It was revealed that the self-referred and custody groups' scores were similar, both pre and post, on the AAPI. However, the abusive population differed from the other two groups, both pre and post, on only two constructs (developmental expectations and corporal punishment). Implications of this research and suggestions for further exploration are presented.
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CHAPTER I
INTRODUCTION

The field of clinical psychology has commonly focused on the psychopathological disturbances of the individual. It is because of this that therapists are trained to work with and counsel patients on an individual basis. However, in recent years, attention of theorists has turned to the family as a unit. This has resulted in therapists treating the family as a distinct entity, with its own set of values, morals, and beliefs. Based on this theory more and more clinics are offering family services.

One such service, is parenting programs for families experiencing difficulties with their young children. Parenting programs offer a wide variety of information to a diverse parent population. Often therapists are placed in the role of evaluating court referred families to determine their knowledge or effectiveness as a parent, or their attitudes toward parenting or their children. This often places the therapist in a dual role, that of trainer and that of evaluator.

Parent Training Research and Programs

Training parents to use behavioral procedures grew
out of a realization of the importance that a person's environment has on their development. Anastasiow (1988), for example, points out that environments can facilitate development, create risk states, and even remediate impairments and handicapping conditions. In a sense, environments can fulfill genetic potentials or stifle them.

In addition to environmental rationales for the use of parents as change agents, there are several other reasons. These include: manpower shortages, practical problems with traditional treatment approaches, and an increase in the use of paraprofessionals as therapists (Reisinger, Ora, & Frangia, 1976). Furthermore, as Glogower and Sloop (1976) note, parents are in a better position to change behavior, than therapists, for they see the child on a more constant basis. Moreover, if the child is enrolled in a clinic program, parental support and continuation of the program principles is vital to maintaining the changes that have occurred (Reisinger, Ora, & Frangia, 1976). It is also important for therapists to provide parents with a basic theoretical framework for them to work from (O'Dell, Flynn, & Benlolo, 1977).
Since the implementation of behavioral programs for parents, many benefits have been discovered. The most evident is economical. When parents are brought together in a group and taught behavioral principles, they constitute an inexpensive, continuous treatment resource (Anthony & Benedek, 1970; Johnson & Katz, 1973). Parents will also continue change efforts over time, without cost to themselves or society (Reisinger, Ora, & Frangia, 1976). Furthermore, as O'Dell (1974) has found, unskilled professionals can be taught behavioral skills very efficiently, many parents/therapists can be taught at once, and the skills require only brief instruction.

In addition to factors which benefit the clinic or therapist, parent education groups incorporate peer interaction and thus provide reinforcement and support for the parents (O'Dell, 1974; Swetnam, Peterson, & Clark, 1982). Parent training groups also allow parents to engage in mutual sharing and feedback in a nonthreatening environment (Eyberg & Matarazzo, 1980).

The most common form of parent education is to teach parents behavioral principles in a group setting and allow them to implement the principles in the home.
(Anthony & Benedek, 1970). Beyond this basic structure, there are many different theories as to the specific components that need to be included. Reisinger, Ora, and Frangia (1976) argue that successful therapy needs to modify the reinforcement patterns that exist in the social environment. They further indicate that it is imperative to train parents in the use of stimulus control and reinforcement scheduling, and to allow for generalization of skills learned to other problem behaviors. Moreland, Schwebel, Beck, and Wells (1982) indicate that parent training must teach parents to identify or define a particular behavior and then train them to give commands, use positive reinforcement, and utilize time-out. Other researchers have found that for parent training to be effective, the skills learned in the group must generalize outside the setting to other environments and with other problem behaviors (O'Dell, 1974). In addition to behavioral skills, Glogower and Sloop (1976) found that teaching problem solving skills to parents was beneficial. Instead of focusing on specific skills, other researchers have found it important to instruct parents in more general concepts, such as knowing about child development, understanding
the need for psychological warmth, clarifying the roles of the parent and child, and learning how to set limits without harshness (Anastasiow, 1988; Tavormina, 1974).

Another goal of parent training concerns the parents' perception of their child. Forehand and King (1974) found that referrals of children to treatment centers may be the result of parental perceptions of their child, as well as the intensity or frequency of maladaptive behavior. In a similar vein, Anthony and Benedek (1970) found that the success of therapeutic intervention by parents is dependent upon the ability of the therapist to produce changes in the perception of the parent about the child. Forehand and King (1977) report that behavioral parent training is associated with positive changes in parental perceptions toward the treated child.

