EXAMINING THE PROCESS OF CHANGE IN AN EVIDENCE-BASED PARENT TRAINING INTERVENTION: A QUALITATIVE STUDY GROUNDED IN THE EXPERIENCES OF PARENTS

By

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ABSTRACT

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The evidence-based parent training intervention known as Parent Management Training – the Oregon Model (PMTO) is one particularly well-supported treatment approach for addressing child behavioral problems. Yet, there remains a need to further examine how this intervention promotes change. The purpose of this study was to develop a grounded theory describing the process through which parents' experiences in the PMTO intervention led to change in their parenting practices. This study was informed by family systems theory and applied a community-based participatory research approach.

Qualitative data were collected through in-depth, individual interviews with 20 parents who had completed the PMTO intervention. Data were analyzed according to the tenets of grounded theory, using the constant comparative method and a sequential process of open, axial, and selective coding. Throughout this process a number of measures were taken to ensure trustworthiness of the research findings.

Study findings revealed that parents' process of change took place through their efforts to attempt, appraise, and apply the intervention material within their multiple life contexts. The changes they achieved in their parenting practices led to improvements in themselves, their children, and their family relationships. The contributions of specific content items (i.e., good directions, skill encouragement, limit setting, emotional regulation), particular methods of delivery (i.e., role play, home practice assignments, troubleshooting, visual aids), and the role of

the interventionist in facilitating parents' process of change were identified. Parents' experiences of engagement, retention, and resistance in the intervention helped to further explicate this process. The resulting theory can inform further adaptations of PMTO and other evidence-based parent training interventions to help continue to improve the services available to families experiencing child behavioral problems. Additional implications for research are discussed, and recommendations for the practice of family therapy are suggested.

DEDICATION

This work is dedicated, with love,
to my husband, Brent Holtrop,
and to my parents, Lori and Tom Harrington.

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we sat down to talk about this project. I hope the findings of this study are able to contribute to the important work you are doing to help families in Michigan and across the world.

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I would not be here today if it was not for the love and support of my husband, Brent Holtrop, and my parents, Lori and Tom Harrington. Brent, I cannot even begin to express my gratitude for everything that you have done for me during my time in graduate school, especially while I have been working on my dissertation. Through all the ups and downs you have loved me unconditionally and have stayed by my side as a calm and steady force. You are an amazing partner in life and I love you very much. Mom, it is truly a gift from God and a tremendous privilege to be your daughter. You have showed me what it means to be a strong woman, you

have always believed in me, and you have continued to instill in me that I can achieve whatever I set my mind to. I am who I am today because of your love and guidance. Dad, I am so grateful for your presence in my life. You have taught me so much about the value of hard work and commitment. You have always been generous with your love as well as your humor, both of which I have benefitted from tremendously. Thank you for all of the sacrifices you and mom have made so that I can be where I am today. I love you both so much!

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

Chapter 1: Introduction

Background of the Problem

Child mental health disorders are a critical public health concern in the United States (U.S. Public Health Service, 2000). The prevalence rate of mental health disorders among children is between 10% and 20%, meaning that approximately 15 million children in this country meet full diagnostic criteria for a mental health disorder, while many more display escalating behavioral problems that put them at risk for developing one (American Psychological Association [APA] Task Force on Evidence-Based Practice with Children and Adolescents, 2008). Mental health disorders among children and youth result in numerous negative consequences, including individual and familial distress, impairment in reaching expected social and educational goals, increased risk of mental health problems into adulthood, and high public health costs (National Research Council and Institute of Medicine, 2009).

Among child mental health disorders, the disruptive behavior disorders (i.e., Conduct Disorder, Oppositional Defiant Disorder) are exceedingly common and constitute the most frequent causes for referral to child mental health care providers (Essau, 2003). Characteristic behaviors of children with these diagnoses include defiance, hostility, aggression, and/or serious rule violations (American Psychiatric Association, 2000). Prevalence rates ranging from 2% to 16% have been reported for Oppositional Defiant Disorder, while as many as one in ten children in the general population may meet the diagnostic criteria for Conduct Disorder (American Psychiatric Association, 2000). These disruptive behavior disorders are also enormously costly to society, with monetary expenses for Conduct Disorder alone reaching hundreds of millions of dollars per year (Essau, 2003; Foster, Jones, & Conduct Problems Prevention Research Group, 2005). With research suggesting that conduct problems have increased in recent decades

(American Psychiatric Association, 2000; Collishaw, Maughan, Goodman, & Pickles, 2004), the burdens posed by child behavioral disorders threaten to become even greater.

The distress associated with child behavior disorders is compounded by the reality that children and youth in the United States frequently fail to receive the mental health care they need (APA Task Force on Evidence-Based Practice with Children and Adolescents, 2008). Of the approximately 15 million children in the United States with a diagnosable mental health disorder, only about one third of these children receive services (Kazdin, 2008). The APA (2003) has issued a resolution confirming children are confronted with a lack of access to appropriate mental health services. Taken together, the negative outcomes faced by children with unmet mental health needs and their families is recognized as a public health crisis that necessitates a decisive response, including a continued commitment to furthering evidence-based treatments that address children's mental health problems (U.S. Public Health Service, 2000).

Parent Training Interventions

Parent training interventions are one evidence-based treatment approach capable of addressing children's mental health problems. In particular, parent training interventions address child disruptive behavior disorders by actively teaching parents a repertoire of skills they can apply at home to manage behavioral problems (Kaminski, Valle, Filene, & Boyle, 2008; Kazdin, 2004). These parenting skills are developed through active teaching methods such as role play and home practice exercises (Kazdin, 2005). Parent training interventions base their conceptual view of change on learning theory and research, particularly drawing from the tenets of operant conditioning (Kazdin, 2005). Treatment principles are based on the relationships between behaviors and their consequences, and typically incorporate positive reinforcement as a means to promote positive behaviors while also suggesting strategies for managing problem behaviors

(Prinz & Jones, 2003). These interventions also consistently incorporate feedback on child behavioral change into the ongoing treatment program (Kazdin, 2005).

To date, strong evidence exists in support of the efficacy and effectiveness of parent training interventions in treating a variety of child behavioral problems (Kazdin, 2004; Maughan, Christiansen, Jenson, Olympia, & Clark, 2005; Northey, Wells, Silverman, & Bailey, 2003; Prinz & Jones, 2003). The results of several decades of research on parent training interventions demonstrate they lead to significant, lasting improvements in child behavior, often reducing child problem behaviors to nonclinical levels (Kazdin, 2005). Treatment gains also frequently extend beyond the targeted symptoms to produce systemic changes in parental well-being and family functioning (Kazdin, 2005). In light of this strong research support, parent training interventions are recognized as evidence-based treatments for child Conduct Disorder, Oppositional Defiant Disorder, and Attention-Deficit/Hyperactivity Disorder (e.g., Eyberg, Nelson, & Boggs, 2008; Kazdin, 2005; Maughan et al., 2005; Pelham & Fabiano, 2008). Several of these parent training interventions appear on the National Registry of Evidence-Based Programs and Practices (Substance Abuse and Mental Health Services Administration [SAMHSA], 2011).

Parent Management Training – the Oregon Model (PMTO)

One particularly well-supported parent training intervention is the approach known as Parent Management Training – the Oregon Model (PMTO). PMTO has demonstrated favorable long-term outcomes (Forgatch, Patterson, DeGarmo, & Beldavs, 2009; Patterson, Forgatch, & DeGarmo, 2010), is based on a sound theoretical foundation (Forgatch & Martinez, 1999; Patterson et al., 2010), and has a rigorous system for monitoring implementation fidelity (Knutson, Forgatch, & Rains, 2003). The PMTO model has been implemented in a variety of program formats targeting challenging clinical populations (e.g., adolescents involved with the

justice system, neglected and maltreated children; Forgatch & Patterson, 2010). These programs have been empirically tested in a host of intervention studies and have consistently demonstrated efficacious outcomes (Forgatch & Patterson, 2010).

While research has established that PTMO leads to improvements in parent and child functioning, there is a need to further understand the processes through which the intervention promotes these positive changes (Forgatch & Patterson, 2010; Patterson & Forgatch, 2010). In particular, it is unknown what occurs during parents' exposure to the PMTO intervention that leads to resulting changes in their parenting practices. It is equally important to investigate which aspects of the intervention may be impeding successful clinical processes and which PMTO strategies help to circumvent parental resistance (Forgatch & Patterson, 2010; Patterson & Forgatch, 2010). Current empirical data on the effectiveness of PMTO provide limited insight into these issues.

In particular, applying a qualitative approach in order to explore the process of change occurring in the PMTO intervention would be highly relevant. Qualitative approaches to process research can be particularly advantageous because they permit the investigation of clinically rich phenomena, especially in areas where there is a lack of existing research (Hill & Lambert, 2004). To date, published studies have not applied a qualitative approach to gain insight into the change processes promoted by PMTO. Furthermore, no qualitative research has examined the process of change taking place in PMTO based on the lived experiences of parents who have participated in the intervention. Past research has only informed the adaptation of PMTO according to qualitative feedback from parents who had not been exposed to the intervention (Parra-Cardona et al., 2009). Therefore, a qualitative study examining how various aspects of PMTO either

facilitate or impede parents' process of change in the intervention would make a valuable scientific contribution to this area of research.

Purpose of Study

The purpose of this study was to develop a grounded theory describing the process through which parents' experiences in the PMTO intervention led to change in their parenting practices. In particular, this study sought to investigate how the content of the PMTO intervention, its method of delivery, and additional characteristics of the intervention reported by parents (e.g., relationship with therapist) either facilitated or impeded parents' process of change. Parents' experiences with PMTO associated with engagement, retention, and resistance were also explored.

To accomplish this, individual interviews were conducted with 20 parents and primary caregivers who had successfully completed the PMTO intervention in a community-based setting. Parents were asked how their experiences with specific aspects of PMTO influenced their parenting practices, according to a semi-structured interview guide designed to elicit detailed data. These data were analyzed according to the principles of the grounded theory approach, using a sequential process of open, axial, and selective coding. Throughout this process a number of measures were taken to ensure trustworthiness of the findings.

These efforts have resulted in the development of a grounded theory that describes the process of change taking place in PMTO, based on the experiences and perceptions of parents who completed the intervention. The study findings can inform further adaptations of PMTO and other evidence-based parent training interventions. They also suggest recommendations for clinical practice relevant to the field of family therapy. Through these applications, the findings

of this study can help to continue improving the services available to families experiencing child behavior disorders and other conduct problems.

Research Questions

This qualitative study examined the following main research question: What is the process through which parents' experiences in the PMTO intervention lead to change in their parenting practices? To arrive at a more thorough understanding of this process, the main research question was explored by investigating the following focal research questions: a) How does the content of the PMTO intervention (i.e., core components and support skills) facilitate or impede parents' process of change?; b) How does the method of delivery of the PMTO intervention facilitate or impede parents' process of change?; c) How do additional characteristics of the PMTO intervention identified by parents facilitate or impede their process of change?; d) Which experiences in PMTO do parents report are associated with their engagement and retention in the intervention?; and e) Which experiences in PMTO do parents report are associated with resistance to the intervention?

Theoretical Perspectives Justifying the Research Questions

Family systems theory. Family systems theory helped to establish the rationale for this study by explaining how improving the effectiveness of a parent training intervention holds promise for ameliorating child problem behaviors. The central tenet of family systems theory is that family members are more appropriately viewed as interrelated parts of a family unit than as individual entities acting in isolation (Galvin & Brommel, 2000). Therefore, family systems theory shifts inquiry away from the study of individual characteristics and behaviors toward a focus on family interaction and patterns of relationships between family members (Becvar & Becvar, 1982; Goldenberg & Goldenberg, 2000; Nichols, 2008).

Family systems theory draws from Bertalanffy's general systems theory, which emphasizes the interaction of parts within living systems, and from the understanding of feedback mechanisms available through the study of cybernetics (Goldenberg & Goldenberg, 2000; Nichols, 2008). Accordingly, family systems are understood to exhibit a number of characteristics. Like other systems, families are organized according to a consistent structure and establish some form of boundary between themselves and the outside environment (Becvar & Becvar, 2006; Goldenberg & Goldenberg, 2000). Families are also purposeful entities that work toward certain goals (Leslie, 1988). One central goal of families is to maintain stability, referred to as homeostasis (Becvar & Becvar, 1982). To monitor progress toward system goals, families utilize feedback loops to regulate their functioning in relation to data from the environment (Broderick & Smith, 1979; Goldenberg & Goldenberg, 2000). If this feedback indicates that goals are not being achieved, family systems may either break down or adapt the system rules to allow for productive change (Becvar & Becvar, 2006; Broderick & Smith, 1979).

Two additional characteristics of family systems are particularly important for conceptualizing family functioning and planning family intervention efforts. The first characteristic is wholeness, which suggests that family members combine to form a family unit that is more than the sum of the individual people who are part of it (Goldenberg & Goldenberg, 2000). As a whole family unit, any change in one family member is believed to influence the entire family unit, and any change in one family member is also partially attributable to changes in other family members (Leslie, 1988). Another related characteristic of family systems is interconnectedness (White & Klein, 2002). This characteristic further emphasizes that family members do not act in isolation, but instead influence one another in mutual patterns (Becvar & Becvar, 2006).

When family systems theory is applied to the understanding of child behavioral disorders, a child's problem behaviors are considered within the context of the family. The problem behaviors are no longer attributed to the characteristics of the child in isolation, but now become indicators of how the entire family unit is functioning. Once the family system becomes the focal point for intervention, efforts to make productive change can be directed toward transforming family interaction patterns. Family systems theory suggests there are many possible avenues for change. In particular, when a family is understood to be a whole, interconnected unit, a change in any one portion of the family will be expected to reverberate throughout the family system (Galvin & Brommel, 2000). Therefore, meaningful change to family patterns involving unwanted child behaviors can be introduced at a variety of locations in the family system.

Viewed through the lens of family systems theory, parent training interventions address child behavioral problems by teaching parents new behavioral strategies that alter family dynamics. For example, increasing a parent's use of positive reinforcement could result in more amicable interactions between a father and his daughter, so that she eventually feels comfortable enough to voice her anger at her father over a past divorce instead of acting out. Although the parents may be the direct recipients of the intervention, its effects will impact every person in the family system. In this way, parent training interventions can produce changes in child behavior as well as potentially improve the functioning of the entire family unit.

Community-based participatory research. The community-based participatory research (CBPR) paradigm informed the way in which study research questions were addressed: by privileging the perspective of parents who had participated in PMTO. More specifically, CBPR seeks to actively involve community members in the process of constructing knowledge

(Israel, Schulz, Parker, & Becker, 1998, 2001; Israel et al., 2003). Israel and colleagues (2001) have set forth the following definition:

> CBPR is a collaborative, partnership approach to research that equitably involves, for example, community members, organizational representatives, and researchers in all aspects of the research process. Partners contribute their expertise and share responsibilities and ownership to increase understanding of a given phenomenon, and incorporate the knowledge gained with action to enhance the health and well-being of community members (Israel et al., 1998). (p.184)

In the CBPR approach, collaborative relationships are developed with community partners in a way that establishes shared responsibility for, control over, and ownership of the research project while allowing each member to contribute their unique resources and expertise (Green, Daniel, & Novick, 2001; Horowitz, Robinson, & Seifer, 2010; Israel et al., 1998). CBPR explicitly acknowledges the strengths and resources that the community can contribute to the research (Israel et al., 2003). This partnership guides all aspects of the investigation, including the identification of research questions, the selection of the study design, project implementation, and the dissemination of findings (Horowitz et al., 2010). CBPR is conducted with the goal of benefiting all partners involved, but is particularly dedicated to producing outcomes that are useful for furthering the goals of the community (Israel et al., 1998). To help accomplish this, research findings are disseminated in collaboration with community partners and made available to all parties involved in the project (Israel et al., 2003). Benefits of the community-based research approach include improving the public health outcomes of the partnering community, strengthening the relevance, validity, and utility of the research findings, and facilitating the development of theory that can guide effective practice (Israel et al., 1998).

The principles of CBPR informed all stages of this research study. Specifically, collaborative relationships were established with key community partners who were responsible for disseminating the PMTO intervention in mental health settings across the state of Michigan.

The research questions and design of this study were developed together with these community partners. Even more importantly, this study was designed to include parents as key informants to the investigation. Specifically, parents who had successfully completed the PTMO intervention were invited to share their perspectives of how PMTO had influenced their parenting practices, and in this way helped to shape the theory of change resulting from this study. A rigorous methodological approach was followed in order to ensure that their experiences were fully understood and valued. Further information about how CBPR principles were applied in this study is provided in the Chapter 3.

Chapter 2: Literature Review

Process Research in Psychotherapy

The study of change. Psychotherapy process research involves the study of the various events and transformations that take place as part of a psychosocial treatment (Orlinsky, 2001). Process research enables the exploration of why and how clinical interventions produce therapeutic change. Despite the importance of such questions, relatively little is known about the mechanisms of change operating in psychotherapy treatment, including child and adolescent therapy approaches such as parent training interventions (Doss, 2004; Kazdin, 2001, 2004, 2005; Kazdin & Nock, 2003; Weersing & Weisz, 2002). Understanding the process of change taking place through parent training interventions is important because this knowledge can be used to improve clinical practice and make treatments more broadly effective (Kazdin, 2005; Kazdin & Nock, 2003).

Components of change in psychotherapy. To help facilitate the study of change in psychotherapy, Doss (2004) has proposed a conceptual and methodological framework that partitions change into three sequential components: (a) change processes, (b) change mechanisms, and (c) ultimate outcomes. According to this framework, change processes bring about change mechanisms which lead to therapy outcomes.

Change processes. Change processes are the "aspects of therapy, occurring during the treatment session or as a direct result of therapy homework assignments, which subsequently create improvements in the change mechanisms" (Doss, 2004, p. 369). Change processes are further conceptualized as either therapy change processes or client change processes. Therapy change processes refer to the actions and interventions performed by the clinician in order to deliver the treatment (Doss, 2004; McKay, 2007; Nock, 2007). Examples of therapy change

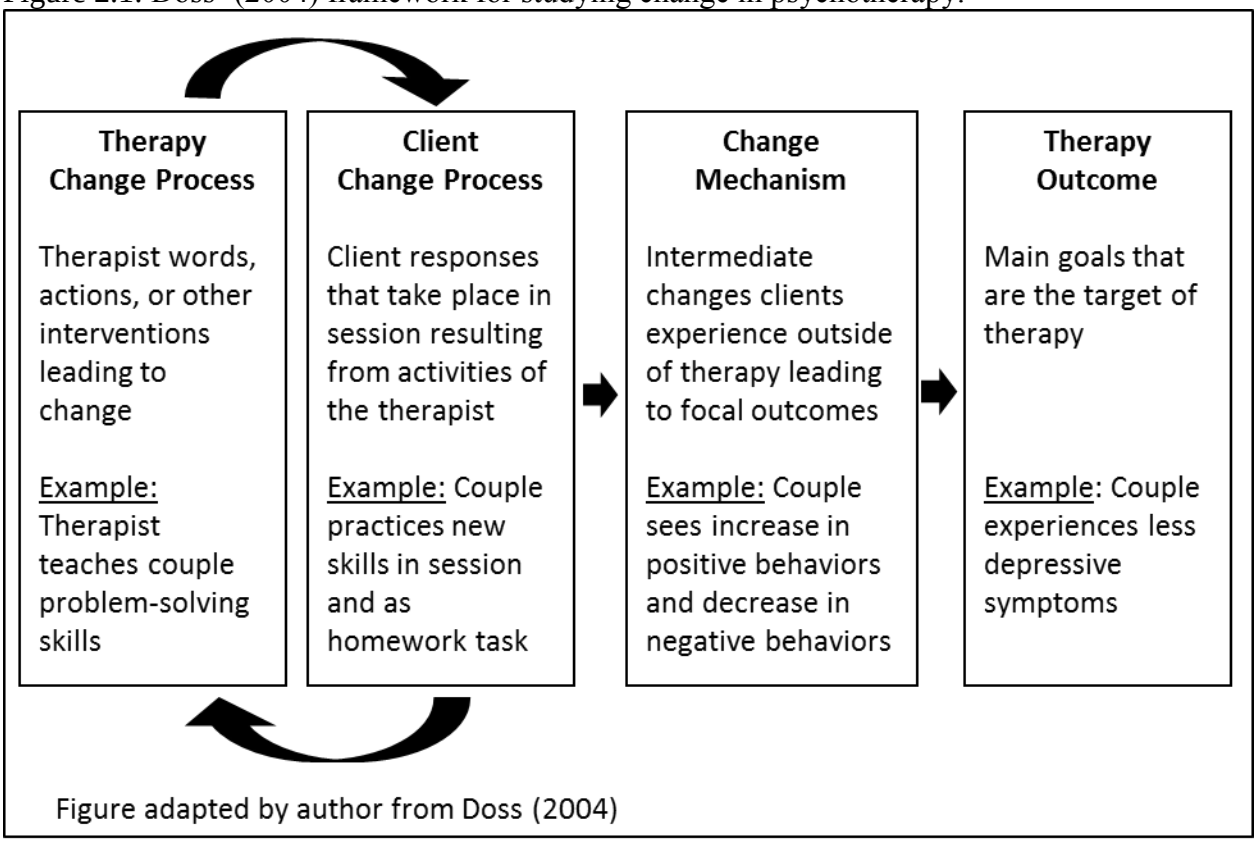
processes include adhering to a treatment protocol, teaching skills, and expressing supportive statements (Nock, 2007). Client change processes include the behaviors and thoughts of the client that take place during a therapy session in response to the therapy change processes (Doss, 2004; McKay, 2007; Nock, 2007). Client engagement and adherence to treatment and client comments made to the therapist have been implicated as client change processes (Nock, 2007).