To achieve these goals, therapists utilize a variety of methods. These could include: direct instruction, modeling and practice of the skills, videotape presentations, reading materials, and handouts. In a study by Reisinger, Ora, and Frangia (1976), it was revealed that in addition to lecture and reading materials, it is important to demonstrate
technique, give feedback to the clients, and have the client count positive and negative behaviors of the child. Written materials complement lecture formats, in that they are a ready reference for the parents to consult in the home (Moreland, Schwebel, & Wells, 1982).

In investigating the effectiveness of parent training programs, many child and parent behaviors have been monitored. Forehand and King (1977) investigated a behavioral parent training program. Their results revealed that the parents' attitudes became more positive, positive parent/child interaction increased, and child compliance increased. In a study by Glogower and Sloop (1976), parents perceived their children as less of a conduct problem following a group parenting program. Parents involved in a behavioral program conducted by Karoly and Rosenthal in 1977 found their families to be less noxious and viewed their child as less deviant.

Compliance in hyperactive children was increased during a study by Henry (1987). Johnson and Katz (1973) compiled a list of behaviors that were modified with behavioral parent training, including: antisocial/immature behavior, speech dysfunction, school
phobia, encopresis/eneuresis, seizures, self injurious behavior, and oppositional behavior. In addition to conducting parent education after problem behaviors begin to occur, Anastasiow (1988) asserts that many disabilities can be prevented ahead of time by mandatory parent education.

Anastasiow (1988) indicates that effective childrearing takes knowledge, education, and economic resources. Many of the families that come to community mental health centers do not have these requirements. Furthermore, many suffer from dysfunctional backgrounds, illiteracy, socioeconomic deprivation, mental illness, or are in a current crisis situation. These problems are only compounded when they have children who are also experiencing behavioral or emotional problems. However, parent education can be helpful. As Reisinger, Ora, and Frangia (1976) have found, parents who are disturbed themselves can be trained to change their child's maladaptive behavior. Furthermore, under structured, task-oriented circumstances, lower-class parents can also be trained to apply reinforcement strategies with their children (Reisinger, Ora, & Frangia, 1976). With some parents who are of lower socioeconomic status or
educational level, according to Johnson and Katz (1973), the therapist may want to supplement instructional material with direct instruction. However, parents from low socioeconomic levels may be harder for the therapist to treat, due to their lack of any child management skills (O'Dell, 1974). Swetnam, Peterson, and Clark (1982) found that groups can be of assistance to single parents, extended family members, court-referred families, and intact families with routine complaints. Research has supported that group parent training can assist many types of parents and change many types of child and parent behaviors. Two types of parents that may be assisted by group parent training are individuals referred to a community mental health center for parent training because of abusive parenting patterns, and those referred because of custody disputes. Each type of parent has a particular set of dynamics that is important to understand before a therapist can conduct parent training.

The Abusive Parent Population

According to Dawson, de Armas, McGrath, and Kelly (1986), approximately 5,000 children die each year as a result of child abuse. There are many more children
that are abused but go undetected. Most of the parents who abuse their children do not see problems with their parenting, so they do not spontaneously seek help (Irueste-Montes & Montes, 1988). Therefore, many of the parents who do seek help are sent under a court's order.

It is important to understand, when working with abusive parents in a parent training setting, the personal dynamics of the abuser. As Blumberg indicated in 1974, most abusers are "caught in the tangle of their own past, each other, the baby, and the crisis situation" (p. 23). In regards to the abusers past, it has been found that many abusing parents were abused, neglected, or deprived of love themselves (Blumberg, 1974; Minor, Karr, & Jain, 1987). There are many factors that occur in the abusers present that exacerbate the situation. Many abusers are socially isolated, hold cultural beliefs that support abuse, or have pathological personality factors (Minor, Karr, & Jain, 1987). Some of these pathological personality factors include the following: continual hostility/aggressiveness, rigidity/lack of warmth, emotionally immature, low frustration tolerance, dependent, impulsive, and self-centered (Blumberg, 1974;
Abusive parents also experience several external difficulties. Rosenberg and Reppucci (1983) discovered that abusive parents exhibit a considerably greater degree of stress than other parents. Abusive mothers also reported a greater level of depression and somatic complaints than low socioeconomic controls (Lahey, Conger, Atkeson, & Treiber, 1984). Blumberg (1974) found that alcohol and drug abuse are common contributors to child abuse.

In addition to personality characteristics of the abuser and environmental stressors, abusive parents exhibit very specific patterns in their parenting. Abusive parents have inadequate child management skills, inadequate child expectations, and lack of knowledge of basic child development (Dawson, de Armas, McGrath, & Kelly; Larson & Juhasz, 1985; Milner & Wimberley, 1979). The lack of knowledge, often leads to unrealistic expectations and demands of the child (Larson & Juhasz, 1985; Rosenberg & Reppucci, 1983; Shorkey, 1978). The unrealistic expectations lead to frustration in both the child and the parent.