***Change mechanisms*.** According to Doss' (2004) framework, the change processes taking place during treatment sessions result in transformations in the client's behavior that are experienced outside of therapy. These are what Doss (2004) refers to as change mechanisms. More specifically, change mechanisms are the "intermediate changes in client characteristics or skills, not under direct therapist control, that are expected to lead to improvements in the ultimate outcomes of therapy" (Doss, 2004, p. 369). For instance, improved problem-solving skills, better impulse control, and greater time spent on enjoyable activities have all been suggested as potential mechanisms of change in psychotherapy (Nock, 2007).

***Therapy outcomes*.** The final component of change in Doss' (2004) framework consists of the ultimate therapy outcomes. These are the targets of therapy usually measured at treatment termination or follow-up (Kiesler, 2004; McKay, 2007). Therapy outcomes may include decreased symptoms of depression, increased relationship satisfaction, or improvements in child behavior. Figure 2.1 illustrates the sequential progression of change processes, change mechanisms, and therapy outcomes as conceptualized in this framework.

Components of change in parent training interventions: A research agenda. Doss' (2004) framework provides a useful tool for systematizing the research to date on change resulting from parent training interventions. A key implication of this framework is that efforts to understand the progression of change occurring in treatment should proceed backward through

Figure 2.1: Doss' (2004) framework for studying change in psychotherapy.



the model. Specifically, research efforts should first determine if a treatment works by evaluating therapy outcomes before investing time and energy investigating how and why it works (Doss, 2004). Therefore, the first step in a research agenda for investigating change in parent training interventions would be to establish treatment efficacy. This goal has been achieved. As described in Chapter 1, numerous outcome studies have demonstrated that parent training interventions are efficacious at promoting significant improvements in child behavioral problems (e.g., Kazdin, 2004, 2005; Prinz & Jones, 2003).

Recent efforts to study change in parent training interventions have progressed to investigating change mechanisms. These studies use research designs and statistical methods meant to determine which client behaviors taking place outside of therapy mediate improvements in therapy outcomes (Doss, 2004; Kielser, 2004). The study of change mechanisms in parent

training interventions is becoming more prevalent through the use of mediational analysis. The primary mechanism of change hypothesized in parent training interventions is that modifications in parenting practices will affect child behavioral outcomes (Weersing & Weisz, 2002). Studies of parent training interventions have established support for the mediating effects of parenting practices and deviant peer associations on child behavioral outcomes (e.g., Beauchaine, Webster-Stratton, & Reid, 2005; Eddy & Chamberlain, 2000; Forgatch et al., 2009; Gardner, Burton, & Klimes, 2006).

The next step in this research agenda is to study change processes occurring in parent training interventions. This will involve investigating the specific therapist and client behaviors that occur during therapy sessions that set the treatment's change mechanisms into motion (Doss, 2004). In order for this to occur, a parent training intervention with an established understanding of its change mechanisms must be identified. The PMTO intervention has the necessary foundation to support initial research into its change processes.

The study of change in PMTO. PMTO stands out among other parent training interventions for the thorough attention its researchers have given to studying its components of change. Early research efforts determined that exposure to the PMTO intervention (i.e., an unspecified change process) produced changes in parenting practices (i.e., a change mechanism), which in turn led to improved child outcomes (i.e., a therapy outcome; Forgatch & DeGarmo, 1999; Martinez & Forgatch, 2001). Follow-up studies illuminated further change mechanisms operating in response to the intervention. For example, during the 30 months following participation in PMTO, reductions in child internalizing behaviors caused decreases in child externalizing behaviors, which were then associated with decreased maternal depression (DeGarmo, Patterson, & Forgatch, 2004). However, reductions in maternal depression have also

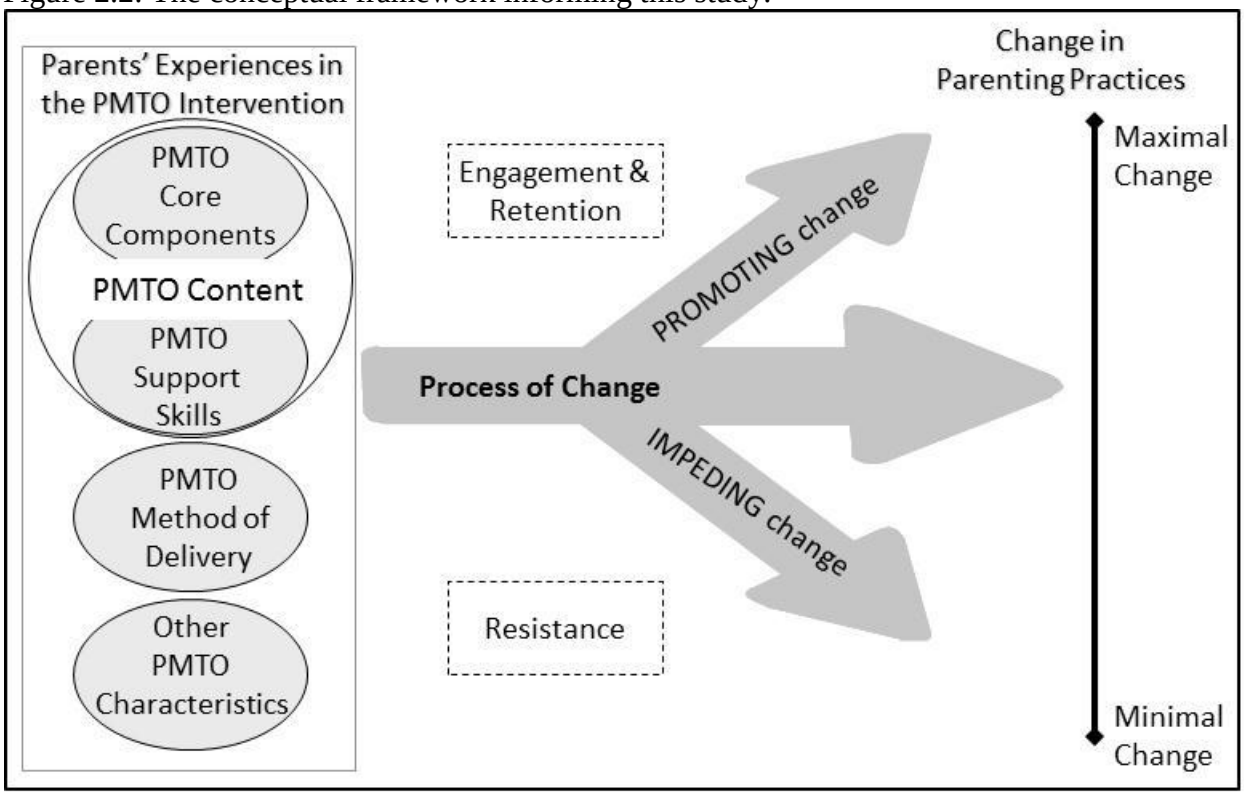
mediated improvements in parenting practices that led to reductions in antisocial behavior (Patterson, DeGarmo, & Forgatch, 2004). Overall, research on PMTO suggests that a variety of mechanisms contribute to the positive intervention outcomes, including changes in parenting practices, maternal depression, and child behaviors (e.g., Forgatch et al., 2009).

This qualitative study sought to advance the research agenda regarding change in parent training interventions by implementing an exploratory investigation of the change processes occurring during the PMTO intervention. More specifically, the process through which parents' experiences in PMTO led to changes in their parenting practices was investigated according to the qualitative reports of parents who had completed the intervention. Potential therapy change processes (i.e., PMTO content, method of delivery, additional intervention characteristics) and client change processes (e.g., engagement, retention, resistance) were explored. Qualitative investigations with participants who have completed treatment can make an important contribution to the study of change processes (Doss, 2004).

Conceptual Framework

Change processes in psychotherapy are recognized to be exceedingly complex, so it is necessary for studies of psychotherapy process to concentrate on a limited subset of variables in order to yield meaningful results (Orlinsky, 2001). Therefore, this qualitative study was guided by a conceptual framework meant to focus the areas of exploration. Specifically, this conceptual framework put forward certain aspects of parents' experiences in the PMTO intervention that were expected to lead to change in their parenting practices: the content of the intervention, its method of delivery, and additional characteristics reported by parents (e.g., relationship with therapist). The potential importance of engagement, retention, and resistance was also explored. The conceptual framework that informed this study is presented in Figure 2.2.

Figure 2.2: The conceptual framework informing this study.



The remaining sections of this literature review will present research and theory related to each element of the conceptual framework.

Parent Management Training – the Oregon Model (PMTO)

Theoretical background. The PMTO intervention is built on a theoretical foundation that integrates coercion theory and the social interaction learning model.

***Coercion theory*.** Coercion theory was developed to explain why children behave aggressively and to delineate how early antisocial behaviors are linked to later criminal delinquency (Patterson, 1982). Coercion theory grew out of an extensive series of empirical studies conducted by Gerald Patterson and colleagues at the Oregon Social Learning Center (Patterson, 1982; Patterson, Reid, & Eddy, 2002). At the core of this model is the concept of coercion, which is the process of using an aversive behavior in a way that controls the actions of another person (Patterson, 1982, 2002). Coercion operates within the small, everyday exchanges

that structure family interaction. Through repeated experience, children participating in coercive family systems learn that escalating an aversive behavior will earn them a desired outcome, usually through the process of negative reinforcement. For example, children may learn that if they scream or cry their parent will concede and give them what they want. While coercion takes place in all families, it comes to dominate the families of aggressive children because prosocial forms of behavior are not positively reinforced and negative behaviors are not effectively discouraged within family interactions. Therefore, the child learns that coercion is an effective strategy for achieving immediate rewards (Patterson, 1982, 2002; Snyder & Stoolmiller, 2002).

The coercion process may begin when children are as young as 10-18 months of age (Patterson, 2002). During this time, adverse biological and contextual characteristics may operate through the child-caregiver interactions to disrupt the parenting skills of the caregiver and produce a family environment where coercion is reinforced to a greater extent than prosocial behavior (Patterson, 1982; Patterson et al., 2002). For example, the depressed mother of an irritable infant may become overwhelmed with her responsibilities and decrease the amount of time she spends caring for her baby because he cries frequently. This disruption in attentive parenting teaches the infant that he must shriek to get the attention of his mother, whereas smiling or cooing goes unrewarded. Therefore, the infant is reinforced for engaging in coercive behavior. In this way, caregiver parenting practices mediate the relationship between contextual factors and the development of coercive interactions (Patterson, 2002).

According to the coercion model, the behavioral patterns that develop during the first year of life between the infant and caregiver set the tone for their interactions for years to come (Patterson, 2002). The difficult infant grows into the noncompliant toddler, who then becomes the antisocial kindergartener. Once in school, further processes operate to propel the child on this

troubled trajectory. Due to under-developed prosocial skills, the child is rejected by normative peers and becomes part of a deviant peer group that provides positive reinforcement for antisocial behaviors (Snyder, 2002). This leads to juvenile delinquency, and ultimately puts the child at risk for adult criminal behavior (Patterson, 1982; Snyder, 2002).

Social interaction learning model. The social interaction learning (SIL) model provides a way of conceptualizing how family members learn new behaviors (Forgatch & Patterson, 2010). It was constructed through several decades of theory development and empirical research, and describes the patterns of interaction that occur within family systems over time that result in either adaptive or maladaptive outcomes (Forgatch & Patterson, 2010; Patterson et al., 2010). The SIL model is applied throughout the PMTO intervention as a way to promote change in family systems.

The SIL model combines aspects of social interaction theory, social learning theory, and the behavioral paradigm (Forgatch & Patterson, 2010; Patterson et al., 2010). The social interaction component emphasizes how everyday interactions occurring between family members mutually shape long term patterns of behavior for each person. The social learning and behavioral elements contribute an understanding of reinforcement contingencies, and suggest that these behavior patterns become established because some behaviors are rewarded while others are not. A primary implication of this model is that parents can influence the long-term behavioral outcomes of their children by learning to interact with them in more productive ways (Forgatch & Marinez, 1999).

According to the SIL model, parents influence the development of their children through their use of positive parenting practices, coercive parenting practices, and to the extent that these practices either expose or buffer their children from challenging contextual contexts (Forgatch &

Martinez, 1999). Parenting practices are seen as the most proximal influence in the lives of children, and are therefore viewed as having a powerful and direct effect on child outcomes (Forgatch, DeGarmo, & Beldavs, 2005; Forgatch & Martinez, 1999). However, many families also face detrimental contextual factors, such as poverty, divorce, or discrimination. The SIL perspective acknowledges these factors have the potential to impact child adjustment, but specifies this impact occurs because of the ways in which these contextual factors disrupt the social interactions between the parent and child (Forgatch & Martinez, 1999; Forgatch & Patterson, 2010). Therefore, child outcomes are directly influenced by parenting practices and only indirectly affected by the external environment. While contextual factors must be accounted for in intervention programs, the SIL model emphasizes that increasing positive parenting practices while decreasing coercive tactics will be the most direct way to intervene (Forgatch & Martinez, 1999; Forgatch & Patterson, 2010).

Empirical support. The PMTO intervention has received strong empirical support and has been designated an evidence-based program capable of treating internalizing and externalizing disorders, delinquency, academic functioning, and noncompliance (SAMHSA, 2011). The positive, long-term outcomes it achieves for both children and parents have been demonstrated to extend as long as nine years after exposure to the intervention (Forgatch et al., 2009; Patterson et al., 2010).

***The Oregon Divorce Study II*.** Strong support for the efficacy of PMTO stems from the Oregon Divorce Study II (ODS II), a long-term research project initiated with funding from the National Institute of Mental Health. In the ODS II, 238 recently separated mothers with sons in grades 1-3 were randomly assigned to either an experimental group receiving a version of PMTO called *Parenting Through Change*, or a no-treatment control group (Forgatch & DeGarmo,

1999). Results revealed that after one year, mothers exposed to PMTO demonstrated better parenting behavioral outcomes than mothers in the control group. In addition, the intervention led to indirect improvements in child adjustment. Superior treatment gains were maintained at 30- and 36-month follow-ups (DeGarmo & Forgatch, 2005; Martinez & Forgatch, 2001). Nine years after the intervention, PMTO was successful in reducing rates of delinquency, reducing police arrests, and reducing the risk of early first arrest for adolescents (Forgatch et al., 2009). Furthermore, mothers exposed to PMTO experienced an improved standard of living, indicated by a greater increase in family income, a faster rate of recovery from poverty, and greater decreases in financial stress, as well as reduced risk of arrest (Forgatch & DeGarmo, 2007; Patterson et al., 2010). Such findings indicate that the PMTO intervention is capable of initiating a sequence of broad and lasting positive change within family systems.

***Additional outcome research*.** The principles of PMTO have been successfully extended to a variety of contexts. For instance, PMTO was found to be efficacious when applied to stepfamilies (DeGarmo & Forgatch, 2007; Forgatch et al., 2005). In particular, the *Marriage and Parenting in Stepfamilies* program was associated with improvement in effective parenting practices and associated decreases in child noncompliance and child problem behaviors displayed at home and school (Forgatch et al., 2005). The intervention was also shown to improve the parenting practices of stepfathers during stepfather-stepchild interactions leading to decreases in stepchild depression and noncompliance two years after the intervention. However, the stepfather effects did not persist at the two year follow-up (DeGarmo & Forgatch, 2007).

PMTO has also been successfully applied to intervene with youth involved in the juvenile justice system through an approach known as Multidimensional Treatment Foster Care (MTFC; Chamberlain, Leve, & DeGarmo, 2007; Chamberlain & Reid, 1998; Leve, Chamberlain, & Reid,

2005). Male adolescents with a history of serious, chronic juvenile offenses demonstrated significantly fewer criminal referrals following placement in MTFC than those adolescents assigned to standard group care (Chamberlain & Reid, 1998). The male adolescents in MTFC also returned to live with their families more often than those in group care (Chamberlain & Reid, 1998). In addition, positive effects have been found with female juvenile offenders. Female adolescents assigned to MTFC demonstrated reduced incarceration levels and rates of delinquency as compared to females in the group care condition at 12-month and 24-month follow-ups (Chamberlain et al., 2007; Leve et al., 2005).

Currently, PMTO is being adapted for various cultural contexts and diverse populations. Within the United States, PMTO is in the process of being culturally adapted for Latino/a and African American families. At the international level, PMTO has been disseminated in Norway (Ogden, Forgatch, Askeland, Patterson, & Bullock, 2005), Sweden, the Netherlands, and Iceland. In a Norwegian effectiveness trial, parents assigned to the PMTO condition demonstrated better disciplinary skills following intervention than parents in the control condition, while their children displayed fewer externalizing problems and greater social competence (Ogden & Hagen, 2008).

Implementation fidelity. The PMTO intervention is supported by a unique fidelity evaluation measure called the Fidelity of Implementation Rating System (FIMP; Knutson et al., 2003). FIMP is an observational measure used to quantify the level of competency and adherence displayed by an interventionist during PMTO implementation. It rates five dimensions of implementation: a) PMTO knowledge, b) session structure, c) skillful teaching strategies, d) appropriate application of intervention process skills, and e) overall session quality (Knutson et al., 2003). FIMP scores have demonstrated predictive validity, in that higher FIMP ratings were

significantly associated with greater improvements in parenting (Forgatch, Patterson, & DeGarmo, 2005). In particular, implementation fidelity during the skill encouragement and discipline sessions accounted for approximately 30% of the variance in parental improvement (Forgatch et al., 2005). The ability to assess implementation fidelity is a defining feature of PMTO that makes it an ideal parent training intervention to study.

The PMTO intervention program. The goal of PMTO is to improve child outcomes by strengthening constructive parenting behaviors and reducing coercive processes. Parents participate in the PMTO intervention in individual family sessions or in a group format with other parents (Forgatch & Patterson, 2010). Sessions generally occur weekly for 60-90 minutes, and are a structured combination of reviewing and troubleshooting previous skills, learning new material, and receiving the next home practice assignment. The PMTO intervention begins with a focus on strengths and goal-setting, and new content is then introduced in a step-wise fashion. The PMTO group format typically covers all intervention material in 14 sessions; individual treatment generally lasts 25-30 sessions (Forgatch & Patterson, 2010).

***Core components*.** PMTO seeks to promote five positive parenting practices which serve as the core components of the intervention (Forgatch & Patterson, 2010; Ogden & Hagen, 2008). The first component, *skill encouragement*, empowers parents to shape the development of competencies in their children through the use of contingent positive reinforcement. Parents are taught to do this by using incentive charts to scaffold complex behaviors that are planned in advance and token rewards to reinforce other behaviors that need to be addressed throughout the day. Both of these approaches rely on the use of tangible rewards (e.g., stickers, candy) that are paired with social reinforcers (e.g., praise, smile) in order to teach children prosocial skills (Forgatch & Patterson, 2010; Knutson et al., 2003). The second component, *limit setting*, uses

contingencies and mild sanctions to establish appropriate and consistent boundaries for child behavior. This is typically accomplished through the use of a structured time out procedure or through assigning work chores for rule infringements. Privilege removal is also used as a backup procedure if the child is noncompliant with the other limit setting approaches (Forgatch & Patterson, 2010). These non-punitive limit setting strategies ensure that the parent-child emotional bond is protected despite temporary aversive responses that children may have as a result of the parent enforcing limits and family rules.

The three remaining core components of PMTO are problem solving, monitoring, and positive involvement. *Problem solving* helps family members to learn to work together to address challenges and accomplish goals. The skills learned through this component are meant to help families manage disagreements, establish rules, and make plans for the future (Forgatch & Martinez, 1999; Forgatch & Patterson, 2010; Knutson et al., 2003). *Monitoring* involves teaching parents to track the whereabouts and acquaintances of their children. Monitoring is akin to the concept of supervision and should take place when children are at home as well as away from home (Forgatch & Marinez, 1999; Forgatch & Patterson, 2010). Finally, *positive involvement* emphasizes the importance of strengthening the parent-child emotional bond by encouraging parents to interact with their children in warm and attentive ways (Forgatch & Martinez, 1999; Forgatch & Patterson, 2010). PMTO is based on the premise that families can experience positive and lasting improvements to the quality of the parent-child relationship and to child behavioral outcomes through the implementation of these core parenting practices.

Support skills. While PMTO is defined by its core components, the intervention also promotes a number of support skills that fortify the parent training program (Forgatch & Patterson, 2010). One support skill is *using good directions*. In particular, parents are taught to

give children simple, clear, and specific directions that indicate what they are expected to do (Forgatch & Patterson, 2010; Knutson et al., 2003). The ability to provide effective directions is considered a foundational skill that enables parents to promote child compliance (Knutson et al., 2003). The next support skill is *behavioral tracking*, which guides parents to purposefully make note of focal noncompliant behaviors as well as prosocial behaviors exhibited by the child (Knutson et al., 2003). The skill of behavioral tracking includes a specific focus on child and family strengths in addition to areas for growth (Forgatch & Patterson, 2010). In addition, PMTO emphasizes the importance of *emotional regulation* as a supportive parenting practice. Parents are taught strategies for managing their negative emotions during limit setting encounters and learn to differentiate their own emotional reactions from their children's expressed feelings (Forgatch & Patterson, 2010; Knutson et al., 2003). In this way, "parents learn to give negative consequences based on the topography of the child's misbehavior, not the parents' emotional state" (Forgatch & Patterson, 2010, p. 168). Finally, PMTO encourages effective *communication*. Parents are coached in active listening and speaking skills in order to improve the quality of their interpersonal interactions (Knutson et al., 2003).

***Methods of delivery*.** The PMTO intervention is characterized by particular methods of delivering session content. PMTO sessions purposefully integrate verbal teaching methods with more active instruction (Knutson et al., 2003). One hallmark of PMTO verbal teaching techniques is the use of raps – succinct, memorable statements of PMTO principles – to convey information (Knutson et al., 2003). For example, a central PMTO rap is that "parents are their children's most important teachers" (Forgatch & Patterson, 2010, p. 167).

PMTO also includes a host of more active strategies, the most salient being the use of role play. Role play allows parents to gain an understanding of various parenting situations from

the perspective of the parent as well as the child. Role plays also allow parents to practice new skills and gain a level of confidence before utilizing them at home (Forgatch & Patterson, 2010). PMTO interventionists take care to explain each role play and to model what is expected during it so that parents can participate comfortably and successfully (Knutson et al., 2003). The role plays are followed by a period of debriefing. Parents also learn by completing home practice assignments in between PMTO sessions that prompt them to practice the strategies they are learning (Forgatch & Patterson, 2010). At the beginning of each session, parents are encouraged to discuss their experiences with the home practice assignment and the interventionist works with families to troubleshoot any challenges they are facing. PMTO interventionists also strive to facilitate the participation of all parents attending the session and to provide ample encouragement (e.g., through positive reinforcement, incentives) along with necessary correction (Knutson et al., 2003).

***Additional characteristics of the intervention*.** Along with PMTO's well-defined content and method of delivery, additional characteristics of the intervention are evaluated to ensure fidelity of implementation. For example, interventionists utilize active questioning to promote a reflexive learning process (Knutson et al., 2003). A PMTO interventionist using active questioning might invite parents to consider the benefits of using the limit setting skills proposed in the model rather than lecturing them on the superiority of non-corporal limit setting strategies. Other process-related skills include using metaphors, avoiding direct confrontation with parents, and normalizing challenges experienced by parents as they implement new parenting skills at home (Knutson et al., 2003). These characteristics foster positive and collaborative relationships with parents by creating a safe and supportive learning environment, which is expected to be important in facilitating parents' process of change (Forgatch & Martinez, 1999; Forgatch et al.,

2005; Patterson & Forgatch, 2010). This study seeks to identify these types of additional characteristics of PMTO that parents describe as important in either promoting or impeding change in their parenting practices.

Engagement, Retention, and Resistance

Engagement and retention. Engagement and retention are considered among the most crucial challenges that clinicians and researchers face in delivering interventions and studying their effectiveness (Coatsworth, Santisteban, McBride, & Szapocznik, 2001). Because families must first attend an intervention before they can be expected to experience its benefits, treatment engagement is considered a necessary, but not sufficient, precursor to successful treatment outcomes (Coatsworth et al., 2001; Cunningham & Henggeler, 1999). Furthermore, clients who are retained in treatment longer are more likely to benefit from the intervention (Kazdin, 1996). Therefore, this study will remain attentive to the possible role of engagement and retention factors as they related to parents' experiences in the PMTO intervention.

Unfortunately, treatment drop out is a significant problem in the provision of mental health services to children and their families (Kazdin, 1996; Kazdin, Holland, & Crowley, 1997). A commonly cited figure is that 40%-60% of participants who become engaged in treatment fail to be retained until treatment completion (e.g., APA Task Force on Evidence-Based Practice with Children and Adolescents, 2008; Coatsworth et al., 2001; Kazdin, 1996; Kazdin et al., 1997). Exploring engagement and retention factors in parent training interventions may be particularly important. This is because families of children with conduct problems are characterized by a number of risk factors associated with premature termination from treatment (Kazdin, 1996). These risk factors include children with more conduct disorder symptoms, high parental stress, harsh parenting practices, and greater child contact with deviant peers (Kazdin,

1996). Therefore, interventions meant to treat this population – parent training interventions, for example - could benefit from an increased focus on treatment engagement and retention.

When looking more specifically into the engagement and retention outcomes among child and adolescent therapy approaches, scholars have concluded that the current state of affairs is acutely concerning (Nock & Ferriter, 2005). Recruitment rates for family-focused prevention interventions are generally quite low (e.g., 20-25%; Heinrichs, Bertram, Kuschel, & Hahlweg, 2005; Spoth & Redmond, 2000). This is complemented by "higher than optimum" dropout rates for family-based treatment approaches, such as those targeting child conduct problems (Prinz & Jones, 2003, p. 281). Parent training interventions are not immune to this problem. It is generally acknowledged that as many as 50% of parents who begin a parent training intervention fail to complete it (Morawska & Sanders, 2006; Nock & Ferriter, 2005). This issue has clear public health implications, as reaching parents in need of services and ensuring their continued participation in treatment is an essential step in reducing child emotional and behavioral difficulties (Morawska & Sanders, 2006).

To date, few studies have examined elements related to engagement and retention in parenting interventions (Heinrichs et al., 2005; Morawska & Sanders, 2006; Nock & Ferriter, 2005). The majority of studies investigating factors related to engagement and retention have focused on sociodemographic variables, such as parent and child characteristics that are accessible from paperwork records (Morawska & Sanders, 2006; Nock & Ferriter, 2005). While the results of such investigations may be interesting, characteristics such as ethnicity, age, and educational attainment are not readily changed, constraining their ability to inform intervention improvements (Morawska & Sanders, 2006). Studying such "variables of convenience" has only produced limited gains (Kazdin, 1996, p. 138; Kazdin et al., 1997, p. 453). Instead, more studies

meant to result in empirically-based, practical strategies for increasing engagement and retention are needed (Heinrichs et al., 2005; Morawksa & Sanders, 2006; Nock & Ferriter, 2005; Spoth & Redmond, 2000).

The most useful findings related to engagement and retention in parent training interventions may come from qualitative investigations. In group-based interventions, parents frequently emphasized the importance of fostering a supportive and non-judgmental group atmosphere (Levac, McCay, Merka, & Reddon-D'Arcy, 2008; Patterson, Mockford, & Stewart-Brown, 2005; Petra & Kohl, 2010; Stewart-Brown et al., 2004). Parents preferred to learn from a variety of teaching methods, and appreciated when material was presented in a way that suggested new behaviors but did not require strict compliance (Patterson et al., 2005; Petra & Kohl, 2010). In addition, parents reported that receiving assistance with child care, transportation, and reminder phone calls all facilitated their participation (Petra & Kohl, 2010).

When parents dropped out of the intervention, most mentioned practical reasons such as work obligations or moving away (Patterson et al., 2005; Stewart-Brown et al., 2004). However, feeling patronized and being intimidated by role playing exercises were also indicated as possible reasons for dropout (Patterson et al., 2005). While these findings provide important initial insights, there remains a great need to expand our understanding of how engagement and retention factors relate to the process of change parents experience in their parenting behaviors.

Engagement and retention research in PMTO. Research on PMTO has not placed a specific emphasis on factors associated with engagement and retention, but limited conclusions can be drawn from published studies. In the ODS-II study of PMTO, 157 divorced mothers were assigned to the parenting intervention. Of these mothers, 7 only attended one group, 53 attended 2-7 groups, and 97 attended at least 8 of the 14 PMTO parenting group sessions (DeGarmo &

Forgatch, 2005). In MAPS, the version of PMTO adapted for stepfamilies, 56 of the 67 families assigned to the intervention group completed at least one session. Families completed an average of 11.71 sessions (SD = 4.71; Forgatch et al., 2005). In the PMTO effectiveness trial in Norway, 100% of the families assigned to the PMTO group reportedly received the allocated intervention, although it is unclear whether this means they completed the entire intervention or a lesser dosage (Ogden & Hagen, 2008).

Resistance. Resistance is considered to be a central construct in psychotherapy observed across the various intervention approaches (Beutler, Moleiro, & Talebi, 2002). It describes the cognitive manifestations or behaviors of clients who do not cooperate or comply with the process of therapy (Beutler, Rocco, Moleiro, & Talebi, 2001). Resistance is often conceptualized as the converse of cooperative involvement in therapy (Orlinsky, Ronnestad, & Willutzki, 2004). It is exhibited in a variety of forms, including dissatisfaction, anger, or noncompliance with therapy, resentment or oppositional behaviors directed toward the therapist, client expressions of cognitive dissonance, or helpless withdrawal (Beutler et al., 2002; Beutler et al., 2001; Clarkin & Levy, 2004). This study was interested in exploring which experiences parents reported were associated with resistance to the PMTO intervention.

A variety of explanations exist for understanding client resistance. Traditionally, psychoanalytic theory has viewed resistance as a manifestation of the client's struggle to conceal repressed material. Therefore, psychoanalytic therapists focus on interpreting resistance in order to provide the client with increased awareness of the unconscious (Beutler et al., 2001). Behavioral approaches, such as parent training interventions, propose that resistance is simply noncompliance that exists because these behaviors have been reinforced in the client's environment. Resistance is seen as an obstacle to therapy best overcome by altering the

reinforcement contingencies experienced by the client (Beutler et al., 2001; Patterson & Chamberlain, 1988). Resistance has also been considered in terms of client resistance to engagement in therapy (Santisteban et al., 1996; Szapocznik, Perez-Vidal, Hervis, Brickman, & Kurtines, 1990). These scholars assert that it is the responsibility of the therapist to intervene with clients in a way that overcomes these resistant processes. Alternatively, feminist scholars have reframed resistance as a psychological strength (Gilligan, Rogers, & Tolman, 1991). From this perspective, resistance is a demonstration that clients are honoring their own voice and experiences instead of yielding to the pressures of the dominant culture that are being expressed through therapy (Brown, 1994; Gilligan et al., 1991).

Despite these differences in conceptualization, those who study resistance agree it plays an important role in the process of psychotherapy. Specifically, greater levels of client resistance are consistently associated with poorer treatment outcomes (Beutler et al., 2002; Beutler et al., 2001, Clarkin & Levy, 2004; Orlinsky et al., 2004). Therefore, therapy approaches that diminish resistance can lead to a better prognosis (Beutler et al., 2001). Alternatively, therapists may promote better client outcomes by using more directive or less directive interventions with clients in response to their expressed resistance to treatment (Beutler et al., 2001).

***Resistance research in PMTO*.** The developers of PMTO have been at the forefront of the study of parental resistance in parent training interventions since the 1980s. They began to investigate this topic by observing videotapes of parent training sessions and categorizing resistant parent behaviors (Chamberlain, Patterson, Reid, Kavanagh, & Forgatch, 1984). The results of their efforts led to the hypothesis that the strategies employed by therapists intending to change parent behavior may be promoting parental resistance to the intervention (Patterson & Forgatch, 1985). In subsequent empirical investigations of this hypothesis, Patterson and

Forgatch (1985) demonstrated that therapist behaviors were related to client levels of compliance versus resistance in therapy. Specifically, therapists' efforts to teach or confront parents increased rates of parental noncompliance, while therapists' facilitative and supportive behaviors were associated with decreases in noncompliance (Patterson & Forgatch, 1985). This led to the conclusion that parental resistance to parent training was due, at least in part, to the behaviors of the therapist.

Subsequent studies expanded this understanding of resistance. For example, the contributions of various client variables were recognized. Specifically, parents' past discipline experiences, negative emotions, level of social disadvantage, and existing pathology were implicated in determining the level of parental resistance (Patterson & Chamberlain, 1988, 1994). Scholars now theorize it is also possible that a history of coercive processes taking place within a family can lead to structural changes that exacerbate resistant behaviors (Patterson & Forgatch, 2010). Furthermore, researchers began to recognize the broader interplay of client and therapist behaviors taking place as a result of resistance. For example, in one parent training investigation, researchers noted that when clients displayed resistant behaviors, therapists responded with more confrontation, more attempts to reframe, and began to indicate greater dislike for the parent (Patterson & Chamberlain, 1994).

Further research uncovered an important pattern of resistance operating in parent training interventions. Parents with successful outcomes often demonstrated a pattern of resistance that started at low levels, slightly increased during the beginning of treatment, and then clearly decreased by termination (Forgatch & Patterson, 2010; Stoolmiller, Duncan, Bank, & Patterson, 1993). This has been labeled the struggle/work-through hypothesis (Forgatch & Patterson, 2010; Patterson & Chamberlain, 1994; Stoolmiller et al., 1993). Parents who display these changes in

resistance over time are more likely to benefit from the intervention than parents who display either high or low levels of resistance throughout the course of therapy. Furthermore, "the failure to struggle and work through resistance issues in therapy" was a significant predictor of child arrests during the first two years after therapy had ended (Stoolmiller et al., 1993, p. 927). In response to these findings, PMTO scholars have asserted the need for further study into the therapeutic processes and variables that alter levels of resistance (Patterson & Chamberlain, 1994). They have expressly encouraged research meant to reveal what therapists can do to avoid eliciting client resistance, and specify that future research must commit to determining ways in which to reduce resistance (Patterson & Chamberlain, 1994).

However, these calls for further research have gone answered. PMTO currently incorporates a variety of teaching strategies that are thought to circumvent resistance (Patterson & Forgatch, 2010). Yet, these processes need further empirical evaluation (Forgatch & Patterson, 2010; Patterson & Forgatch, 2010). In response, this study sought to explore which elements of PMTO were associated with parental resistance, and how parents' experiences of resistance related to changes in their parenting practices. An enhanced understanding of these processes could be useful for increasing the effectiveness of PMTO when applied in community settings.

Chapter 3: Methods

Research Design

Overview of approach. This study investigated the process through which parents' experiences in the PMTO intervention led to change in their parenting practices. Specifically, this study explored how the content of the PMTO intervention, its method of delivery, and additional characteristics of the intervention reported by parents either facilitated or impeded this process of change. Parents' experiences with PMTO associated with engagement, retention, and resistance were also explored.

To address these research questions, this study utilized a qualitative research approach guided by the tenets of grounded theory while applying the principles of CBPR. Qualitative data were collected through in-depth, individual interviews with 20 parents who had completed the PMTO intervention. Data were analyzed using the constant comparative method and a sequential process of open, axial, and selective coding. Throughout this process a number of measures were taken to ensure trustworthiness of the research findings.

Qualitative research. A qualitative research approach was selected for this study so that parents' experiences with PMTO could be thoroughly explored and their insights could be applied to produce a better understanding of how participation in the PTMO intervention may lead to change in parenting practices. Qualitative research is a distinct field of inquiry that is well-suited for pursuing this type of contextualized, in-depth understanding of social processes and the meanings people attribute to their experiences (Merriam, 2009; Snape & Spencer, 2003; Willig, 2001). Qualitative research is particularly appropriate for studying clinically rich phenomena (Hill & Lambert, 2004) as well as for investigating topics that are not well understood (Ritchie, 2003). In general, qualitative findings are meant to produce a deeper and

more nuanced understanding of phenomena than can be attained through aggregations of numerical data and statistical analysis. As such, a qualitative research approach is likely to be valuable in addressing complex issues and in leading to the generation of specific hypotheses that can be evaluated quantitatively in later stages of research. As discussed in Chapter 1, utilizing a qualitative research approach allowed this study to make an important scientific contribution to the understanding of PMTO, while remaining consonant with CBPR principles.

In general, qualitative research approaches study people in their natural environments and place value on how phenomena are understood and experienced by participants (Denzin & Lincoln, 2005; Merriam, 2009; Ritchie, 2003; Willig, 2001). In particular, "the word *qualitative* implies an emphasis on the qualities of entities and on processes and meanings that are not experimentally examined or measured (if measured at all) in terms of quantity, amount, intensity, or frequency" (Denzin & Lincoln, 2005, p. 10). Qualitative research methods are particularly well-suited for studying the complexities of human experience (Snape & Spencer, 2003). In order to do so, data collection frequently involves close interaction with a small sample of participants so the researcher can gain proximity to their perspective (Merriam, 2009; Snape & Spencer, 2003) and allow for "participant-generated meanings" to emerge (Willig, 2001, p. 15). The focus of qualitative research is to interpret and convey the meaning of textual data, using the researcher as the primary instrument of analysis (Merriam, 2009; Rossman & Rallis, 2003; Smith, 2003). Qualitative data are applied inductively to develop concepts and theories, which are generally reported through rich descriptions and quotations that convey the words of participants (Merriam, 2009).

Grounded theory. The specific qualitative research approach employed in this study was grounded theory. Grounded theory is both an approach for examining social phenomena and a

set of research methods used for collecting and analyzing data (Corbin & Strauss, 2008; Strauss & Corbin, 1998). Grounded theory was chosen because it is highly congruent with the research questions guiding this investigation and stands out among other qualitative approaches because of its systematic research methods (Charmaz, 2003; Hawker & Kerr, 2007; Patton, 2002).

The core feature of grounded theory is that it seeks to inductively generate theory based on empirical data (Charmaz, 2003; Glaser & Strauss, 1967; Payne, 2007; Richards & Morse, 2007; Willig, 2001). Since its introduction in the 1960s, different variations of grounded theory have been set forth (Payne, 2007; Richards & Morse, 2007; Willig, 2001). To be precise, the approach used in this study may be regarded as a modified version of grounded theory because the research process departed in some ways from traditional grounded theory procedures (e.g., those detailed in Glaser & Strauss, 1967). For example, data collection and analysis were preceded by a review of the literature, guided by a conceptual framework, and subjected to certain pre-planned recruitment strategies in order to receive approval from the dissertation committee and relevant institutional review boards. Nonetheless, the overarching aim was to develop a theory *grounded* in the data as the end result of the analytical process.

In grounded theory research, textual data are collected and analyzed according to a set of strategies designed to allow the identification of concepts, the integration of categories, and the discovery of relationships within the data (Glaser & Strauss, 1967; Willig, 2001). Data collection, analysis, and interpretation characteristically occur in tandem and are continuously informed by one another (Glaser & Strauss, 1967; Payne, 2007; Willig, 2001). This approach is intended to result in a coherent theory that explains the phenomenon under investigation (Payne, 2007). Grounded theory is particularly applicable in research studies such as this one that aim to explore new topics, elicit the experiences and knowledge of participants, or answer questions

about process (Merriam, 2009; Payne, 2007; Richards & Morse, 2007). This approach has become increasingly prevalent over the last two decades (Payne, 2007).

The core methods of grounded theory are explained in detail throughout this chapter. To further clarify this approach, several examples of key analytic processes performed during this research project are provided in Table 3.3, located in the data analysis section of this chapter.

Applying a CBPR Approach

Review of the CBPR paradigm. The CBPR paradigm emphasizes a partnership stance to research where community members, agency representatives, and project investigators all share equitably in the research process (Israel et al., 2003). That is, community research partners actively collaborate with project investigators in all stages of the investigation, including selection and integration of the research design, recruitment of participants, implementation of the study, data analysis, and dissemination of findings. A guiding principle of CBPR is that target populations and communities are empowered and receive benefits after participating in the research process (Israel et al., 1998). The principles of CBPR informed all stages of research associated with this study.

Designing the study. The idea for this study was conceived near the beginning of 2010 when the original developer of PMTO and key personnel from Implementation Sciences International, Inc. (ISII), the non-profit organization responsible for training interventionists and disseminating PMTO, began discussing the prospect of a qualitative research study with representatives from the Michigan Department of Community Health (MDCH). A few months later the principal investigator and co-investigator met with representatives from MDCH to discuss the possibility of a collaborative project. The goal of this developing partnership was to

initiate a qualitative examination of the PMTO services being implemented in the state of Michigan in order to help improve the mental health care offered to families.