In addition, abusive parents often project their
anger onto their child while denying and repressing it in themselves (Blumberg, 1974). Role reversal, or the child taking on the parents responsibilities, is also common (Blumberg, 1974). Dawson, de Armas, McGrath, and Kelly (1986) found that abusive parents are less able than matched controls to solve everyday child-care problems.

The behavior of abusive parents is very different from other types of parents. In addition to the abuse itself, abusive parent often act in ways that are oriented to their own needs, versus the needs of their child (Larson & Juhasz, 1985). In a study conducted by Lahey, Conger, Atkeson, & Treiber (1984) abusive parents engaged in a lower frequency of positive or supportive verbals and higher degree of negative or aggressive verbals.

Abusive parents also perceive their child differently than other parents. They often see their child's negative behavior as ingrained and stable rather than a reaction to situations in the environment, according to Rosenberg and Reppucci (1983). They also found that abusive parents perceive their child's age-appropriate behaviors as willful and describe their
child as "bad".

With the above characteristics in mind, the therapist can proceed with treatment. Bavolek, Kline, McLaughlin, and Publicover (1979) found that parent education could be viewed as the single most important prevention and intervention variable in child abuse. Parent education can assist abusive parents, by teaching them child management techniques and child development (Moreland, Schwebel, Beck, & Wells, 1982). Dawson, de Armas, McGrath, and Kelly (1986) found positive results from a program for abusive parents that included teaching nonviolent child management and anger management skills. Supportive and problem solving therapy can also be important components of a program for abusers according to Wolf, Aragona, Kaufman, and Sandler (1980). They found that parents with younger children are more amenable to treatment and are more able to utilize the information.

The Custody Dispute Parent Population

Another population that is often brought to a community mental health center is those involved in a dispute over the custody of children. Unfortunately, as Everett and Volgy (1983) report, legal disputes
regarding child custody and visitations are increasing. The gradual shift toward more androgenous sex roles in the family has produced incongruent role perceptions and expectations for both spouses. The movement of the judicial process away from the traditional presumption for maternal sole custody has set the stage for an increase in custody disputes. Unfortunately, the court process often increases the stress, hostility, and acrimony between spouses, making custody arrangements less likely (Duquette, 1978).

In many custody dispute situations, the final divorce only symbolizes the final stage of the enduring family dysfunction (Everett & Volgy, 1983). During the dispute, each parent paints themselves as favorable and the other person as sinister (Musetto, 1981). Furthermore, according to Musetto (1981) parents involved in child custody disputes have hidden agendas including: seeking revenge, attempting to control, reinvolving the other parent in the marriage, patching up their self-esteem, or seeking emotional stability.

The victims of the custody battle are always the children. It is because of this that Jackson, Warner, Hornbein, Nelson, and Fortescue (1980) assert that
custody decisions should be mindful of the child's
development, versus the parent's needs and wishes.
Children are also victims in this process, because
parents often use their child as a weapon in the battle
(Duquette, 1978). The chaotic custody process,
according the Everett and Volgy (1983) can leave
children with fragmented attachments, truncated grief,
and a sense of being trapped without supporting
networks.

Often the mental health professional is involved in
child custody disputes as an assistant to the court in
determining which parent should have sole custody or
more visitation (Musetto, 1981). When completing an
evaluation, it is important to look at the following:
parent attitudes and capabilities, attachment of the
parent and child, and the impact of the divorce on the
family members (Jackson, Warner, Hornbein, Nelson, &
Fortescue, 1980). According to Everett and Volgy in
1983, court ordered custody evaluations have
predominantly focused on child development, attitudes
and skills in parenting, parent education, stability and
morality, environmental continuity, and appropriateness.

Parent education with those involved in a custody
dispute can serve more than an evaluative purpose. The parents involved are facing parental dynamics never faced before and the children involved may be experiencing behavioral or emotional difficulties as a result of the divorce process. Moreland, Schwebel, Beck, and Wells (1982) found that parents in a child custody dispute can learn how to increase their reinforcement value to their children, develop new parent skills and adapt to life as a single parent, by attending parent training groups. Parent education for custody dispute families is further supported by evidence from Jackson, Warner, Hornbein, Nelson, and Fortescue (1980), who found that there are usually limitations in each parent's ability to interact and take care of their children.

The Dynamics of Court Ordered Clients

Both abusive and custody dispute parent populations usually do not come to parent education or therapy on their own. They are usually ordered by the judge or court system to receive parent education as part of an evaluation or treatment program. This creates certain dynamics in the therapy setting. According to Watkins (1984), court systems view therapy as an alternative to
jail for crimes committed within the family. Therefore, in order to be effective, a therapist must understand the court system and be aware of its impact on the family (Belcher & Salts, 1985).

Court ordered participation in therapy of any kind, including parent training, can have negative repercussions. Many families that are court ordered feel abused and confused by the system by the time they come to the therapist (Belcher & Salts, 1985). Lehmer (1986) reported that it is often difficult to establish a therapeutic relationship with court ordered clients, as they view therapy as a prison sentence. Court orders can, according to Irueste-Montes and Montes (1988), make clients resistant and less receptive to treatment. Resistance is shown by being late or failing to meet for an appointment, refusing to talk in therapy, and confusion over why they are in treatment (Belcher & Salts, 1985). Lehmer (1986) reported that court ordered clients also present a well developed denial system, because they are under duress.

Court ordered treatment can also have a positive effect on the family. The courts can be the catalyst for getting abusive or reluctant families into treatment
(Irueste-Montes & Montes, 1988; Lehmer, 1986). These same courts can ensure that families remain in services until completion and until they meet certain criteria (Lehmer, 1986). This is also beneficial to the therapist in that it gives them greater leverage and helps to reduce drop-out rates (Irueste-Montes & Montes, 1988). For example, Wolfe, Aragona, Kaufman, and Sandler (1980) found that 61% of non-court ordered families dropped out of services. Court ordered therapy can also be helpful in protecting abused children and rehabilitating families (Lehmer, 1986). Irueste-Montes and Montes (1988) found that court ordered parents in their Project Respite & Remediation improved parenting skills at a similar rate to volunteer families.

Similarly, Gant, Barnard, Kuehn, Jones, and Christophersen (1981), implemented a behaviorally based, social skill oriented program in the home to improve constructive communication. They found that their program was able to improve intrafamilial communication with families of court ordered adolescents. They also found that behavioral interventions can change the clients perception of therapy by providing clear cut expectations for success.
To achieve positive results, it is the responsibility of the court to explicitly indicate types of behavior changes desired and conditions for termination, as well as the nature of the therapy, by whom, with what frequency, and for what period of time (Irueste-Montes & Montes, 1988). A therapist must keep in mind that the court has ultimate power over the family, remembering that a judge's final ruling may be opposite of what the therapist would have wanted (Belcher & Salts, 1985). It is also imperative for both the client and the therapist to remember that the goal of therapy is not to establish guilt or innocence, or fitness or unfitness as a parent (Lehmer, 1986).

The Adult-Adolescent Parenting Inventory

When parents are ordered to participate in court ordered treatment, often the request of the court is for an evaluation of skills before and after treatment. There are many assessment devices that the therapist can administer to the client, including devices that measure parenting skills, developmental knowledge, parental perceptions, and parental attitudes. One such measure is the Adult-Adolescent Parenting Inventory (AAPI), which is designed to measure the degree of abusive
parenting attitudes that a particular client posseses.

The AAPI has four constructs that were developed from a review of literature, interviews with clinicians in treatment settings, and adaptations from instruments that were already existing (Bavolek, Kline, McLaughlin, & Publicover, 1979). The first construct examines inappropriate expectations. This construct was developed because abusive parents often inaccurately perceive the skills and abilities of their child. It also stems from parents lack of developmental knowledge, and because abusive acts often surround self-help types of behaviors. The second construct measures empathy, or the ability to understand the state of mind of the child without actually experiencing it. Abusive parents lack empathy, fear spoiling their children, and often neglect basic needs. The AAPI also investigate the degree of belief that the parent has in corporal punishment. They found that abusive parents use physical attacks to correct bad behavior or an inadequacy on the part of the child. Furthermore, abusive parents often defend their right to abuse. The last construct measures the degree of role reversal in the family. Role reversal refers to the degree that the child is taking on the physical and
emotional responsibilities of the parent. Abusive parents fail to meet their child's emotional needs. However, the children are often expected to be the source of comfort and care for the parents.

The AAPI has been explored in only a few settings. Larsen and Juhasz (1985) used the AAPI to investigate the relationship between knowledge of child development and social-emotional maturity as factors associated with positive or negative attitudes toward parenting. Fox, Baisch, Goldberg, and Hochmuth (1987) found significant differences between white and black pregnant adolescents on three subscales (Empathy, Corporal Punishment, & Role Reversal) of the AAPI. Minor, Karr, and Jain (1987) found that inmates who scored high on the abusive scale of the MMPI-2 also displayed abusive parenting patterns on three scales (Inappropriate Expectations, Empathy, and Role Reversal) of the AAPI.