While planning this study it was important to recognize that each party needed to respond to a different set of interests and requirements (Wallerstein & Duran, 2003). For example, MDCH collaborators were involved in the statewide dissemination of PMTO and were primarily interested in a qualitative examination of the intervention implementation. This was a specific priority for them because quantitative efficacy data was already being collected across the state. The principal investigator wanted to contribute to these efforts, but was concerned that conducting a study at the statewide level would not be feasible for a dissertation. Through negotiations with study collaborators and consultation with ISII, it was agreed that the principal investigator would seek to engage in an initial, exploratory study of the PMTO intervention. This study would serve as the first step in a larger research project meant to provide a statewide, qualitative examination of PMTO that could be continued by the co-investigator's research team.

After reaching common agreement regarding the relevance of the proposed study, a series of meetings and conference calls were held over the course of several months to further refine the project objectives. As the study evolved, representatives from Community Mental Health Services of Livingston County were invited to join the partnership. These collaborators had expertise in delivering the PMTO intervention and contributed critical insights toward refining the research questions and study methodology. During the course of this study, representatives from Washtenaw County Community Support and Treatment Services and from Monroe County Community Mental Health Authority also agreed to serve as collaborative partners. Together, these community mental health representatives served as advocates for the families in their communities, helping to ensure their rights as research participants would be protected and that

the families would receive benefits from their collaboration on the research project. Many of the families exposed to PMTO had already completed lengthy efficacy assessments, and it was important this study would not represent an additional burden to them. Bringing together these collaborators has resulted in a de facto community advisory board that remained in place for the duration of the study.

Implementing the study. The implementation of this study relied heavily on the participation of community members in the research process. In this study, parents who had completed PMTO were invited to contribute their insider perspectives and expertise in order to explore the process of change taking place though PMTO and to potentially inform future adaptations of the intervention (Horowitz et al., 2010). The principal investigator became a co-learner alongside parents from the community, and both parties had the opportunity to gain knowledge from the unique skills of the other (Israel et al., 1998). For instance, the principal investigator was able to contribute her knowledge about qualitative data collection and analysis. However, only parents who had participated in the PMTO intervention could provide insight into the subjective aspects of the experience (Green et al., 2001). By expressing to parents their contributions were critical to the success of this research project, this study sought to provide an empowering experience that allowed participants to increase control over their mental health care and the mental health care offered to other families in their communities (Minkler & Wallerstein, 2003). This process of communication was facilitated by the partnerships that had been established with MDCH and community mental health representatives.

Disseminating study findings. Study findings will be disseminated to all project partners according to the formats that they have expressed would be helpful (Israel et al., 2003). For example, community mental health representatives have suggested the possibility of

summarizing study findings in an agency newsletter. They have also expressed interest in learning what parents have to say about their participation in PMTO, what is working well in the intervention, and what improvements can be made. The principal investigator has committed to synthesizing these relevant study findings and will distribute them to the collaborators from partnering community mental health agencies. In addition, the results of this study will be summarized and sent to all study participants who indicated they would be interested in receiving this material. This summary will present relevant study findings in a manner that is readily understandable and emphasizes the important contributions that participants made to this study. The results of this study will also be disseminated to representatives from MDCH, to the developers of the PMTO intervention, and within the broader scientific community in order to maximize the benefits resulting from this collaborative project.

Limitations in applying CBPR. While this study endeavored to apply the principles of CBPR during the research process, it did not achieve the standard of equal participation throughout the project that CBPR seeks to promote (Horowitz et al., 2010; Israel et al., 1998). In reality, this type of work is complex and those attempting it will inevitably make mistakes (Beckwith, 1996). A number of factors challenge truly collaborative CBPR partnerships, such as time demands, competing institutional pressures, and political dynamics (Israel et al., 1998). This study was not immune to these obstacles. Nevertheless, this research project proceeded from the beginning according to the premise that it is better to aim for the standard of CBPR and fall short – to "pecca fortiter!" (i.e., "sin bravely!"; Beckwith, 1996) – than to forgo this approach completely. Stoeker (2003) has pointed out the tendency for academics to over-analyze the application of CBPR and end up paralyzed. Instead, he argues that showing true respect for community partners entails trusting them to point out the mistakes being made and then learning

from these mistakes (Stoeker, 2003). In this way, this study can constitute an important step toward integrating the CBPR approach into research on PMTO in spite of its limitations.

Participants

Sampling sites. The sample for this study was selected from among the population of parents and primary caregivers living in southeast lower Michigan who had completed PMTO. More specifically, participants in this study were drawn from Livingston County, Washtenaw County, and Monroe County. The PMTO intervention is currently being applied throughout Michigan by the child mental health system, and the importance of studying issues of PMTO implementation among this population have been highlighted (Forgatch & Patterson, 2010).

Consistent with the CBPR principles guiding this study, the sampling sites were identified in collaboration with representatives from MDCH. MDCH collaborators took the lead in identifying community mental health (CMH) agencies that were actively disseminating the PMTO intervention and within a reasonable driving distance for the principal investigator. CMH agencies in extremely urban or rural counties were not selected as research sites because of concern that parents and primary caregivers in these communities may be exposed to unique contextual stressors affecting their participation in PMTO that would be outside the scope of this exploratory study.

The first potential sampling site identified for this study was Livingston County. MDCH collaborators made contact with the regional PMTO coordinator who was based at Community Mental Health Services of Livingston County and arranged a meeting to discuss the project. The principal investigator and co-investigator were introduced to the PMTO regional coordinator at this meeting and began to establish a collaborative relationship. This eventually led to a working relationship with this agency, and subsequent meetings were critical for addressing many

questions related to the collaborative nature of the project, including what time commitments would be asked of agency personnel and what benefits the agency would like to receive for their participation. Once these details were discussed, representatives from Community Mental Health Services of Livingston County officially agreed to collaborate on this project. As it became evident that additional sampling sites would be needed for the study, collaborators from both MDCH and Livingston County were critical in identifying further sites and in facilitating relationships with these agencies. In this way, representatives from Washtenaw County Community Support and Treatment Services and eventually Monroe County Community Mental Health Authority joined the project as collaborative partners.

Site characteristics. Livingston County has an estimated resident population of 180,967 that is 96.7% White, 0.4% Black, 0.8% Asian, 0.4% of another race, 1.3% multiracial, and 1.9% of Latino/Hispanic origin (U.S. Census Bureau, 2011a). In fiscal year 2009 (from October 1, 2008 – September 30, 2009), the Community Mental Health Services Program (CMHSP) of Livingston County served 1,813 persons. The population served was 86.7% White, 0.8% Black, 0.3% Asian, 0.4% of another race, 9.5% multiracial, and 2.8% of Latino/Hispanic origin (MDCH, 2010). While the median annual household income among all residents in Livingston County is $68,514 (U.S. Census Bureau, 2011a), persons receiving mental health services from Livingston County reported annual incomes well below the county average. Specifically, 79.8% of service recipients reported a yearly income of less than $10,000 (MDCH, 2010).

Washtenaw County has an estimated resident population of 344,791 that is 74.5% White, 12.7% Black, 7.9% Asian, 0.3% of another race, 3.4 % multiracial, and 4.0% of Latino/Hispanic origin (U.S. Census Bureau, 2011c). In fiscal year 2009, The CMHSP of Washtenaw County served 3,747 persons. The population served was 59.5% White, 24.8% Black, 0.9% Asian, 0.5%

of another race, 9.1% multiracial, and 8.3% of Latino/Hispanic origin (MDCH, 2010). Service recipients in Washtenaw County also reported annual incomes well below the county average annual household income of $54,939 (U.S. Census Bureau, 2011c). In particular, 91.4% of persons receiving mental health services from Washtenaw County reported a yearly income of less than $10,000.

The estimated resident population of Monroe County is 152,021. This population is 94.4% White, 2.1% Black, 0.6% Asian, 0.3% of another race, 1.8% multiracial, and 3.1% of Latino/Hispanic origin (U.S. Census Bureau, 2011b). In fiscal year 2009, the CMHSP of Monroe County served 1,828 persons. The population served was 90.4% White, 5.8% Black, 0.0% Asian, 0.5% of another race, 2.3% multiracial, and 2.9% of Latino/Hispanic origin (MDCH, 2010). Similar to the other sites, service recipients in Monroe County reported relatively low annual incomes in comparison to the county average household income of $53,224 (U.S. Census Bureau, 2011b). Specifically, 83.6% of service recipients reported yearly incomes of less than $10,000 (MDCH, 2010). Overall, these demographic characteristics indicate that the study sampling sites serve a primarily White, low income population.

Recruitment. Recruitment activities were carried out by the principal investigator in collaboration with CMH agency personnel who were involved in the coordination and implementation of PMTO. Each collaborator reviewed his or her case files to identify parents/primary caregivers who had completed PMTO and met the eligibility criteria for the study. CMH agency personnel then contacted these individuals by phone, briefly explained the study according to a recruitment script provided by the principal investigator, and invited them to learn more about the opportunity to participate in an individual interview. During this phone call, it was clearly expressed that participation in this study was purely optional and would not affect

potential participants' access to mental health services in any way. Agency personnel also explained the interviews would be conducted by an outside researcher and that no one from the agency, including the PMTO interventionists, would have access to information linking participants to the specific interview responses they provided. If the potential participant was interested in learning more, permission was obtained so that agency personnel could provide relevant contact information to the principal investigator so that she could follow up to provide more information about the study. Within one week of receiving the contact information, the principal investigator began trying to make phone contact with interested parents/primary caregivers to provide them with an overview of the study and an opportunity to ask any questions they had about participating. If the parent/primary caregiver was willing to participate in the study, the principal investigator talked further with him or her to confirm that eligibility criteria were met.

Inclusion and exclusion criteria. This study meant to employ inclusive eligibility criteria, so that the study sample maximally represented the population of parents/primary caregivers who had participated in the PMTO intervention in the selected counties.

In order to be included in the study, individuals had to meet six inclusion criteria. First, they had to be a parent or primary caregiver (e.g., step-parent, cohabitating partner) in a single or two-parent family. Second, they were required to have completed the PMTO intervention. This inclusion criterion helped ensure that every participant in the study had been exposed to the components, methods of delivery, and additional characteristics of the PMTO intervention that were being explored. The determination of completion versus non-completion was made by the parent or primary caregiver's PMTO interventionist. In order to have completed PMTO, the parent or primary caregiver must have attended the number of sessions necessary to learn about

each of the five PMTO core components, practice these skills in session and at home, and review and troubleshoot these skills as needed with the interventionist. Third, the parent or primary caregiver must have been seen by the PMTO interventionist during the certification phase of training or after the interventionist had received PMTO certification. The process of PMTO certification ensures that interventionists are thoroughly trained in the model and can deliver PMTO with high fidelity. Therefore, this inclusion criterion provided assurance that participants had been exposed to the true PMTO model and not a variant of the intervention. Fourth, the parent or primary caregiver needed to have a target child, at the time of the intervention, between 4-16 years old. Fifth, all individuals in the study had to be 18 years of age or older. And sixth, individuals were only included in the study if they were interested in participating in one in-depth, individual interview regarding their experiences with PMTO.

This study also applied certain exclusion criteria. In particular, individuals were excluded from the study if they did not meet the inclusion criteria, or if they: a) had a serious diagnosed mental health condition (e.g., schizophrenia) that impeded their ability to participate in the study; or b) had a serious substance abuse problem that impeded their ability to participate in the study. Participants were screened for these exclusion criteria by CMH personnel during the initial review of their case files.

Sample size. This study utilized a sample of 20 participants, which is an acceptable sample size for grounded theory research (Creswell, 2007; Starks & Trinidad, 2007; Teddlie & Tashakkori, 2009). In grounded theory, data collection typically proceeds until the point where a coding category has become thoroughly developed and adding additional data to the category does not further improve understanding (Glaser & Strauss, 1967; LaRossa, 2005; Payne, 2007; Willig, 2001). This occurrence is known as theoretical saturation (Glaser & Stauss, 1967).

Empirically-based guidelines suggest that data saturation can be achieved within 12 interviews, and that main themes in the data can be identified in as few as six interviews (Guest, Bunce, & Johnson, 2006). In this study, saturation of major themes was indicated after the eighth interview. At this point the main categories emerging from the data had been identified and additional data that were being coded only provided further instances of these major themes. Saturation of more detailed categories in the developing grounded theory was evident following the eleventh interview. At this point data coding had become redundant and new variations in the data were no longer being discovered. Data collection continued through the 20th interview for the purposes of confirming the emerging theory and in order to collect numerous examples of participants' experiences so that study findings could be thoroughly articulated.

Participant characteristics. A total of 20 parents and/or primary caregivers participated in this study. The majority of participants were female (85%) and all were Caucasian. This sample of participants was fairly diverse in terms of annual family income, marital status, age, and education level. Approximately one third of participants had an annual family income of less than $10,000, another third made more than $60,000 per year, and the final third reported annual family incomes in between these two amounts. Marital status was linked to annual family income in this sample, with participants who were married or a member of an unmarried couple generally reporting higher annual family incomes than those who were single or divorced. Participants ranged in age from 28 to 64 years old. Most participants had graduated from high school and had at least some college education. More detailed information regarding the demographic characteristics of participants is reported in Table 3.1.

In order to be eligible for this study, all participants had completed the PMTO intervention. In doing so, participants attended an average of 18 PMTO sessions (SD = 10).

Table 3.1. Demographic characteristics of participants.

Demographic Characteristic	n	%
Gender		
Female	17	85%
Male	3	15%
Annual Family Income		
< $20,000	7	35%
$20,000 - $40,000	4	20%
$40,001 - $60,000	2	10%
> $60,000	7	35%
Marital Status		
Married	6	30%
Divorce	6	30%
Single	4	20%
Member of Unmarried Couple	4	20%
Race		
Caucasian	20	100%
Age		
26 – 30	2	10%
31 – 35	5	25%
36 – 40	4	20%
41 – 45	6	30%
46 – 50	2	10%
> 50	1	5%
Education		
Some High School	2	10%
High School Graduate	5	25%
Some College	8	40%
Associate Degree	4	20%
Bachelor's Degree	1	5%
Number of Children		
1	2	10%
2	11	55%
3	6	30%
4	1	5%
County of Residence		
Livingston	11	55%
Monroe	6	30%
Washtenaw	3	15%

The mean duration of participation in PMTO was 10 months (SD = 6). Participants were interviewed across a wide range of time points following their participation in PMTO which allowed for a more complete understanding of how change was being experienced across time.

Interviews took place from within a month following completion of PMTO to as long as 53 months after completion. On average, participants in this study had completed PMTO 20 months (SD = 16) prior to being interviewed.

Participants were also required to have a target child between 4 and 16 years old at the time of the intervention. The target children in this study had received various mental health diagnoses, including ADD/ADHD, Oppositional Defiant Disorder, or a Pervasive Developmental Disorder, and were frequently reported to have severe behavioral issues that precipitated each parent's engagement in the PMTO intervention. These often included violent and threatening behaviors. For example, two children had threatened others with a knife. Many of the target children were referred because of physical fighting and destruction of property. Some children had also been suspended or expelled from school. In relating participant characteristics it is therefore important to note that the parents in this study shared a key contextual variable: Each participant had at least one child with clinically significant behavioral issues.

Data Collection

Method. Qualitative data were collected through in-depth, individual interviews with parents/primary caregivers who had completed the PMTO intervention. In cases where both parents from a two-parent family participated in this study, separate interviews were conducted. This allowed each parent the opportunity to answer every interview question, from his or her own perspective, without being influenced by the responses of the other parent. In-depth, individual interviews are a primary means of data collection in qualitative research (Legard, Keegan, & Ward, 2003; Ritchie, 2003; Rossman & Rallis, 2003). The interviews in this study all took place face-to-face with participants, as this format was believed to be more conducive for

establishing rapport (Hill & Lambert, 2004) and fostering an interpersonal context in which personal experiences and meaning could be discussed in detail (Legard et al., 2003).

In-depth, individual interviews were well-suited for this study for a number of reasons. Most importantly, they offered the opportunity to gather in-depth information from the personal viewpoint of participants (Marshall & Rossman, 2006; Patton, 2002; Ritchie, 2003). Individual interviews were chosen instead of focus group discussions because they specialize in eliciting individual experience (Lewis, 2003; Ritchie, 2003). In-depth, individual interviews also provided an immediate opportunity to ask follow-up questions in order to deepen and expand the data as well as to ensure correct understanding (Legard et al., 2003; Marshall & Rossman, 2006; Patton, 2002). In addition, interview methods permitted data to be gathered on past experiences so that participants could be interviewed after having completed the PMTO intervention (Merriam, 2009; Patton, 2002). Finally, collecting data through individual interviews was consonant with the grounded theory approach (Payne, 2007; Richards & Morse, 2007; Willig, 2001).

Procedure. At the conclusion of the recruitment process, parents/primary caregivers interested in participating in the study were contacted by the principal investigator and those meeting the eligibility criteria were invited to schedule an individual interview. Of the 23 potential participants whose contact information was provided to the principal investigator, 20 participants (87%) ultimately took park in this research study. Of the three potential participants who did not participate in the study, one could not be reached, one could not complete an interview due to scheduling difficulties, and one was not interested in participating in the research study. Participants were given the option of completing the interview within their homes, at their local CMH provider's building, at another community location more comfortable to them, or on the campus of Michigan State University. Sixteen participants chose to complete

interviews in their homes, two preferred to meet at a CMH building, and two selected other locations within the community. Interviews were offered at a variety of days and times to accommodate participants' schedules. All interviews were conducted by the principal investigator, who has had extensive experience carrying out individual interviews in other research studies.

Each interview session started with a period of rapport building, during which the principal investigator introduced herself in person, thanked the parent/primary caregiver for being willing to participate in the study, and talked informally with the participant. Establishing rapport with participants is a crucial factor in conducting successful interviews (Legard et al., 2003; Willig, 2001). The principal investigator then transitioned into a description of the study objectives and interview process. Next, the principal investigator engaged in the process of gaining informed consent from the participant, by providing the participant with the informed consent document, reviewing the consent document with the participant, answering any questions that were raised, and then obtaining the participant's signature on the informed consent document. The informed consent document used in this study is provided in Appendix A. The participant was then asked to complete a brief demographic questionnaire and description of his or her participation in PMTO (e.g., date of participation, number of sessions attended). After this paperwork was completed, the interview began. Interviews ranged in length from 39 minutes to 89 minutes with an average of 60 minutes (SD = 16 minutes). All participants received $25 as compensation for their time and assistance.

Each interview focused on exploring how the parent/primary caregiver's experience in PMTO led to changes in his or her parenting practices. Interviews were conducted in a semi-structured format, meaning that open-ended questions were asked to maintain the focus of the

interview while also allowing participants flexibility to contribute their unique insights (Merriam, 2009; Patton, 2002; Willig, 2001). Semi-structured interviews are compatible with the grounded theory approach (Richards & Morse, 2007; Willig, 2001).

An interview guide was used to standardize this process (Patton, 2002). The guide consisted of a combination of more general, grand tour questions along with specific probes that were asked if needed to elicit more detailed information (Legard et al., 2003; Lofland, 1971; Willig, 2001). For example, grand tour questions included, "Please tell me about how the topics you talked about in the parenting program [PMTO] helped you, or did not help you, with your parenting practices" and, "As you were learning about all of these different parenting skills in the parenting program [PMTO], what was it like to practice using them at home in your daily life?" When indicated, probes such as the following were used to gather further information: "How did learning through role plays help you, or not help you, with your parenting practices?" and, "Were there any topics in the parenting program [PMTO] that made you upset or reluctant to change your parenting practices?" In line with the tenets of grounded theory, the questions asked to participants evolved over the course of the study to accomplish theoretical sampling (Schrieber, 2001). The interview guide used in this study can be found in Appendix B.

Theoretical sampling. Theoretical sampling is a process that unfolds out of the simultaneous practice of data collection, data analysis, and theory development in the grounded theory approach. It is a strategy of data collection in which the researcher actively seeks to address underdeveloped categories in the data by asking interview questions meant to provide further insight into those areas (Charmaz, 2003; Glaser & Strauss, 1967; Payne, 2007; Strauss & Corbin, 1998; Willig, 2001). The purpose of theoretical sampling is to fully develop and refine data categories to ensure the emerging theory fits the data (Charmaz, 2003; Glaser & Strauss,

1967; Willig, 2001). This contrasts with statistical sampling methods which occur prior to data analysis with the purpose of producing representative descriptions of a population.