Conclusions

Research supports the effectiveness of implementing parent training with various populations in order to reduce many negative behaviors of children and to improve the relationship between parents and children. The most common form of parent training is to place
parents in groups and teach developmental information and behavioral skills.

Several types of parents may be included in parent therapy groups: these include parents with abusive histories and parents who are involved in a child custody dispute. Each of these populations has dynamics that are unique to them. It is imperative that the parent group leader, or therapist be fully aware of these before a group begins. Furthermore, abusive and custody dispute parents are usually court ordered. This creates further complications and can confound the outcome of treatment.

When parents are court ordered to therapy, the court is usually requesting that an evaluation be completed. One of the instruments that has been shown to be helpful in assessing abusive parenting attitudes is the Adult-Adolescent Parenting Inventory (AAPI). Each of the four scales on this measure have been derived from research, interviews, and pre-existing measures.

Hypothesis

Although studies have been completed on many populations demonstrating the effectiveness of parent
training approaches, most of these studies have focused on the degree to which the parents have learned the specific skills which were taught or on a reduction in the child's negative behaviors. There are few studies that have examined the changes which occur in parents' attitudes following a parenting program, and even fewer that look at changes in court ordered clients.

This study examines the changes that occur in abusive attitudes in self-referred, court ordered custody, and court ordered abusive parenting populations following a behaviorally based parent training program. There are several hypotheses involved: all three groups (custody, abusive, and self-referred) will make gains on the Adult-Adolescent Parenting Inventory (AAPI) when compared to themselves; court ordered custody clients will not be significantly different from self-referred clients on a pre-test measure on the AAPI; Abusive clients will score lower initially on the AAPI; All three groups will reflect similar scores on the AAPI following the implementation of the parent training program. This study will also assist in validating the current use and effectiveness of the AAPI in parent training programs.
CHAPTER II
RESEARCH METHOD

Subjects

The subjects in this study were parents chosen randomly out of those who completed a Group Parent Therapy course at Children's Behavioral Services (CBS) in Las Vegas, Nevada. The parents completed the courses between January 1990 and February 1991. For the purposes of this study, the parents were classified as either "abusive", "custody", and "self".

Abusive parents were those who had been court-referred or ordered to attend the parent training group due to abusive incidents in the home. The custody group consisted of parents engaged in a court battle over the primary custody of the child or children in their home. The self-referred group included those parents who initiated services with the agency without any court mandate and were not reported for any abuse. Sexual abuse and neglect cases were not involved in this study. Several of the parents involved in this study were concurrently receiving services from CBS for themselves, or for their children, other than the parent
training program.

Information on the referral source of the subjects and the demographic information was obtained from the initial screening packet. Demographic information on the subjects, broken down by the three categories of parents, includes the following: sex, age, income, race, marital status, education, and number of children living in the home. Specific information on the demographics of the subjects are found in Table 1.

Insert Table 1 about here

Group Parent Therapy Program

The CBS Group Parent Therapy Program is designed to teach parents specific behavioral skills, provide developmental information, establish an environment to enhance positive behavior, and enhance the relationship between the parent and the child. These goals are achieved through the parent(s) participating in an eight week course offered one time per week, two hours per session. The eight week course has five levels of intervention (see Table 2), ranging from pre-tests to determine the initial skill level through practicing
of specific techniques. Although individual therapists
are allowed to use different mediums (art activities,
parent-child interactions, and role plays) to teach the
course, the basic concepts, handouts, homework, and
lectures are identical.

Variables

Independent Measures

Independent variables in this study are the three
categories of subjects established by the researcher.
As indicated above, the subjects are classified as
abusive, custody, or self-referred. Previous research
has indicated that these three types of subjects differ
on several variables. These include the motivation to
learn new information, demographic information (age,
income, marital status), resistance to treatment,
personality characteristics, and child rearing
practices. Research has also indicated that each of
these groups can learn and apply new information to
become a more effective parent following the completion
of a parent training program.
Dependent Variable

Adult-Adolescent Parenting Inventory (AAPI)

The Adult-Adolescent Parenting Inventory (AAPI) was chosen to measure the level of abusive attitudes in the three subject categories. The AAPI is one of several measures that are given to all parents before and after the parent therapy program. The AAPI consists of 32 items which the subject responds to on a five point Likert scale, ranging from Strongly Agree to Strongly Disagree. The responses on the AAPI yield STEN scores on four different constructs. A higher score (7-10) indicates a less abusive, more appropriate response. A low score (1-4) indicates abusive attitudes, middle scores (5-6) are average.

Construct A measures the subjects' knowledge of development of young children (Bavolek, 1984). A low score on this construct would reveal inappropriate expectations. These parents would have expectations that are too high for their children, or lack understanding of what can be expected of children at certain ages. A high score on this construct would reveal a parent that understands normal child development and allows children to exhibit normal
developmental behaviors.

Construct B measures the degree of empathy that the parent has for the child. Parents who score low on this construct fear spoiling their child and they often lack nurturing skills. These parents may also be unable to handle parental stressors. A high score on this construct would indicate that the parent understands and values children's needs. It would also reveal that communication with the child occurs and that the child's feelings are recognized as important and valid.

Construct C investigates the parent's belief in the use of physical or corporal punishment. Parents who receive low scores on this construct often use physical punishment and feel they are appropriate in doing so. They tend to be rigid, controlling, and authoritarian. Those parents who obtain high scores on this construct value alternatives to physical punishment. They have respect for their children and their children's needs, as well as having rules for the whole family, not just for the children.

Construct D measures the roles in the family. A low score on this construct would indicate that the roles in the family are reversed. That is, children
tend to take on the role of meeting the adult's needs. This indicates low self esteem, poor social life, and poor self awareness on the parents part. A high score on this construct would reveal that there are appropriate roles in the family. The parent is getting his or her needs met from peers, rather than through the children. These parents tend to have high self esteem and feel worthwhile as persons.

Reliability and validity data for the AAPI is provided in the AAPI manual (Bavolek, 1984). Test-retest reliability of all items is .76. Internal reliability coefficients on the four constructs ranges from .75 to .86 for adults. Bavolek (1984) found that abusive and nonabusive adolescents and adults scored significantly different (p < .001) on the constructs of the AAPI.
CHAPTER III

RESULTS

There are several questions involved in the current study. The first involves whether clients in all three groups can make significant improvements on all four constructs of the AAPI within their own groups. The next question involves the differences or similarities, pre-test and post-test between the three groups. The questions will be addressed in the following sections.

Pre-Test and Post-Test Differences in AAPI scores

To determine whether each group was able to make gains on the AAPI after completing the parent training program, a correlated t-test was computed (See Table 3). This analysis did not reveal significant differences on any of the constructs for any of the groups, with the exception of a positive change on Construct D (family roles) for the abusive population.
Pre-test and post-test differences between groups

To determine the differences between the abusive, custody, and self-referred subjects on both pre-test and post-test, an Analysis of Variance (ANOVA) was computed between all of the groups. Planned comparisons were also computed between the custody and self-referred subjects, and between the abusive and custody combined with self-referred subjects. These analyses revealed that there were significant differences between the

three groups on pre-test constructs A (developmental expectations) and C (corporal punishment) and post-test constructs A and C. No significant differences were revealed on any other constructs. Planned comparisons on pre- and post-test constructs A and C revealed no significant difference between the custody and self-referred subjects. However, significant differences on constructs A and C were revealed when comparing abuse with custody and self-referred combined.
CHAPTER IV
DISCUSSION

The current study examined several hypotheses. The first predicted that each subgroup (abuse, custody, and self) would make positive gains on the Adult-Adolescent Parenting Inventory (AAPI) following a parent training program. The next hypothesis predicted that the custody population would score similar to the self-referred population on the AAPI. Further, it was hypothesized that the abusive group would initially score lower than the other two group and then make gains during treatment becoming equal to them. Each of these hypotheses will be discussed separately, along with treatment recommendations, and the need for further research.

Pre-test and Post-test AAPI Differences

The hypothesis that each group would make positive changes in their scores at the post-test was not supported in all instances. None of the custody or self-referred clients made significant gains on any of the constructs following the parent training intervention. Nor did the abusive clients make gains on any of the constructs, with the exception of Construct D
(Family Roles).

Even though most of the groups did not make gains, the information revealed is important. There may be several reasons for this lack of improvement. At the pre-test, all of the custody and self-referred subjects were already scoring in the average to appropriate range (5-10 STEN score). Therefore, they were already in possession of appropriate attitudes toward children and childrearing, lacking in abusive attitudes.

The abusive subjects did not make significant gains on Constructs A, B, and C. The mean for Construct C was in the appropriate range. This is consistent with other research in that many subjects tend to false report on a scale which measures the use of corporal punishment, especially when the results may determine their reunification with their child. Even though scores were low (1-4) on Constructs A and B, significant gains were not revealed. Specific developmental information is taught in the course of the class. These parents may not be retaining the information or the information that is given may not be broken down enough for them.