Theoretical sampling helps to focus data collection and make it more efficient (Glaser & Strauss, 1967). To do this, the questions asked during an interview will change over the course of a grounded theory study, usually shifting from general inquires to more specific probes (Schreiber, 2001). In this study, the amount of emphasis placed on certain interview questions shifted so that less-developed areas of the theory could be explored in more detail over time. For example, participants talked about certain PMTO content items early and often during the course of data collection. However, it was necessary to probe other areas, such as participants' reasons for remaining in PMTO, in order for these aspects of the developing theory to be adequately understood. Theoretical sampling is also used during the theory building stage to test working hypotheses against the data (Hawker & Kerr, 2007). An example of theoretical sampling is provided in Table 3.3, located in the data analysis section of this chapter.

Data preparation. The audio data from each interview was digitally recorded and then transcribed to preserve the language of participants. These practices are commonly recommended for capturing qualitative interview data (Legard et al., 2003; Merriam, 2009; Willig, 2001). For this study, participant interviewing, transcribing, and coding activities took place concurrently because data collection and analysis occur together in grounded theory (Payne, 2007; Willig, 2001). The principal investigator transcribed 17 of the 20 interviews, including the first three interviews, in order to become more fully immersed in the data. A confidential online transcription service performed the other three transcriptions. When transcription was performed by the transcription service, the principal investigator read through

each completed transcript while listening to the original audio recording in order to ensure the quality of the transcriptions and to review the data prior to coding.

Note taking. In addition to the verbal interview data being collected, the researcher engaged in multiple forms of note taking to capture additional data during the research project. Notes were recorded in a variety of formats throughout the process of data collection and analysis to best suit the needs of the researcher (i.e., in a word processing program, in the qualitative data analysis software used for coding, and in a research journal the principal investigator carried with her while collecting and coding data). The different types of notes recorded by the researcher are summarized in Table 3.2.

Table 3.2: Types of notes taken during the study.

Type of Notes	Note Characteristics
Field Note/ Observational Note	• Concrete statements about observed behaviors and events (Lofland, 1971; Schatzman & Strauss, 1973) • Contain minimal interpretation (Lofland, 1971; Schatzman & Strauss, 1973) • Answer questions related to who, what, when, where (Schatzman & Strauss, 1973)
Methodological Note/ Audit Trail	• Chronicle methodological process (Schatzman & Strauss, 1973) • Include operational acts, decisions, and timing (Lincoln & Guba, 1985; Schatzman & Strauss, 1973) • Can be used to establish dependability and confirmability of study findings (Lincoln & Guba, 1985; Morrow, 2005)
Reflexive Journal	• Personal introspections and feelings (Lincoln & Guba, 1985; Lofland, 1971) • Insight into self may provide insight into participants (Lofland, 1971) • Monitor biases and role in research (Lofland, 1971; Merriam, 2009; Payne, 2007)
Analytic Memo	• Written record of process of data analysis (Corbin & Struass, 2008) • Central to data analysis in grounded theory (Charmaz, 2003; Corbin & Strauss, 2008; Hawking & Kerr, 2007) • Described in greater detail in subsequent section
Sources: Charmaz, 2003; Corbin & Strauss, 2008; Hawking & Kerr, 2007; Lincoln & Guba, 1985; Lofland, 1971; Merriam, 2009; Morrow, 2005; Payne, 2007; Schatzman & Strauss, 1973	

Data Analysis

Overview. Data were analyzed according to the principles of grounded theory. During grounded theory research, data analysis takes place concurrently with data collection, and together the processes of data collection, data analysis, and theory development proceed in reciprocal fashion, continuously informing one another (Glaser & Strauss, 1967; Payne, 2007; Willig, 2001). This grounded theory analysis utilized the constant comparative method to guide a sequence of open, axial, and selective coding (Glaser & Strauss, 1967; Hawker & Kerr, 2007; LaRossa, 2005; Strauss & Corbin, 1998). Using a specific set of procedures to guide data analysis allows for a more systematic process of theory construction than afforded by other approaches (Glaser & Strauss, 1967).

Constant comparative method. At the core of grounded theory is the constant comparative method, whereby data that are being coded are continually judged against other data that have already been placed into categories (Corbin & Strauss, 2008; Glaser & Strauss, 1967; LaRossa, 2005; Payne, 2007; Strauss & Corbin, 1998). This allows researchers to identify the various properties and dimensions inherent in each category, taking into account the full diversity of the data (Corbin & Strauss, 2008; Glaser & Strauss, 1967; Willig, 2001). The constant comparative method can help researchers to distinguish between data categories and to recognize emerging subcategories (Corbin & Strauss, 2008; Willig, 2001). This may require categories to be redefined and data to be reorganized during the course of data analysis (Payne, 2007). In this study, the principal investigator used the constant comparative method throughout the course of data analysis to compare new data with data that had already been coded and grouped into categories. Engaging in constant comparison is a defining feature of the grounded

theory approach that enables the resulting theory to handle complexity and to closely reflect the data (Glaser & Strauss, 1967; Strauss & Corbin, 1998).

Open coding. Data analysis began with open coding, "The analytic process through which concepts are identified and their properties and dimensions are discovered in the data" (Strauss & Corbin, 1998, p. 101). Open coding took place as the researcher slowly read through each transcript and identified every meaningful piece of text. These units of data are referred to as indicators, and can be compared and contrasted to other indicators to identify, label, and develop concepts out of the data (LaRossa, 2005; Strauss & Corbin, 1998). Each concept identified in the interview transcripts was then given a descriptive name. When concept names are derived directly from the wording of participants they are referred to as *in vivo* codes (Corbin & Strauss, 2008; Hawker & Kerr, 2007).

As the concepts continued to develop, they were subsequently grouped into higher levels of abstraction referred to as categories (Glaser & Strauss, 1967; LaRossa, 2005; Strauss & Corbin, 1998). Categories are somewhat analogous to variables and represent analytical ideas developed from the data (LaRossa, 2005; Strauss & Corbin, 1998). Throughout the process of open coding the categories identified in the data became more robust. This happened as various concepts accumulate within a category, revealing its multiple characteristics (i.e., its properties) as well as its range of variation (i.e., its dimensions; Strauss & Corbin, 1998). By the end of open coding, the researcher had identified a large number of categories. Each category was informed by several concepts, and each concept was exemplified by a variety of indicators (LaRossa, 2005). An example of the open coding that took place in this study can be found in Table 3.3.

Axial coding. The next step in data analysis was axial coding. The focus of data analysis during axial coding is to inspect each category and to suggest how it is linked to other categories

in order to discover what relationships and patterns exist in the data (Hawker & Kerr, 2007; LaRossa, 2005; Payne, 2007). In doing so, the researcher may select a focal category and then pose a number of questions in order to hypothesize how the focal category is related to other categories (LaRossa, 2005). In this study, the researcher chose to select the categories that stood for the change processes described by parents as a group of focal categories and then explored how the other categories in the data were associated with them. These related categories, referred to as subcategories, have the ability to add greater explanatory power to the focal category/categories by describing the causes, consequences, contingencies, contexts, conditions, and covariances that exist in the data (Glaser, 1978, LaRossa, 2005; Strauss & Corbin, 1998). In other words, during axial coding, subcategories were used to develop a more thorough explanation as to the process through which parents' experiences in the PMTO intervention led to change in their parenting practices. The desired outcome of this coding stage was to arrive at a smaller number of major categories, the axial codes, which reflected the researcher's working hypotheses about the relationships in the data (Hawker & Kerr, 2007; LaRossa, 2005). An example of the analysis involved in axial coding is provided in Table 3.3.

Selective coding. Selective coding was the final activity of data analysis. During this process, the developing theory was integrated and refined (LaRossa, 2005; Strauss & Corbin, 1998). A variety of approaches can be used to assist with the integration process, such as reviewing memos, drawing diagrams, or writing a story from the data (Strauss & Corbin, 1998). In this study, the researcher found it helpful to make sketches depicting major categories and the relationships between them and to discuss the preliminary findings with project collaborators.

During selective coding, the core category emerging from the data is identified (Hawker & Kerr, 2007; Payne, 2007). A core category is one that is well-developed, central to the data,

and capable of reflecting the main theme emerging from the research (LaRossa, 2005; Strauss & Corbin, 1998). This core category is then used to draw together the body of data in a way that reflects its relationship to other categories (Hawker & Kerr, 2007; LaRossa, 2005). In this way, all other data categories are organized around the core category (Strauss & Corbin, 1998). The resulting configuration of ideas and the relational statements connecting them comprise the grounded theory. Alternatively, a grounded theory could consist of a number of related categories unconnected by a central theme (Payne, 2007; Willig, 2001).

In this study, three core categories were identified. These categories related closely to each other and reflected the main theme in the data: the process of change being experienced by participants. This main theme was then used to help organize and make sense of the other categories in the data. Selective coding continued until these other categories were related to the core categories in a way that demonstrated their contribution to parents' process of change. When this integration process was complete, the categories had been combined into a coherent theory centered around parents' process of change in PMTO. An example of selective coding is illustrated in Table 3.3.

Table 3.3: Examples of key analytic processes performed in this research study.

Analytic Process	Research Example
Theoretical Sampling: "… To collect data from places, people, and events that will maximize opportunities to develop concepts…" (Corbin & Strauss, 2008, p. 143)	As the researcher conducted the interviews and started to analyze the data, she began to identify areas in the data that were not well-developed. For instance, she noticed that many participants talked at length about what led them to become engaged in the PMTO intervention. However, it was unclear what caused them to remain in the intervention over time. In subsequent interviews, the researcher asked more specific questions about this issue. For example, she asked participants what made them want to stay in the intervention once they had started participating, or why they decided not to drop out after experiencing some type of challenge. By engaging in theoretical sampling related to this area, the researcher was able to more fully develop the category labeled *retention*.

Table 3.3 (cont'd)

<u>Open Coding</u>: "The analytic process through which concepts are identified and their properties and dimensions are discovered in data" (Strauss & Corbin, 1998, 101)	The researcher went on to analyze the data by reading over the transcripts and labeling phenomena she identified in the text. These labeled phenomena are called ***concepts*** in grounded theory. For example, the researcher discerned *incentive, praise,* and *breaking task into steps* as concepts in the data. Each of these concepts was exemplified by multiple indicators. Indicators of the concept *incentives* included *Scooby loop, sticker, and sib chip*. Next, the researcher grouped these concepts under more abstract headings referred to as ***categories***. Categories are higher order concepts with explanatory power. In this study, the researcher grouped the concepts *incentive, praise,* and *breaking task into steps* together under a category labeled *skill encouragement* because this was a common feature uniting these different concepts. The researcher further developed the category *skill encouragement* by exploring its ***properties*** and ***dimensions***. A property is a characteristic of a category that helps to distinguish between its concepts. For example, incentive, praise, and breaking task down into steps differ in their *types of reinforcement* related to skill encouragement. Incentives provide a tangible reward while praise is a social reinforcer. A dimension describes the range of variation in the category. Skill encouragement may vary along a *continuum of parental time required*, ranging from types of skill encouragement requiring little time (e.g., parent saying "good job") to practices requiring more time (e.g., writing out an incentive chart).
<u>Axial Coding</u>: "The act of relating categories to subcategories along the lines of their properties and dimensions" (Strauss & Corbin, 1998, p. 124).	In this phase of coding the researcher works to relate categories to one another in a way that helped explain the phenomenon under investigation. This is traditionally accomplished by considering a ***focal category*** in relation to other categories (i.e., ***subcategories***) that help to make sense of what is going on. In this study, the researcher found it useful to consider the category of *skill encouragement* in relation to other categories such *as good directions, limit setting, and emotional regulation*. By making these comparisons she began to understand how skill encouragement fit into parents' experiences of PMTO. Together with these other categories, it constituted an important content item of the intervention that parents were trying to learn and use in their families. This helped her to consolidate the categories in the data into main ***axial codes*** and to hypothesize about the relationships between them.
<u>Selective Coding</u>: "The process of integrating and refining the theory" (Strauss & Corbin, 1998, p. 143)	During selective coding the researcher linked the axial codes together into a coherent theory about the research topic. Traditionally, a grounded theory is organized around a ***core category*** that emerges from the data as integral to the topic being studied. In this investigation the researcher found the three core categories of *attempt, appraise,* and *apply* linked together the majority of the axial codes. From there, she integrated a theory explaining parents' process of change in PMTO according to the way in which these core categories drew together the data. In this way the researcher arrived at a ***grounded theory*** developed out of the data.

Memo writing. The act of writing memos is a hallmark of the grounded theory approach that is fundamental to the process of data analysis (Charmaz, 2003; Corbin & Strauss, 2008; Hawking & Kerr, 2007). In memo writing, the researcher writes down his or her ideas about the data, hypothesizes about potential relationships, and reflects on what theoretical notions are emerging (Hallberg, 2006; Hawking & Kerr, 2007; Richards & Morse, 2007). This process aids the researcher in exploring the data, making comparisons, defining codes, illuminating properties and dimensions, identifying relationships, recognizing gaps in the literature, and organizing ideas during the entire coding process (Charmaz, 2003; Corbin & Strauss, 2008; Glaser & Strauss, 1967). Memos also serve as a written record of analysis and theory development (Corbin & Strauss, 2008; Payne, 2007; Willig, 2001). Accordingly, the principal investigator engaged in memo writing throughout the course of data analysis.

Computer software. NVivo 9 (QSR International, 2010) software was used during the process of data analysis. This qualitative data analysis software enabled interview transcripts to be imported into the NVivo program and then coded on the computer. This allowed for the organization of large amounts of interview data and facilitated the coding process. The researcher also used the memo function of NVivo to record certain analytic insights during the process of data analysis. The primary investigator had prior experience and training using NVivo software prior to this study.

Role of the researcher. In qualitative research methods, the "personhood" or "self" of the researcher plays a central role in the research process. This is because the researcher is the primary vehicle through which data are collected, analyzed, and synthesized into study findings (Merriam, 2009; Rossman & Rallis, 2003). As such, in grounded theory, "Researchers are generally acknowledged to be co-producers of the data" (Payne, 2007, p. 85). While this human

element contributes many strengths to the research endeavor (Merriam, 2009), it is important for researchers to participate in a process of reflexivity aimed at remaining aware of their role in the research (Merriam, 2009; Payne, 2007; Rossman & Rallis, 2003). Unlike some qualitative approaches, grounded theory does not assume that researchers can set aside their biases and preconceptions (Payne, 2007). Therefore, in this study, it was particularly important that the researcher reflected on her gender, age, race, academic background, and other social locations in order to recognize and monitor how these identities may have been shaping her interactions with the data (Merriam, 2009; Payne, 2007; Rossman & Rallis, 2003). The processes of constant comparison and analytic memo writing helped to foster this type of critical awareness (Payne, 2007). The note taking activities described previously also helped the researcher to record her personal thoughts, feelings, and reactions during the research process. Finally, the researcher had the opportunity to engage in discussions with study collaborators in order to further reflect on her role in the research.

Trustworthiness

Being able to assess the reliability and validity of research findings is a critical component in the scientific production of knowledge. The standards of rigor applied in qualitative research are different than those used in quantitative research, because these approaches are based on different philosophical underpinnings (Merriam, 2009). In qualitative research, emphasis is placed on establishing the trustworthiness of the findings. Standards of trustworthiness help ensure "the conceptual and analytical soundness of the inquiry" (Fassinger, 2005, p. 163). In particular, four criteria of trustworthiness must be addressed: a) credibility, b) transferability, c) dependability, and d) confirmability (Lincoln & Guba, 1985; Morrow, 2005).

Credibility. The standard of credibility addresses the level of rigor present in the research study (Gasson, 2004; Morrow, 2005). Similar to internal validity, it is concerned with the degree to which the findings represent reality (Merriam, 2009). In this study, credibility was demonstrated primarily through triangulation of the data and member checks (Lincoln & Guba, 1985; Merriam, 2009). To accomplish triangulation, the co-investigator reviewed 30% of the coded transcripts and provided feedback to the principal investigator about the level of agreement or disagreement between the sets of codes.

Member checks were employed informally during data collection by asking interview questions meant to confirm or disconfirm the findings. During data collection, the principal investigator also met with one of the CMH representatives to discuss the emerging findings. Once data collection was completed and the final results were being integrated, a formal set of member checks was performed according to the preferences described by participants. To conduct these member checks, the principal investigator contacted study participants by phone, explained the process of member checking, and asked if the participant would be interested in providing feedback. The principal investigator then went over the main findings and discussed each one with participants, asking which areas best matched their experiences and what suggestions they had for improving the results. At the end of the phone call, participants were asked to rate the results in regard to how well they captured their experience or the experiences they thought most parents had in PMTO. Member checking proceeded until approximately one third (35%) of participants had provided their feedback. All three participating counties were represented by the member checks. On average, the member checking participants rated the overall fit of the theory to their experience as a 9.4 (Range = 8-10) on a 10-point scale. This

indicated a high level of overall fit. The feedback gained throughout this member checking process was used to further refine the results.

Transferability. Transferability is the criterion concerned with exploring how applicable the research findings may be to other contexts (Gasson, 2004; Morrow, 2005). Qualitative researchers do not assume their findings can be generalized to other populations or other settings because of the unique contextual anchoring of their research, small sample sizes, and choice not to employ statistical analysis (Lincoln & Guba, 1985; Morrow, 2005). Instead, qualitative researchers allow readers to decide if the study findings can be applied to their situations (Merriam, 2009). To enhance transferability, researchers should provide detailed information about their study. Accordingly, this study documented information about the participants, research methods, study context, and project investigators (Lincoln & Guba, 1985; Morrow, 2005). This study will also rely heavily on participant quotations when reporting the findings in order to further enhance transferability (Merriam, 2009). In addition, researchers can seek maximum variation in their sample so that study findings may be more widely applicable to other research and practice settings (Merriam, 2009). This study was successful in recruiting a sample with broad variation in terms of participant marital status, annual family income, age, education, and participation in PMTO. However, transferability to certain contexts will be limited by the lack of racial diversity present in the sample.

Dependability. The issue of dependability ensures the study is carried out in a reliable and consistent manner and that the methods of the study are clearly described so they could be repeated by other researchers (Gasson, 2004; Morrow, 2005). Qualitative researchers acknowledge that human behavior is not static and do not expect that replicating a qualitative study would lead to the same results (Merriam, 2009). Instead, they seek to demonstrate their

results are dependable and make sense in light of the data collected (Merriam, 2009). Dependability is established using many of the same methods as credibility (e.g., triangulation; Merriam, 2009). In addition, dependability can be demonstrated by keeping record of an audit trail. An audit trail includes information such as the timeline of research activities, factors influencing data collection and data analysis, a record of developing concepts and themes, and analytical memos (Morrow, 2005). In this study, the primary investigator kept an audit trail and consistently informed the co-investigator of key methodological decisions. The experience of the co-investigator in conducting qualitative research further enhanced study dependability.

Confirmability. Lastly, the standard of confirmability certifies that the research findings are grounded in the data rather than the assumptions, biases, or beliefs of the researcher (Gasson, 2004; Morrow, 2005). While asserting that completely objective research is not possible, qualitative researchers rely on the criterion of confirmability to maintain the integrity of findings (Morrow, 2005). To demonstrate confirmability, the researcher must indicate how the data were analyzed and used to arrive at the results. Similar to dependability, confirmability is customarily addressed through the use of an audit trail (Lincoln & Guba, 1985; Morrow, 2005).

In addition to keeping record on an audit trail, the principal investigator included other project partners in the process of substantiating confirmability. Throughout the process of data analysis, she worked closely with the co-investigator to remain transparent about her research process. Study findings were also shared with participants during member checking to strengthen the CBPR approach as well as to monitor confirmability.

Consideration of Key Human Subjects Issues

This study implemented the procedures necessary for reducing the risks to research participants associated with this investigation. Before the initiation of research, this study was

approved by the Institutional Review Board of Michigan State University, the Institutional Review Board of MDCH, and relevant personnel at each partnering CMH site. Each Institutional Review Board required an application that thoroughly detailed the procedures in place for protecting human subjects. These applications included, but were not limited to, the key human subjects issues addressed in this section.

One risk to participants was the possibility of feeling pressured or coerced into participating in this study when initially recruited by the CMH interventionist, who may have been their therapist. To reduce this risk of coercion, the interventionist followed a recruitment script when contacting participants that clearly stated that study participation was optional and would not affect the mental health services they may already have been receiving at the agency. Furthermore, these initial recruitment efforts did not ask parents/primary caregivers to agree to participate in the study, but were limited to asking if they would be interested in learning more about it from the principal investigator. Participants were informed that the CMH interventionist would not have access to the record of who eventually participated in the study and who did not. Potential participants had several opportunities to decline participation in the study, such as over the phone during the call from the principal investigator, by leaving a voicemail for the principal investigator, or by not returning the phone calls of the principal investigator.

A second risk to participants was if community mental health personnel were given access to information connecting the name of the parent/primary caregiver to his or her interview responses. To minimize this risk, project data were kept confidential and were stored securely in a locked file cabinet or on a password-protected computer in a locked office on the campus of Michigan State University. The only people with access to the personal identifying information of participants were the principal investigator and co-investigator. Furthermore, interview

transcripts were de-identified so the name of the participant was not associated with the transcript; any other personally identifying information contained in the transcript was also removed or de-identified. Study findings are reported without reference to any uniquely identifying feature of participants that might be used to link them with their data. Study collaborators agreed with this need for confidentiality and were invested in protecting the rights of the families in their communities.

In addition, it was possible that participants may have been at risk of experiencing distress during the interview while disclosing certain demographic information or reflecting on negative experiences they may have had with the PMTO intervention. In response, participants were reminded of their right to refuse to answer any question during the interview and to withdraw from the study at any time without penalty. None of the participants in this study expressed an extreme level of anxiety during the interview, although a plan was in place to refer clients to specialized services in the community if this had occurred.

Chapter 4: Results

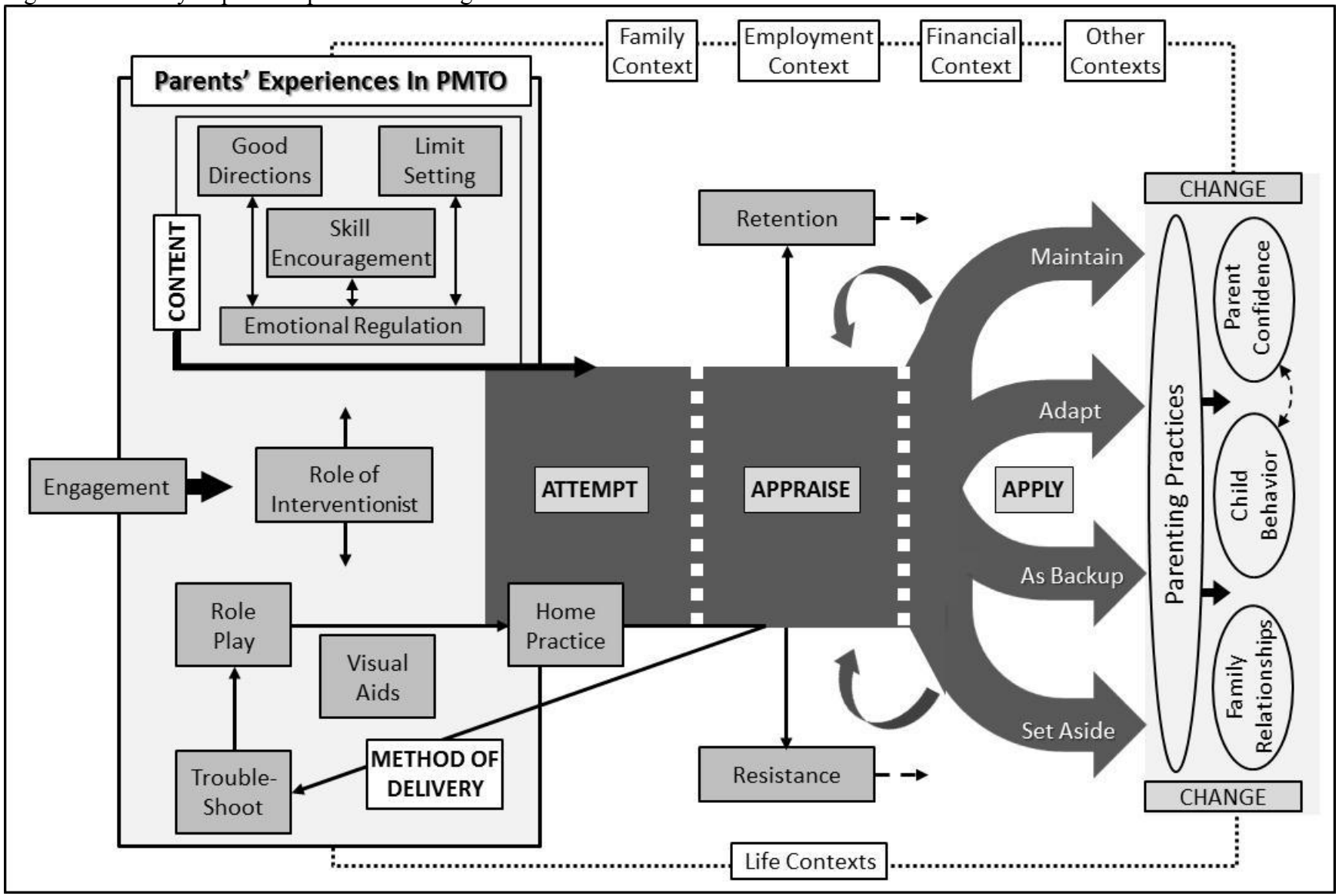
The goal of this study was to investigate the process through which parents' experiences in the PMTO intervention led to change in their parenting practices. This study has resulted in the development of a grounded theory that explains this process of change based on the experiences and perceptions of PMTO reported by parents who had successfully completed the intervention. The theory is visually depicted in Figure 4.1.

Three major categories emerged from the data, revealing parents' process of change took place through their efforts to attempt, appraise, and apply the PMTO intervention material within their multiple life contexts. The changes they achieved in their parenting practices then led to improvements in themselves, their children, and their family relationships.

The development of other categories helped to further explicate this process. The PMTO content items of good directions, skill encouragement, limit setting, and emotional regulation were identified as important. In particular, parents reported that learning about these parenting strategies helped facilitate their process of change. Examining the method of delivery of PMTO suggested that role play, home practice assignments, troubleshooting, and visual aids helped parents to practice the PMTO intervention material and experience greater success in these efforts. The role of the interventionist was also recognized as an additional PMTO characteristic that was central to promoting growth in parenting practices.

In addition, the findings suggest that parents became engaged in PMTO after facing challenging circumstances and realizing they needed to seek assistance with their parenting efforts. Parents are retained in the PMTO intervention as they see it is working. And while the parents in this study experienced little resistance overall to the intervention, when resistance did occur it resulted from doubts that the intervention material would actually be effective.

Figure 4.1: Theory of parents' process of change in PMTO.



Findings of the Main Research Question: The Process of Change in PMTO

The main research question posed in this qualitative study called for an examination of the process through which parents' experiences in the PMTO intervention led to change in their parenting practices. In answer to this question, three major categories emerged from the data. These categories came together to describe a process through which parents *attempt*, *appraise*, and then *apply* what they have learned in the PMTO intervention, within their multiple life contexts, leading to change in their parenting practices. These efforts resulted in improvements to the parents[1] themselves, their children, and their family relationships.

Attempt. Participants described their efforts to attempt what they were learning in the PMTO intervention as the first step in their process of change. When attempting the intervention, parents would start to practice the PMTO parenting strategies in session with their interventionist, often through role play. One parent (Participant #16) described her experience attempting in session what she had learned:

> We did scenarios. She would be the parent and I would be the kid. [Or] I would be the parent, she would be the kid. So we did hands-on with the strategies, different things that she was trying to teach me.

Another mother (Participant #09) provided this example of attempting good directions:

> One of us would be the kid and the other would be the parent. And we would have to, she would throw a coat on the floor and say, "Okay, give [son] direction to pick the coat up." So then we'd practice it. "[Son], pick up the coat now, please."

As parents began to master a skill, they were sometimes asked to go home and practice with their partner or another adult during the course of the week. As one mother (Participant #12) remembered:

[1] This study included both parents and primary caregivers. However, for ease of reading and to protect against referring to any uniquely identifying feature of participants, the term *parent* will be used for both parents and primary caregivers when reporting results.

> She would have us [mother and her partner] role play for the week with each other and see words to use, phrases to use. And then the next week she'd sit down with us and say, "Okay, what did you guys do? What do you think is going to work? Are you comfortable doing it?"

When parents felt confident with their successes at role playing a parenting skill, they would transition to implementing these skills at home. One parent (Participant #19) shared her experience as she first tried PMTO at home. She explained:

> You're still a little bit nervous like especially without having somebody in the house that has heard the PMTO language too. You get nervous like what if I do that wrong? Or during it you're kind of like walking through the steps, like okay at first I do this, I give the good direction, I do this, then I do this…. Because I felt like I didn't want to do anything wrong because I really wanted it to work.

In addition to being nervous, a common theme that parents reported was how it was sometimes awkward to attempt these new parenting strategies at home because their children were unsure how to respond to these changes. One father (Participant #06) remarked, "[Daughter] was cracking me up. She is a firecracker like you wouldn't believe. [She would say], 'Stop talking that way….Why are you both talking that way?' Still, the whole time, she's still carrying her laundry to the laundry room…" Another parent (Participant #02) recalled, "It was funny when I would try to talk like that because I didn't talk like that….It just wasn't the way we talked….And they were just like, they didn't know how to respond to it other than laughing."

Yet in spite of their discomfort over trying something new, parents found their experiences with attempting the PMTO intervention material to be beneficial in helping them begin to transform their parenting practices. In the words of one mother (Participant #11):

> Once you start doing it…you'll role play it, and role play it, and role play it. And then a couple weeks of that, then you start it with your kid. Then the next week you go back and talk about how things went and where were you having issues and then you do it again, and again, and again. It's like basic training.

Appraise. The next step in parents' process of change was appraisal. During appraisal, participants continually evaluated their experiences with PMTO in order to assess the merit of

the various parenting practices and to inform their decisions on how they would apply PMTO in their daily lives. The appraisal process began as soon as parents were introduced to the PMTO intervention material and persisted from that point on. Parents' appraisal efforts can be thought of as a filter of experience through which they judged each PMTO content item in light of certain considerations they found important. In practice, the appraisal process took the form of a series of questions that parents asked themselves regarding their perceptions of PMTO and experiences with different intervention components.

The most critical question parents asked in order to appraise the PMTO intervention centered on its perceived effectiveness: Is PMTO working for my family? This issue was highly relevant to parents and was often one of the first things participants commented on when asked to describe their experience in the intervention. For instance, one mother (Participant #12) immediately shared, "I liked it. Figuring out what worked for her and seeing that hey, she could actually listen and when rewarded she'll do what she's supposed to do. I didn't know she could actually behave that well." Another parent (Participant #14) responded, "It's been good. It's helped a lot. I mean I was getting zero compliance. Now I get 70% to 90%." When sharing their appraisals of PMTO and its components throughout the course of the interview, participants continued to focus on this issue. In the words of one mother (Participant #07): "But it worked, I can't say enough, like I can't complain the something didn't work because it works. I mean, we're an odd family, and things don't always work….and this works."

Parents' appraisals of PMTO's effectiveness influenced their use of the intervention. Satisfactory appraisals were encouraging to parents and helped to promote positive momentum in PMTO. As one mother (Participant #19) explained, "So, I always got really excited to go home and like try something. And then when I saw that it was working I'm like yes! So you get

excited." In general, parents tended to utilize the components of PMTO that worked for them and to set aside those that were not having the desired effect. One parent (Participant #07) shared her view that, "I think you need to take what… works for you and works for your kids and use it and if the other stuff doesn't work, don't use it." A father (Participant #06) shared such an experience, saying, "So what I did is I remembered the things that truly did work, the ones that didn't we stopped using right away. Obviously you don't put into practice something that isn't working." However, this was not always the case. A minority of parents decided to persist with PMTO even though it did not seem to be working for them. One mother (Participant #01) acknowledged:

> It's a work in progress that I hope to have a success at the end. But it's not, I haven't really had any success yet I guess….You learn stuff and you implement it but until there's true success at the end it's hard to say that this or that was successful in my life at that point. But it's all tools and stuff that I've kept.

While the most common point of appraisal for parents was whether or not PMTO worked for their family, other questions were also considered. It was important for some parents to evaluate whether they could consistently implement the various aspects of PMTO. For example, one mother (Participant #08) explained how she thought that using incentives to encourage positive behavior in her children was a good idea, but that she was not using this strategy because it was difficult for her to implement:

> It's hard for me to stick to them, me specifically, to stick to those types of things because I forget. I mean, it's hard for us to do allowances because I forget to pay the kids and then like a month goes by and we're trying to figure it out. So it was hard. It's a good thing and my kids actually responded to that very well, it's just mom was the failed part in that whole thing 'cause I would forget to do stuff or whatever.

Other parents appraised PMTO according to how well PMTO fit with their existing worldview on such issues as encouragement, authority, and punishment. As one mother (Participant #18) expressed, "I'm also a person who doesn't like to punish. I've never been big on punishing. And I really like that this isn't really big on punishing either." In addition, a small number of parents

talked about evaluating PMTO according to their own family of origin experiences. For example, one participant (Participant #15) made the following comment after learning to say "please" while giving her children a direction:

> So that was hard because I don't recall my mom - and I know his [husband's] parents - didn't say please and all that stuff…. I don't recall growing up with this. It's a whole new concept for me… 'cause neither one of us grew up this way.

Apply. In the third step of this process, parents went on to apply what they had learned in the PMTO intervention based on the conclusions they had drawn while attempting and appraising the parenting strategies throughout the course of the past two steps. In the application phase, parents implemented what they have learned in the PMTO intervention in a manner that integrated their current perceptions of the parenting material with a consideration for their various life contexts. In particular, parents applied what they had learned in the PMTO intervention according to four pathways of application: (a) maintaining implementation, (b) adapting the strategies, (c) using PMTO as a backup, or (c) setting the skills aside.

Maintaining implementation. Parents who followed the *maintaining implementation* pathway were committed to practicing PMTO strategies in their daily lives, and aimed to do this according to the original methods that were modeled in the intervention. When sharing their experiences in PMTO, parents who were applying a PMTO skill in this manner confirmed that they were putting into practice what they had learned in the intervention. Some did this through direct statements similar to this mother (Participant #10) who stated, "I mean we still use, you know, how they said to give directions." More commonly, parents provided examples of this type of application from their daily lives. For example, one mother (Participant #16) said, "Well I do still say, 'Pick your toys up now, please.' And I do go up to him and ask him to do something versus like [being] out of the room." Another parent (Participant #14) provided this detailed example of how she has been using the limit setting sequence taught in PMTO:

> Then [I] would say, "[Daughter]….pick up your book bag and place it by the door now please." Then she'll start in. Then you walk away, you say, "That's not listening. Now, if you don't pick up your book bag you'll be placed in a time out." And while you're waiting for them to do it you count…. One, then you count three seconds, two, then you count three seconds, three, then you count for three seconds, four, then you count to three seconds, and then five. Then at five she gets a five minute time out. Then you put her in a place where you know every time she's gonna have to go there for a time out.

A common theme among parents who were maintaining implementation was that over time these PMTO strategies would be integrated into their lives and become habit. As one mother (Participant #18) explained, "Once I start rolling with it it's gonna become habit and it will be really easy. It'll be like yeah, there's this and that and this and that and I know it all now." Other participants shared how they were already experiencing this occurrence. As one mother (Participant #11) explained:

> It all falls into place with the language that they teach you to use. And it takes a while to get into that….And it's just learning that language. And it sounds so simple, but it's not. When you're stuck in the house over Christmas break and everyone is stir crazy and the kids don't want to go outside because it's cold. It is, you gotta stop and think sometimes. And then it will just become habit….The language will become habit for you.

Often parents were invested in implementing PMTO in this manner because they believed, like this father (Participant #06), that "the best way is obviously just to do it and never stop doing it."

Adapting the strategies. Another major pathway of application was *adapting the strategies*. Parents who implemented PMTO in this manner were also committed to utilizing PMTO in their lives on a regular basis. However, they preferred to modify some of the skills to better fit their life contexts. In general, parents chose to adapt what they had learned in PMTO in order to respond to children growing older, to avoid monotony, and to ultimately try and make the parenting strategies work better for them. For example, one parent (Participant #11) described making changes to traditional charting by turning it into a countdown where her children could earn more substantial rewards. She explained, "Well, we [did] do a star chart….Ten stars and then you get a little prize. Well, they're prized out with little goody bag

prizes….So, we've been doing charts where you get a toy if they can go five consecutive days without hitting." She goes on to clarify, "And it has to be five consecutive days. I'll start, I'll put numbers up and say 5-4-3-2-1. And as soon as he messes up I'll rip that down and put 5-4-3-2-1 up there [again]."

Most frequently, parents felt compelled to modify the parenting strategies in an effort to make them more effective. As one father (Participant #06) disclosed:

> And obviously I'm no PhD in psychology, I shouldn't really be intermingling it all, but I know what works, I've seen what worked, and I have no option because I have no other ideas. So I'm going to try to hybrid them and it's what I do. It's what I do at work. This idea is good and this idea is good but I don't get invested in anything. I'm a technical expert. My job is to look at the facts and make it work.

For example, one mother (Participant #17) found that in order to make good directions work for her family she had to alter the wording when she spoke to her children. She expressed that, "[Interventionist] did the please and thank you with me. And I tried it and they just laughed and laughed like I was a joke. So it's like I changed the words around, [saying], 'Do it now.'" Although her children sometimes accuse her of being mean when she speaks this way, she replies, "Well, that's the only way you guys will respond to me. If I tell you 'please' or 'thank you,' you just laugh at me. So do it now." Another parent (Participant #20) explained how she discovered that her son was more responsive to limit setting when she had him select an appropriate consequence for his noncompliance. She described that:

> Sometimes I would even ask him okay, what consequences do you think that you deserve for this particular action? I would make him think. You know, [interventionist] didn't give me that idea, but I kind of came up with that one on my own. But I would make him think about it. Hmmm, what do you think? What privilege do you think that you ought to lose for doing this?

Using PMTO as a backup. Instead of implementing the PMTO strategies all of the time, a third pathway of application for participants was to use them only when they would be most useful. This was a very pragmatic approach described by parents who were often busy and

experienced many demands on their time. Interestingly, parents often described seeing changes in their children's behavior following their participation in the PMTO intervention to the point where consistently implementing the parenting strategies was no longer necessary. These parents often used PMTO as a backup that they could call upon when needed. As one mother (Participant #08) acknowledged:

> I didn't feel like I needed to continue doing the constant "now, please." I feel, like I said, we don't do it all of the time. Now I only do it when I feel like they're not really focusing or paying attention to what I need to get done and then I will use it.

Another parent (Participant #07) shared her reasons for deciding to use a certain strategy, where skill encouragement is fostered through the use of incentive loops, more sparingly:

> It was working, we did the positive thing, but eventually the loops were all over the house, I'm vacuuming them up 'cause I don't even care to bend over and pick them up. But I still do have a bunch and every once in a while I need to go back to them. So it has been, it's been a tool where, I just sometimes I pull it out to see, sometimes I put it away for a while. But I use the basics and then sometimes I pull out…you just have to pull it out once in a while.

In addition, similar to parents who chose to make adaptations to avoid monotony, some parents decided to use the PMTO strategies on a more limited basis for this same reason. As one mother (Participant #11) explained:

> We did star charts so much that they kind of got sick of that and I like to, I could keep a chart running all the time, but I don't want to lose the novelty of it because what do I do then after that?... So, I really like the charting for that but I don't want to use it too much. So when I notice bad behavior creeping up again I'll bust out a chart.

Setting the skills aside. The final application pathway that emerged from the data was *setting the skills aside* because they were no longer deemed useful by the parent. Some of the parents interviewed did stop utilizing certain PMTO strategies because they were not working for their family or had worked in the past but were no longer effective. One mother (Participant #02) explained her experience struggling to implement the PMTO strategies like this:

> I tried 'em, and I tried 'em and then I got to the point where I'm like, okay once in a great while it would help. It was nothing. It wasn't like he would do it like maybe four out of the five times. It was whenever he felt like it. And so, even if I would do it and do it and then he would never do it…so I basically said okay, forget it then.

Another parent (Participant #17) spoke about how she had to stop using incentives with her children because of their extreme reactions:

> But the reward thing, I tried the reward thing too, like if they accomplish so much. We talked about the dollar menu at McDonalds, stuff like that. No! It started, then she started going into constant fits, wanting it more or less every time we passed McDonalds. She'd have to have the McDonalds. And it was good fits to the point, she got so aggressive with me at times, she would grab me by the hair on the head when I was driving and stuff.

In contrast to these cases, most parents who reported they were no longer implementing aspects of PMTO explained this was because the strategies they were using had successfully transformed their child's behavior and therefore were no longer needed. As one parent (Participant #07) expressed, "I think the biggest successes were, like I said, using the stickers, using the Scooby loops, that kind of stuff. And then not having to use them anymore because it was working." Another parent (Participant #09) related:

> Do I use incentives right now? No, I've kind of I guess gotten away from the incentive…Right now they're doing things more right, I don't have to use incentives to get them. It was more just [to] develop the good behaviors.

Finally, a small number of parents stopped implementing certain techniques because they believed their child was getting too old or was tired of them. This was similar to the reasoning shared by certain other parents who adapted the strategies or chose to use them more sparingly.