As previously mentioned, the abusive subjects did make significant gains on Construct D (Family Roles).
This could be due to the parents learning specific behavioral skills that place them in command of making changes in the home. The parents self-esteem may be raised, if they are feeling successful in the acquisition of the skills, or are feeling support and validation from the therapist or other group members. Furthermore, they are instructed on specific developmental expectations that may increase the likelihood that the children are no longer completing tasks and responsibilities outside of their range.

The fact that all groups did not make significant pre-test to post-test changes may not be all due to the treatment program. Although Bavolek (1984) indicated that positive changes occurred following intervention, several other studies have found similar results on only some of the constructs. Furthermore, as the parenting program is very skill-oriented, the AAPI may not be the best instrument to measure the information that has been acquired or the ability to utilize the information in the home setting.

Similarities and Differences Between the Groups

The hypothesis that there were similarities or differences between the groups is two-fold. First, it
was theorized that the abusive population would differ, by scoring lower, on the pre-test than the other two populations. Furthermore, the abusive population would make gains at the post-test to be equal to the other two. Secondly, it was hypothesized that the custody and self populations would score similar at the pre- and post-test.

The hypothesis that the abusive population would score lower on the pre-test was supported, but only for Constructs A and C. These differences were also maintained at the post-test. On Construct A (Developmental Expectations) the difference decreased from $p < .001$ to $p < .05$. This indicates that the abusive population more closely models that of the other two groups. This could be due to the subject learning some developmental information. However, the gain may not be large enough to show up on the comparison of the pre-test and post-test scores on Construct A.

The differences being maintained on Construct C would indicate that the abusive parents attitudes on the use of corporal punishment are not similar to those in the custody or self groups. However, the abusive parents did initially score in the average range on the
pre-test. The absence of change in the scores could represent a failure of the treatment program to change ingrained beliefs in the use of corporal punishment or a failure to teach alternatives to it that the abuser felt were viable.

The lack of differences between the groups on Constructs B and D may be due to several reasons. First, all of the groups scored in the average to appropriate range at the pre-test. Therefore, the AAPI will not be able to discriminate between the three groups on empathy or family roles. It may also be that all three groups, including the abusive population, already possess appropriate empathy for their children and roles in their family. Furthermore, the parent training program may not be teaching the groups anything more about these two topics, with the exception of the positive pre-test/post-test gain exhibited by the abusive population.

Treatment Recommendations

In light of the information presented above, several recommendations for the further treatment of the three groups can be made, along with recommendations for the group parent therapy program. First and foremost,
it is important to point out the possible need for a specific parenting program for abusive parents. Although Children's Behavioral Services has the abusive parents attend a two session Parent Awareness Program before attending the parent training classes, this may not be enough. The abusive parents may not be realizing the full impact of the abuse on their family, or may not be making changes which will stop the abusive cycle. Furthermore, ingrained, abusive beliefs about childrearing may not be changed.

It is important when using the AAPI, with this population, that it is not only used for diagnostic and evaluative purposes, but also as a tool for treatment. With abusive parents, the therapist could go over the specific answers to questions on the AAPI and devise a therapeutic structure surrounding these answers. In this way, the AAPI would assist the therapist in treatment planning issues and assist the client in confrontation of belief systems and abusive tendencies.

Self and custody groups did not differ pre- or post-test, appeared similar on the AAPI constructs, and had average to appropriate range scores. It appears that whatever information parents are learning in the
course, it is not being measured by the AAPI. It has been found that parent training can be helpful to these two populations by assisting them with behavior management and changing maladaptive child behaviors. However, each population does not appear to need specific information on abusive parenting patterns or tendencies. It may be that they need specific information on their own circumstance, be it single parenting, parenting developmentally delayed children, or stress management. Therefore, the AAPI may not be the most appropriate instrument to give these populations before or after the parent training program.

Future Research Issues

Although this study supported some of the hypotheses and rejected others, it is in no way conclusive. There is much needed research in many areas to be conducted. The first area is the need for more research on the AAPI instrument itself. This study brought up several questions on its ability to discriminate between groups and to reflect information that has been learned. Furthermore, more information needs to be gathered on the types of programs that produce positive results on the AAPI.
Research also needs to be conducted on the group parent therapy program at Children's Behavioral Services. It is important to determine the types of skills that are being taught and whether they generalize to home settings. Furthermore, it needs to be investigated whether the teaching of specific skills can change long held, ingrained beliefs. It is also important to determine if the subjects participation in other therapy would impact on their scores on the AAPI.