Engaging in a process of change over time. As parents described their process of change over time, three additional considerations became clear. First, parents' process of change did not take place as a linear progression starting with attempt, then going on to appraise, and ending with application of the strategies. Instead, it continued in a cyclical fashion over time. Parents' first attempts to implement an intervention component influenced their appraisal and

subsequent application of this parenting strategy. Then, over time, they reappraised their use of this intervention component and based future decisions about applying the parenting strategy on such continued reappraisals. Therefore, their process of change was ongoing and responsive to changing life contexts. This characteristic is reflected in Figure 4.1 by two smaller arrows curling right to left, indicating that change is taking place in a cyclical fashion.

Second, while parents described four pathways for implementing the PMTO intervention, each parent did not limit their application to one discrete course of action. Instead, it was normal for parents to utilize different forms of application over time and across parenting strategies. At first, parents were most likely to apply the parenting strategies just as they were learning in the intervention. Parents who perceived that the strategies were working tended to maintain their application of these strategies. After a while, some of these parents may have been able to apply these strategies less frequently because they were working to improve their child's behavior and were needed less often. Alternatively, parents who perceived the parenting strategies were not working usually engaged in some type of adaptation. A few parents never found a way to make a certain strategy or strategies work for them, and they eventually stopped using them. However, most parents did find a satisfactory way to adapt the strategies to their context. Over time, they may have applied these adapted strategies less often as their child's behavior improved.

While it is difficult to make generalizations across parents' experiences, at the time of their interview, just under half of the parents were primarily maintaining implementation of the parenting strategies. Slightly less than that were primarily adapting the strategies, and it was less common for parents to be using the skills as backup or setting the skills aside. Yet, there were exceptions to this pattern. Some parents had set aside charting or using incentives as a means for skill encouragement and had begun using other practices such as relying on verbal praise. In

addition, many parents had adapted the limit setting component because they preferred to use the privilege removal strategy as compared to time out, or had found the need to alter the time out strategy in another way. While these trends are informative, it is best to recognize that parents' experiences applying the PMTO intervention were dynamic, influenced by the cyclical nature of their process of change, and responsive to their changing life contexts.

Third, as parents discussed their experiences implementing PMTO over time, they agreed that having access to a booster session or some other type of opportunity to review the PMTO material would be very beneficial. Some parents talked about how a booster session would help influence them to continue implementing PMTO. One mother (Participant #14) expressed that "A booster course…would be great because it helps you keep more on track and focused." Other parents talked about how attending a booster session would give them a means to correct mistakes they were making or to learn new ways of applying PMTO as their children grew older. In addition, some parents believed they would benefit from the encouragement of other parents who were experiencing similar situations. As one mother (Participant #20) shared:

> Because sometimes when we're in the middle of such incredible frustration, sometimes you might forget. You might forget just how to handle something…. So I think it would be awesome to be able to touch base with other parents….It helps sometimes to know that you are not alone, other people are having the same doggone difficulties that you are. And we can encourage each other and we could boost each other up and say, "Hey, you know what, I get ya. I understand. You're not alone." So that'd be so cool.

Taken together, these three considerations help to provide a better understanding of parents' process of change over time. In particular, parents efforts to attempt, appraise, and apply the parenting material were cyclical and dynamic in nature and may benefit from a booster session that would help to refresh their knowledge of PMTO over the course of time.

Influence of life contexts. As parents went through the process of attempting, appraising, and applying the material in the PMTO intervention, they were influenced by their various life

contexts. In particular, parents in this study identified multiple life contexts that had an effect on their experiences in PMTO or the process through which the intervention led to change in their parenting practices over time. This section will outline the different life contexts and how they influenced participants in this study

Family contexts. Parents frequently mentioned the significance of their family context. More specifically, they discussed what it was like to be parenting together with another person, to be divorced, or to be single. Some parents also had other family members involved with the caregiving and shared how this related to their experience with PMTO. While each of these family contexts posed different challenges, parents commonly emphasized the importance of consistency and support.

Two-parent context: "Being on the same page." The main theme for participants in a two-parent context was the importance of being on the same page with the other partner. However, participants talked about how they often contended with a lack of consistency across parents. One mother (Participant #08) commented, "I just think it's a struggle because we both see parenting totally different." Some participants speculated that differences in parenting could result from dissimilar family of origin backgrounds. One husband (Participant #04) expressed, "My wife and I were brought up in different households with disciplines that were different." Other parents attributed this to contrasting parenting histories. As one parent (Participant #09) stated, "I think the challenge for our family was more so between me and [partner]. Only because of her already raising children and me never raising children." Still others offered additional explanations. Participant #08 maintained, "I think it goes back to him being more pessimistic and me being more optimistic about things and we just see through different lenses."

At the same time, many parents had found that the PMTO intervention helped them to become more consistent as a couple. One father (Participant #04) confirmed, "I mean, it did help us [with] being on the same page." Another parent (Participant #08) agreed, "I do think it kind of helped us both come more on the same page. We still struggle on some areas, but I think we did come together more so than not." And when this consistency was reached, parents reported multiple benefits. For instance, parents were able to better support one another's parenting efforts. One parent (Participant #10) described:

> Together now here we both do the same thing. She might do hers in a different way than what I do mine, but I mean we both still work on it. And if I say this then she goes along with it. Or if she says this than I [go along].

In particular, participants shared that when both parents learned about PMTO, they could help one another when implementing the intervention strategies. One mother (Participant #12) recalled, "What I would fall back on he would be there to fix it or pick up where I left off. I think it was actually very helpful." Some parents also reported that taking part in PMTO together helped to improve their couple relationship. For instance, Participant #12 went on to conclude, "It made us build each other up a little bit more."

Divorce context: "So that's been my monkey wrench." Participants who were divorced reported facing greater challenges to the consistency of their parenting. One issue they struggled with was parenting alongside an uncooperative former spouse. One mother (Participant #11) explained:

> Their dad is large and in charge. He's a very scary guy and my son is terrified of him. And he will come in here and say oh, how stupid this is blah, blah, blah. "You're still doing that?" And any time I build something he wants to tear it down…. Even if he did think something is a good idea he would never say that. And he would do everything, anything he could to knock that idea down….So that's been my monkey wrench, is the other parent.

Another mother (Participant #14) described how it was difficult to implement PMTO when her ex-husband would not help reinforce their daughter's new skills. She remarked, "It didn't get done. Because I wasn't there to do it, supervise it, and he wasn't gonna [supervise]. So it is hard when you have one parent compliant and one not. Because it was gonna get done his way."

In addition, parents found it was difficult to strive to make changes in their children's behavior using PMTO when their children lived a portion of the time in another household. One mother (Participant #08) stated, "I think the biggest challenge is they go from here to their dad's [house] and they have two totally different environments….I think it's hard to try to get their minds changed back into the mindset to come back here…" Another mother (Participant #02) responded, "The thing that was so bad is that the time that they spend with their dad, everything was funny. There was no discipline. So, the four days a month that they were gone it was [a] free-for-all party." She went on to report, "Whenever they would come back from being with him it would take me two to three days to get them back to where I had them when they left."

Finally, parents talked about the difficulties inherent in adding step-parents to the family context. One father (Participant #06) reasoned that exposing children to multiple parenting influences made it harder for the positive practices of any one parent to make a difference. He said, "So these kids have four different styles of parenting that they're dealing with. And it doesn't matter how good one parent is." Another parent (Participant #08) remarked how a step-parent plays a different role in the family and that this needs to be taken into consideration when implementing the parenting practices taught in PMTO. She explained, "I think even with discipline, you have to be careful where a stepparent is involved….But I think we have to be careful just because, I just think there's boundaries sometimes where stepparents are concerned."

Single parent context: "It's just mom." A common theme that emerged among the single parents in this study, all of whom were women, was how they were solely responsible for the caregiving. Some parents talked about experiencing a lack of support and sense of isolation. One mother (Participant #19) commented, "It's a little bit harder when you're single parenting through it because you kind of feel like there's nobody to troubleshoot with at home." Sometimes children were also sensitive to these circumstances. As one parent (Participant #03) shared, "His fear factor probably was, if mom's not here, who's gonna pick up the pieces? There was simply nobody else…and there still isn't. I mean, who? There is no family close by. And his dad doesn't see him." Similarly, another mother (Participant #02) observed, "I think part of that is they like totally freaked because we don't have anybody. It's just mom."

Some mothers were concerned about their children growing up without a father and struggled to try and fulfill both of these roles. As one mother (Participant #01) acknowledged:

> I don't know how to be a mom and a dad. I mean, I know how to be a mom. I don't know how to be the dad, never have been. You know, it makes it very difficult on a parent to try to figure that out when there's no help.

Another mother (Participant #07) highlighted the challenge she faced deciding whether or not to introduce a boyfriend into her children's lives versus being concerned about leaving her children without a male role model. She explained:

> I think that sometimes [it] is on a case to case basis, like you know if men you're dating should be involved or not. Because [son] wants it and needs it. I think as a single mom it is my job to fulfill those needs. And also I feel like a safety level…my daughter needs male attention and if I didn't have a good man in my life….she will go and talk to like weirdos at the playground.

Other caregiver context: "Maybe if they got some information." During the interviews, participants were asked if anyone besides the child's parents helped out with parenting inside or outside of the home. In the cases where other caregivers were involved, grandparents were the ones engaged in the parenting. Parents described how it was challenging when these additional

caregivers were not able to implement PMTO. One mother (Participant #14) expressed how it was, "Difficult. Absolutely, completely difficult. Because, like with my mom, [I'd say],'Mom, when you talk to [daughter] about doing stuff it's helpful when you say [describing PMTO sequence]'….But when my mom doesn't do that it creates behavior issues." Most parents believed it would be beneficial if this other caregiver could become familiar with PMTO. One parent (Participant #13) explained:

> I think overall if anyone comes into that situation like ours where they have someone else like a grandparent who is babysitting the kids in the afternoon, I think it would be really helpful if that person was involved. Or as involved as they could be…. Overall just how to deal with them the same way we are, have the same reinforcement.

Another parent (Participant #16) suggested, "I'm thinking maybe if they got some information on it maybe it might make more sense to them and then they're not gonna say, 'Well, why you doing that?'" However, not all parents agreed that exposing grandparents to PMTO was necessary or would be effective. One mother (Participant #14) dismissed the idea, stating, "My mom won't take it. She's too old."

Employment context. Parents who were employed outside of the home reported this limited the amount of time they were able to spend with their children. One father (Participant #13) explained:

> I worked 11-8 [o'clock]…so I got them up in the morning, got them to school…I was able to do that, but I wasn't really able to do homework, able to do anything like that. So overall it just, I don't know, working weird shifts like that just seems to get in the way.

Another father (Participant #06) reported, "I wake up, get ready to leave, and as I'm leaving I wake up the oldest for school. That's my parenting influence in the morning." In the words of one mother (Participant #02), "[I] kill myself working all these hours and trying to spend time with them and trying to do all this school stuff with them, because that suffers."

Parents described how being away at work for long hours made it difficult to supervise their children. One mother (Participant #15) remarked, "I worked odd shifts. I worked first shift and then midnights then this and that and I'll be sleeping and it's like they end up getting in trouble." Another mother (Participant #10) expressed her discouragement with her similar situation. She acknowledged:

> It's hard to monitor your kid when you're at work….you just never got that break or that breathing room or any of the successes that you were looking for when you leave your kid home and you're trusting them. But then you find out that this, this, and this happened while you were gone. You know, it's hard.

Participant #02 described the tension she experienced between pressures to work and the importance of being home to supervise, saying, "You know you gotta work…you gotta do this to survive. But, you also need to make sure they're not hurtin' each other and stuff like that."

While these parents described the PMTO intervention as helpful, they also reported that the demands of their employment made it difficult to implement. One mother (Participant #12) admitted that it had been a struggle to try and work on skill encouragement with her daughter now that she had been working more hours. She reported:

> I don't feel very involved much anymore. Most mornings I'm not getting her dressed and ready for school which is what one of her charts was. The only one I feel like I have anything to do with is bedtime. And that's a rough way to go. You know I'm just getting home. She hasn't seen me all day. They're getting wild and she doesn't want to go to bed.

A father (Participant #04) spoke about how his work demands limited his ability to assist his wife in implementing the intervention. He remarked that his work context "made it a challenge for the fact that I was not home to support as much as I could have been just because I traveled a lot." Another parent (Participant #14) described how difficult it was to try and practice PMTO when she would not see her daughter until very late at night:

> I was unable during the school year to do most of that. But if they had Christmas off or [other holidays] and I had her those days we didn't have school I'd do it in the morning. Like on the weekends we could do it in the morning. But my job just didn't give me the opportunity working 3-11. It's really hard. Trying to find a daytime job is even harder.

Overall, parents' employment context affected their ability to attempt, appraise, and apply the PMTO intervention because it limited the amount of time parents were able to spend with their children. Many parents felt they did not have adequate time to perform even basic parenting functions. This made their efforts at implementing PMTO a much greater challenge.

Financial context. Many of parents in this study were dealing with moderate to high levels of financial strain. For instance, participants described struggling with factors such as unemployment, the financial burden of separating or divorcing, low paying jobs, and a history of bankruptcy. The reports of these parents were quite evenly split between those who reported their financial context affected their experiences in PMTO and those who said it did not.

Some parents agreed their economic strain constituted an obstacle for attending and implementing PMTO. One mother (Participant #03) recalled, "I remember gas was an issue to put in my car just to come to counseling every week. And I remember thinking, wow, I wonder if I can do this because of the gas prices." It was also common for parents to express having trouble affording incentives, a key element of the intervention. One father (Participant #13) agreed that finances were an issue, "Just because she might want to go see a movie. And [what] if you don't have the money that week to go see the movie?" Another parent (Participant #18) explained how she had been using a token incentive known as a Scoopy loop to positively reinforce her son's behavior. She recalled, "I'd just see him do something [compliant]…and I'd just give him a Scooby loop. And then I told him when he saved up all the loops, he could go and buy a toy." She goes on to express her concern that, "He's still got them all saved up. I just, I'm hoping that I get some money before he gets them all."

Other parents reported their financial strain was not an issue. For instance, one mother (Participant #17) explained that she did not incur a cost for participating in PMTO. She said, "Well with PMTO they come here, so I don't really have to leave the house. But if I have to [go] out and stuff, that's when I fall into [financial] problems." Another mother (Participant #01) took pride in the fact that she had always made sacrifices to get her son the services he needed:

> I don't make a lot of money…. But, I have always done what I needed to do for my kids. You know, I give up everything for myself for them….Even when I was struggling trying to find somebody to help him I went to different agencies, like therapists and stuff. I paid out of pocket, whatever it was.

In some families it appeared that financial strain was having more of an indirect effect on parents' experiences in PMTO. One mother (Participant #15) remarked, "We're always financial by paycheck to paycheck. But, you still have to push on even though you're tired and drained emotionally from other stuff." Other parents found that financial pressures created time demands that kept them from implementing PMTO with their children. One parent (Participant #18) commented, "It's just a matter of practice and it's just difficult right now because of all this." She went on to explain how she is selling many of her possessions because the family is in need of money and how this process has been very time-consuming. A more common time demand parents talked about was having to work long hours to support their family.

Overall, parents in this study experienced a variety of financial contexts. A small number reported their lives were free of financial stress, but many participants were facing one or more financial challenges. When asked how these financial challenges impacted their experience in PMTO, parents were roughly equivalent in expressed their financial situation constituted an obstacle and in stating that it did not. The data also suggested ways in which participants' financial context had an indirect effect on their experiences implementing PMTO.

Other contexts. Participants also mentioned a number of other life contexts that played a role in how they experienced the PMTO intervention. One context mentioned by parents was when a child or parent was diagnosed with a severe mental illness. One father (Participant #04) remarked that while PMTO was helpful, it was really finding the correct diagnosis (i.e., Schizophrenia) and the right medication that made the biggest difference in his daughter's behavior. Another important context parents described was dealing with physical health issues. One parent (Participant #17) reported that her children's behavior digressed after she was unable to implement PMTO for a while because she was severely ill. She recalled, "I went down with the bronchitis really bad to the point I was on the couch….and right there everything slacked. They were going behind my back cycloning everything." Another parent (Participant #14) spoke about how her daughter had an adverse reaction to some medication and took several months to recover. During that time this mother halted her implementation of PMTO because she did not feel it was appropriate to do under those circumstances.

Other parents reported they experienced the loss of a loved one during their participation in PMTO. This was a difficult situation for both parents and children alike. Furthermore, participants acknowledged they or their children sometimes participated in counseling services in addition to PMTO. This influenced their mood and behaviors as well. A few of the mothers also disclosed an abuse history that influenced how they felt about relationships and punitive forms of discipline. Finally, many parents pointed out the influence of maturation and aging and the differences they noticed in parenting as their children grew older. These additional life contexts certainly exerted various influences on how parents were able to attempt, appraise, and apply the PMTO intervention.

Resulting improvements. In this study, parents described how they attempted, appraised, and applied what they were learning in the PMTO intervention, within their multiple life contexts, to arrive at changes in their parenting practices. They went on to report how these efforts resulted in improvements to themselves, their children, and their family relationships.

PMTO helped me [the parent]. Following their involvement in PMTO, participants noticed how the changes they had achieved in their parenting practices led to broader improvements in themselves as parents. A main theme that emerged from participants' interviews was how their experiences in PMTO gave them more confidence and self-assurance in their parenting. One mother (Participant #08) explained how PMTO helped her feel more confident about her parenting abilities even though she often faced pressures as a single parent:

> I felt like I had everybody trying to tell me how to parent….It'd make me feel like an inadequate parent. So when we started taking this it made me feel more positive about my parenting because…I felt like everybody was trying to tell me what I should do, how I should handle my children…or making me feel guilty for the way that I handled [them]….I just think that it did help me refocus on myself and say, you know what, this is how I'm going to do it and the rest of you, let me do this myself.

Another parent (Participant #01) expressed how PMTO helped her feel more credible as a parent because she knew the parenting strategies she was implementing were sound. She said:

> As a parent you do things when your kid is like, you know, resistant to what you do. But then they know that you're seeing somebody and you're getting help and stuff. So like when you implement something different they know it's actually coming from somewhere else. So, it kinda helped.

Other parents talked about feeling more in control as a result of PMTO. As one mother (Participant #11) remarked, "It helped me – it's not that it's made me feel different as a parent – it's made me feel like I'm in control in a positive way." Another parent (Participant #20) observed, "In a lot of ways it has made me a stronger person in as much as I knew that I had just a little bit more control over what is going on in my household." In one case, a mother (Participant #17) acknowledged that she had been afraid to set limits prior to PMTO:

> I had trouble standing up against my daughter after what she did to me. I was scared to even be around her alone…. So at that time she was running my household…. Doing those classes, testing some of the stuff out, it kinda helped me to get over what had happened and not be so scared to say, "No, it don't work that way. Go ahead and throw your fit. When you're done, you're still gonna do it."

In addition to feeling more confident and self-assured, parents also talked about how PMTO had helped them to help their children be more successful. One mother (Participant #05) expressed, "[My interventionists] helped me. And if they didn't help me, then how could I help them? It was me. They had to help me so that I could help them. So it was me that they changed." Another mother (Participant #07) praised her experience in PMTO, saying, "I got the help that I needed that helped [son]." Similarly, Participant #09 shared how helping her sons was a motivation for her:

> In order for these two little boys to grow up to be productive young adults, it's gonna be based on my parenting skills….So, I'm gonna be the best parent that I can be and I think that's where this class has helped. It's helped me be more disciplined, keep me in check so that I can keep them in check and teach them the right things.

PMTO helped my child(ren). Along with experiencing changes in themselves, participants noticed improvements in their children's behavior. The majority of parents commented on the progress they had observed in the outward behaviors of their children. One mother (Participant #07) expressed, "The fact that [son] has not been suspended at all this year, the fact that oh my gosh, [daughter] can clean her room. You know, less arguments." Another parent (Participant #20) reported, "He listens better. He doesn't have those insane tempers he used to….. He's not kicking or punching, doing any of that stuff he used to do, breaking things….So that's huge." In particular, it was common for parents to have detected improvements in compliance. A mother (Participant #16) remarked, "I was able to get him to do a lot more things. And you know, he did listen a lot better." A father (Participant #13) said, "In general, I can just get her to do what I need her to do. So from that, from my standpoint it's just

overall being able to get her to mind better." One mother (Participant #18) was so excited about the improvements she witnessed that she made the following exclamation about PMTO and her parenting manual. She declared, "This is good. This is like a good little, kind of like *The Hitchhiker's Guide to the Galaxy*, this is like *The Child's Bad Behavior Guide to Perfection!"* Other parents had noticed smaller improvements. As one mother (Participant #15) shared, "Even putting the seatbelt on…is a challenge….And [I] only have to say it once or twice [now]. His mouth is going to argue with you, but he's doing it. Before, his mouth was going and he wasn't doing it."