Further research in all of these areas would not only assist the therapists and clients at Children's Behavioral Services, but also the community and therapeutic practice as a whole.
REFERENCES


Table 1
Demographic Information for Subjects
Adult-Adolescent Parenting Inventory Study

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<th>Mean</th>
<th>Standard Deviation</th>
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TABLE 2: OVERVIEW OF PARENT GROUP THERAPY PROGRAM

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<th>Intervention Level</th>
<th>Objectives</th>
<th>Activities</th>
<th>Master Criteria</th>
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<tbody>
<tr>
<td>I. Assessment and Goal-Setting</td>
<td>- Establish group rapport</td>
<td>- Therapist discusses group purpose and format</td>
<td>Parents</td>
</tr>
<tr>
<td></td>
<td>- Assess pretreatment parenting skills</td>
<td>- Parents complete written pre-quiz and videotaped assessment (Miller, 1975)</td>
<td>- Attend two sessions</td>
</tr>
<tr>
<td></td>
<td>- Teach parents how to specify and communicate age-appropriate expectations</td>
<td>- Therapist observes or videotapes in vivo parent-child interaction</td>
<td>- Complete assessments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Parents view introductory film &quot;Parents and Children&quot;</td>
<td>- Return completed home assignment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Group discusses age-appropriate expectations and practices verbal and non-verbal communication</td>
<td>- Suggested time for master: 4-6 hours of group contact</td>
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<tr>
<td></td>
<td></td>
<td>- Therapist and parent define at least one target behavior and develop home recording system</td>
<td></td>
</tr>
<tr>
<td>II. Social Learning Concepts</td>
<td>- Provide parents with basic knowledge of general social learning concepts</td>
<td>- Therapist discusses behavioral consequences (praise/ignore/punish)</td>
<td>- Attend at least one session</td>
</tr>
<tr>
<td></td>
<td>- Provide parents with general advice on social learning concepts into daily routines</td>
<td>- Therapist discusses ways to structure child's routines</td>
<td>- Complete home recording of target behaviors</td>
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<tr>
<td></td>
<td></td>
<td>- Parents develop child routines</td>
<td>- Achieve 75% on written post-quiz</td>
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<td></td>
<td>- Parents complete written post-quiz</td>
<td>- Suggested time for mastery: 4-6 hours of group contact</td>
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<table>
<thead>
<tr>
<th>Intervention Level</th>
<th>Objectives</th>
<th>Activities</th>
<th>Master Criteria</th>
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</table>
| III. Effective Parental Attention Techniques | - Improve parents' ability to attend selectively to child behavior and to recognize praisable, ignorable, and punishable behavior(s)  
- Teach parents to use basic techniques of praise, ignore, punish | - Group views and discusses videotape "Effective Parental Attention" (Miller, 1975)  
- Parents role-play techniques for praising, ignoring, punishing child behavior(s)  
- Parents complete post-videotape assessment (Miller, 1975) | - Attend at least one session  
- Complete home recording or praise/ignore/punish list  
- Achieve 75% correct on post-videotape assessment (Miller, 1975)  
- Suggested time for mastery: 4-6 hours of group contact |
| IV. Home Application Program | - Have parents demonstrate proper use of basic techniques with their child's behavior in the clinic  
- Have parents successfully implement techniques at home, using a structured Home Application Program | - Parents practice techniques with child in the clinic with therapist coaching and feedback  
- Parents and therapist develop individualized Home Application Program with therapist coaching and feedback, if necessary | - Attend at least one session  
- Document progress on Home Application Program Chart  
- Demonstrate proper use of basic techniques with minimal therapist coaching |
<table>
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<th>Intervention Level</th>
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<th>Activities</th>
<th>Master Criteria</th>
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<tr>
<td>V. Limit-Setting</td>
<td>- Have parents successfully demonstrate use of time-out techniques</td>
<td>- Therapist discusses limit-setting techniques&lt;br&gt;- Parents practice limit-setting in clinic with their child with therapist coaching and feedback&lt;br&gt;- Group discusses Home Application Program and revises or adds limit-setting, as necessary</td>
<td>- Attend at least one session&lt;br&gt;- Demonstrate proper use of limit-setting in clinic with minimal therapist coaching&lt;br&gt;- Suggested time for mastery: 4-6 hours of group contact</td>
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<tr>
<td>Abusive Construct</td>
<td>Pre-Test M</td>
<td>SD</td>
<td>Post-Test M</td>
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* p < .05
Table 4

Results of Analysis of Variance Between AAPI Constructs and Planned Comparisons (Custody vs. Self, Abuse vs. Custody/Self)

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*p < .05  
**p < .01  
***p < .001