Another parent (Participant #09) went into detail explaining how at the beginning of PMTO the family had participated in an activity where they were planning a pretend vacation together. She recalled, "If you had watched the video tape of the first session, it was a disaster. The kids were under the table. They wouldn't listen. They were just not focused and obviously we couldn't get them to focus…" This mother went on to describe the difference after they had completed PMTO and repeated this same activity. She said, "I would love to see the video because we functioned more as a family. They were interested, they were involved, they were taking part in the decision making, they were good listeners. They weren't under the table."

These reports were supplemented by accounts from parents who had also recognized improvements in the internal state of their son or daughter. One mother (Participant #03) shared, "I notice when he comes home now he's just calm. He is a calm person now. There is not that anxiety that was always there, and the agitation. There isn't the picking, the meanness." Another mother (Participant #20) recalled, "I saw a lot more smiles out of my youngest one….He truly enjoyed the encouragement that he got." One parent (#08) reported an even more drastic change, observing that her son, "doesn't talk about wanting to kill himself or be dead anymore."

Other parents observed increases in self-esteem and confidence. One mother (Participant #08) talked about how learning new behaviors had led to increased feelings of self-efficacy in her children. She explained:

> When they do something that they've done themselves, without my help, it's a new sense of pride for them. Even with the youngest…she has a hard time with independence and even with picking out an outfit for school…and when she does it by herself she's proud of herself, you know….I think it's just recognizing that they can do it.

A father (Participant #13) expressed the joy he experienced seeing the changes in his daughter:

> Just to watch her, she has more confidence now too. She makes better decisions now. She knows when to ask for stuff, when to try something, and when not to. So I think overall just to see her change…it wasn't something that we necessarily thought we'd see or even knew about but…it was a very nice kind of ending to it.

In a manner similar to how participants expressed that growth in themselves as parents was important in promoting changes in their children, some parents observed that noticing changes in their children helped them to feel better about their parenting. Therefore, there was some indication of a reciprocal relationship between these two outcomes. One mother (Participant #05) acknowledged, "She's doing awesome and I feel good. And I feel like I didn't fail her. I feel happy." Another parent (Participant #12) expressed, "Mine and her relationship is a lot better. We don't argue anymore. You feel better about yourself and you see that in her too. It builds you guys up." In addition, Participant #14 shared:

> It felt good when [daughter] would do what I asked her to do. 'Cause I was getting zero compliance. And then at first I was getting about 50[%] to 60[%]. Then I was so excited when I got like 70[%]…. [It] made me feel better as a parent, that I actually did something without yelling at her today or having to take away [a] privilege.

PMTO helped improve our family relationships. In addition, parents were aware of a variety of improvements that had taken place within their family relationships as a result of the PMTO intervention. Improvements in the parent-child relationship were most commonly noted. One mother (Participant #05) shared, "She hated me. She didn't want to be in the same room as

me. [Now] she's going to a women's Bible study with me. She'd rather do that than go…with the teenagers. She's just blowing me away." Another parent (Participant #12) described:

> We actually get along better. She hugs on me more. She wants to do things with me more. She tells me I'm the best mom….So it's made our relationship a lot better. She doesn't look at me as a big mean person that yells all the time anymore.

Similarly, Participant #07 shared a touching change she had encountered:

> I think that we've had a mundane day and I'm like, "It's time for bed." And [son] comes out and he gives me a hug and he's like, "Thank you." And I'm like, "For what?" And he's like, "I don't know… I had a nice evening."

She went on to explain such indications that she is fostering a close relationship with her children are important to her because she sometimes feels pressured because she is not raising them in a traditional family. Or, in her words, "not being so like Ward and June cleaver around here."

A few parents had also observed changes in other family relationships. For instance, one mother (Participant #09) remarked how PMTO had promoted a positive relationship between her two sons. She said, "Honestly I think this whole program has actually brought them closer together….It's really brought the two closer together as brothers. And I think it's strengthened their relationship." And, some parents had seen the whole family benefit from their experience with PMTO. Participant #09 believed that in addition to bringing her sons closer together, "[PMTO] has brought the family together as a whole." As another parent (Participant #05) shared, "What I've found in the end is that there's more peace and joy and happiness. And we all got along better. And the threats and the hurting and the anger and stuff started going away."

But PMTO did not fix everything. Despite parents' excitement over the improvements they experienced following PMTO, it is important to note that PMTO did not fix everything. One mother (Participant #02) remarked, "Yeah, there's times when I wanna say that they don't respect me…It's like a teenage thing." Another parent (Participant #17) said, "My kids are bull-headed. So I still have issues to this day with them." Some parents were still concerned about

certain behaviors their children exhibited. One mother (Participant #03) explained, "He's still kind of a hermit….and I really don't know what the tool is gonna be for him to get more outgoing." Participant #08 maintained that "I think he still needs some counseling. Specifically, one-on-one just to help him learn how to deal with his anger and how to deal with just interacting with people." Other participants acknowledged that even after PMTO, they still struggled with parenting at times. One mother (Participant #07) admitted, "I still do, I still get overwhelmed."

Summary and synthesis. Study findings revealed that parents experienced change in their parenting practices as a result of attempting, appraising, and then applying what they learned in the PMTO intervention. In particular, parents' efforts to apply the intervention material occurred through maintaining implementation, adapting the strategies, using PMTO as a backup, and/or setting certain skills aside. These change processes were cyclical in nature and responsive to parents' changing life contexts. In this study, parents recognized the effects of their family context, employment context, financial context, and other life contexts. They also reported how they experienced improvements in themselves as parents, in their children's behavior, and in their family relationships as a result of the changes they were able to make. The process of change parents experienced in the PMTO intervention is illustrated in Figure 4.1.

Findings of Focal Research Question A: The Content of PMTO

The content of the PMTO intervention emerged as the most highly salient aspect of parents' experience in PMTO. Participants spent the majority of their time during the interviews discussing their perceptions and use of the various parenting strategies. Subsequently, four of these content items - two core components plus two support skills - emerged as major and consistent facilitators of parents' process of change: good directions, skill encouragement, limit setting, and emotional regulation. Two additional topics, family problem solving and monitoring,

are considered central to the PMTO intervention but appeared to be less central to parents' experience of the intervention. This section presents each of the content items parents discussed as significant in their experience of PMTO as well as the various elements inherent to each of these parenting strategies.

Good directions. The parenting skill of giving good directions is presented toward the beginning of the PMTO intervention and helps parents learn to give effective directions to their children in a way that promotes compliance (Forgatch & Patterson, 2010; Oregon Social Learning Center [OSLC] & Implementation Sciences International, Inc. [ISII], 2006). This content item was the most prominent aspect of PMTO for participants and was described as having the biggest impact on their parenting practices. Numerous parents made comments to this effect. One mother (Participant #09) stated, "Good direction. That was the first part of it and the strongest part of it, was to give good directions. The same type of direction every single time." Another parent (Participant #08) shared, "Just asking them to do something and using the now please. That was huge for our family." Participant #16 explained why learning about good directions had been so helpful to her:

> It helped a lot with my patience, you know, 'cause then I realized it wasn't just him ignoring me, it just, he really probably didn't hear me. And I had a tendency to have him do three, four things. "[Child], go upstairs, go get your shoes, [child], make sure you wash your face and hands and…" You know what it's like. So it helped a lot.

In the words of one mother (Participant #19), "It changes the whole way that you're thinking….If you don't learn anything else, the good direction."

Elements of good directions. As participants talked about giving good directions, several principles integral to this skill were evident in their accounts. These principles help to explain how giving good directions led to the changes in parenting practices that participants were experiencing.

Using "now, please." One feature that stood out to parents when learning to give good directions was the emphasis placed on using the phrase "now, please." One parent (Participant #07) poked fun at the way this was a central focus of her experience in PMTO. She explained, "That was the catch phrase, the now please, now please, like now please. Now. Please. Not later, now please." Parents recognized this wording gave children a clear timeframe for when this behavior was expected. Participant #14 put this simply, "So it's giving them a clear direction, what you want them to do, and you're saying 'now, please' – 'now' so they know you want them to do it now." Yet, incorporating the word "please" helps the direction to come across in a kind and respectful tone. One father (Participant #13) talked about how this can be thought-provoking for parents in the way they perceive their children:

> It almost reminds you to say please, it reminds them to ask instead of just demand and it just kind of brings it more, you know, they're little people…You almost don't think of them as little people but they are. So it kind of puts that in your head more.

A few participants were hesitant to use the word "please" when giving their children a direction. Still, most participants reported incorporating this phrase into their parenting repertoire and finding it to be effective.

Getting the child's attention. A second principle identified by parents was the importance of getting the child's attention before giving a direction. One parent (Participant #09) expressed, "The program was structured so it taught us how to address the kids. Get their attention without being…I don't know what the right word is, but not being mean I guess is simplest way to put it." Parents mainly talked about getting this attention by saying the child's name and making eye contact. One mother (Participant #16) shared, "Like instead of yelling across the room to your kid, '[Child], clean your room up!' I would go up to them, get their attention, say '[Child], pick up your room now please.'" Another parent (Participant #11) emphasized, "With [son] you have to, whatever you're doing you always have to make eye contact with him or he will just blow

you off." One mother (Participant #19) observed that combining this principle with the now please phrase, as instructed in PMTO, circumvented many of the excuses her child used for noncompliance:

> You know you call their name, "Hey [child] come on, pick up your shoes, put them in the closet now, please." Okay, you can't say you didn't hear me. You can't say you didn't know I was talking to you. You can't say well I didn't know you wanted it done now. And well you didn't ask nice. Any excuse that he could have given me before seemed to be covered as long as I was doing the good direction right.

Being simple and specific. Another important principle of a good direction for parents was being simple and specific. One father (Participant #06) talked about how PMTO, "helped reinforce the need for simplification. This is how you say it, this is what will happen. Don't go into any extra, ain't gonna do you any good." Another parent (Participant #05) affirmed that, "Yes, I have to tell them exactly what I want done and how I want it done." Participants came to understand that giving simple, specific directions to their children could help avoid conflict in the future. One mother (Participant #08) went into detail about this issue, disclosing:

> A lot of times you tell your kid to go put their shoes up. Well, they take them and throw them in their room. That's not what I wanted them to do, so when I go in their room and see them, I'm like "[Child]!!!" And I'm mad because he didn't put his shoes up. Well, to him he put them up. He took them out of the spot where it was and put it in a spot where he thought that I wanted it. If I say "Put it in your room" but I don't tell him exactly where in his room, who am I to get mad at him because he did what he was asked?

Additional principles. Several additional principles of giving good directions were acknowledged less commonly by parents. For instance, they talked about giving a direction in the form of a command instead of a choice. One parent (Participant #16) expressed that, "It's not giving him an option. It's saying 'Pick your toys up now, please', instead of '[Child], can you pick your toys up?' I used 'can' a lot before and now I use 'now, please.'" Participants also described the importance of learning what constitutes average child compliance. As one father (Participant #13) pointed out, "The whole lesson part of it I guess was helpful because it also set

the limits of where they're going to be 70% of the time. That was helpful to me because I just knew what to expect." The significance of following through on directions, avoiding sarcasm, and being attentive to the timing of directions were also mentioned.

Illustration: How giving good directions can facilitate change in parenting practices. This section provides an example of how parents in two families attempted, appraised, and then applied the skill of giving good directions over time, leading to change in their parenting practices. In particular, this section will highlight the experiences of Judy[2] (Participant #08) and her husband Dean (Participant #06), a married couple with three children, as well as a divorced mother, named Celeste (Participant #18), who had one son.

More than any other content item, participants described their initial attempts to give good directions both in session and at home as awkward. Judy recalled, "It was uncomfortable at first just because none of us were used to it. I would laugh at first, I thought it was funny. I thought this sounds so ridiculous. And the kids were like, 'What?'" Likewise, Celeste admitted:

> It was different at first. And when I did the now please thing I used to get embarrassed. I'd be like, "[Child], you're done playing on the swing set." Or, something like, "[Child], time to go now, please."…And then there'd be other parents and I'd just be like all embarrassed, just because it was new.

However, these participants quickly began to notice their children were responding to this parenting practice. Judy observed, "Even with [daughter] when I use the now please, I get a more quicker response from her than I would before." After experiencing success giving good directions herself, Celeste reported that she was no longer embarrassed to do this in front of other parents. She bragged, "But now I don't care. Now I'm just like [giving good directions]. And it works. And I'm like, 'See, it works! Laugh at me all you like, but my kid is listening.'"

[2] All names have been altered to protect the confidentiality of study participants.

At the time of her interview, Celeste had recently completed PMTO and was excited to implement all the parenting strategies she had learned in the intervention, including giving good directions. Judy and Dean had completed PMTO more than a year and a half ago and had continued to apply the principles of giving good directions since that time. More specifically, they had experienced an overall improvement in their children's behavior and now only used this method of giving directions as a backup. As Judy explained, "Even now when I ask them to do something, if they don't do it right away and I use the now please, they do get up and do it right away." They had also modified the wording to a degree in order customize this skill to the specific context of their family. As Dean explained, "I don't necessarily say it that way. The philosophy that comes from that is get their attention, tell them exactly what you want done simplistically, be polite. That's what it is….That's the real premise of that statement."

Skill encouragement. After learning about giving good directions, parents typically are exposed to the core component of skill encouragement, where they learn to use contingent positive reinforcement to teach children new behaviors (Forgatch & Patterson, 2010; OSLC & ISII, 2006). This was another content item that was central to parents' experience in PMTO. Topics related to skill encouragement were frequently mentioned by participants during the interview and several main categories emerged from the data. These describe the elements of skill encouragement that played an important role in facilitating parents' process of change.

Elements of skill encouragement. Specifically, six elements of skill encouragement were apparent in the data. These elements include several principles of skill encouragement as well as different parenting tools that enabled parents to carry out this core component with their children.

Practicing positive reinforcement. The principle of positive reinforcement stood out during the parenting interviews. The majority of participants talked about their experience learning about this topic in the intervention and practicing positive reinforcement at home with their children. They reported numerous beneficial outcomes associated with this parenting practice. For instance, one mother (Participant #03) talked about how focusing on positive reinforcement allowed her to see her son in a different light. She explained:

> So I think that giving him a complement and being proud of him as an individual opened my eyes, like wow, you know I am proud of him. I mean he really does do awesome stuff. But I kind of needed somebody to pick that out of me.

Other parents noticed positive changes in their children and their parent-child relationships. One mother (Participant #12) observed "[Daughter] likes to be praised, she likes to be shown, hey, I did a good job. And I think that gave her more confidence too. I think it made her feel better about herself." Another mother (Participant #14) realized, "Every time I would say something positive to [daughter], rather than negative, she would just light up. And it just changed our relationship."

Some parents commented on how they believed positive reinforcement was a more effective tool for shaping behavior than always focusing on what is being done wrong. One father (Participant #12) surmised:

> I think it helped set an expectation too. 'Cause you're recognizing she did something well, you're telling [her] that. Then she knows if she keeps doing this she's going to be doing it correctly. Whereas only telling her what she's doing wrong doesn't let her know how to do it right.

Using incentives to motivate behavior. Another element of skill encouragement parents found to be significant was the strategy of using incentives to motivate behavior. In PMTO, parents are taught to pair tangible incentives with social reinforcers to help children learn to understand and appreciate social rewards (Forgatch & Patterson, 2010). During the interviews,

parents typically shared their use of incentives and how their children responded to this practice. For example, one mother (Participant #20) talked about how she had set up a reward system in her home:

> He would earn, for every time that he did what I asked him to do the first time, he was rewarded with what we called [child]-bucks. And he could save those up and every week… he would be rewarded, either by cash…[or] activities to do with me.

Another parent (Participant #18) reported, "It does work, and he liked it. And also some of the rewards that we came up with too would be like going for a walk with me, because he likes to walk with me, or going to the park." Participant #07 expressed her surprise and delight that using incentives had succeeded in getting her daughter to clean her room, a long sought-after behavior:

> She did! I mean she shoved all the toys in her bed and all the clothes went in her closet and all art supplies went in the desk, like shoved. She shoved it. But it was like, oh my god! Like, I went in there and I could safely vacuum and wouldn't have to take the vacuum for repair afterwards.

Personally, one of my favorite moments of conducting these interviews came while talking about incentives, and highlights just how much many children enjoyed receiving them. I had asked one mother (Participant #16) if she recalled talking about skill encouragement in PMTO. She replied affirmatively, saying, "Yes. And I did do it too. And he liked that a lot with the Scooby loops and stuff like that." Scooby loops are brightly colored, nylon bands children can wear around their wrists that are often traded in for prizes after so many are accumulated. Hearing this reply, her son, who had been playing quietly in the corner, looked up and joyfully exclaimed, simply, "Scoooooby looooooops!"

Struggling to find effective incentives. While many parents thought that incentives worked well, they pointed out that practical, effective incentives could be difficult to find. A commonly reported problem among parents was that children asked for incentives that cost more than parents could afford. This was particularly a problem for parents of older children. One

mother (Participant #15) explained, “But our kids expect big incentives like I get a video game that costs 70 bucks. Well, that ain’t happening.” Another mother (Participant #01) shared, “Kids, they just feel they’re entitled to everything. So it’s not like I could run out and buy him a PS3, you know, to…be an incentive or something like that.”

Even though interventionists encouraged parents to utilize free or low-cost incentives, this often proved challenging. One father (Participant #04) recalled how he and his wife had tried to transition his children from a monetary incentive to activity rewards, saying, “I think we’ve discussed it, but it really wasn’t anything that clicked with our kids.” He went on to elaborate, “It’s just the activities didn’t seem to ring their bells more than the money did for that one.” Another parent (Participant #08) remarked that her interventionist, “very much encouraged ways that didn’t cost a lot of money, knowing that people didn’t have money. But it’s hard to get creative with those types of ideas.”

Doing the charting. Participants also talked about learning to use charts in the PMTO intervention. Overall, parents found these to be a helpful way to show children what was expected of them and to provide a visual reminder of their responsibilities. As one father (Participant #06) explained:

> When I tell them to, for instance, do their chores...it’s not like, “What were my chores again?” It’s pick up your room, and by pick up your room I mean put your toys over here, put your clothes over here, dirty laundry goes in the laundry hamper, make your bed.

Parents also reported that charts helped to structure an incentive schedule for children and to keep a visual reminder of their progress. One mother (Participant #19) commented:

> It was a visual aid to them where they could see their progress as well. Which I felt was motivating to them….You earn privileges for the stars that you have accrued throughout the week. And it showed them where they were improving with their behavior and with their compliance with my requests. So that helped.

Another parent (Participant #12) offered her thoughts on why charting has proven effective for her daughter, saying, "I think seeing her progress is a big thing for her too. She can see oh well I missed stickers this day but I have these stickers this day. I think that has helped her visually."

Breaking it down into steps. Another component of skill encouragement, often talked about in relation to charting, is the importance of breaking complex behaviors down into more manageable steps. One mother (Participant #15) explained:

> Breaking it down, like instead of saying clean your room, first telling them put your clothes away. Pick up the toys. Pick up the blankets. Pick up the pillows. Breaking it down to simple, easy commands that can be done. We learned that.

Some parents initially expressed incredulity at the need for explaining behaviors they believed to be so simple. One mother (Participant #19) shared the following response:

> And one of the funniest things to me was how you break down, how much they break down a chore. And [interventionist] was like, "What are we working on?" And it was to feed and water the dog. And she comes with this big board and she's like, "We're gonna write down the steps." I'm like, "The steps? Feed and water the dog. Hey, he's like past ten years old. He knows what that means."

Despite such initial reservations, many parents described implementing this strategy with success. One mother (Participant #14) shared, "It did help me teach [daughter] how we wash dishes, how we sort our clothes…. I've learned this, that the simpler you keep it, the easier it is, the more likely they're gonna be able to do it."

Teaching new behaviors. The ultimate goal of skill encouragement is to teach children new behaviors. This was often a central objective for parents, such as for this mother (Participant #14):

> I have one job as a parent, to teach her how to follow rules and directions and to teach her things – how to wash clothes, how to keep your house clean….How to do things that she needs to do just to function.

As a result of implementing the different strategies of skill encouragement, parents were often pleasantly surprised at the new behaviors their children were capable of learning. One participant

(Participant #07) admitted, "I really thought she couldn't clean her room. I thought she couldn't hang up her clothes. I thought that because of her disability she couldn't pay attention enough to do it." Yet, after putting an incentive program in place, this mother was able to witness her daughter being successful at these tasks. Another mother (Participant #11) explained how she was able to teach her son to manage his anger through the use of charting, where before she had not realized he was capable of controlling it. She provided this illustration:

> I have witnessed [son] sitting in his chair in the living room. [Sister] is up in his face... Where normally he would just grab her and beat the heck out of her. And [now] he's like, "Mom, mom, [sister]'s bugging me." And I'm like, "Well, do you need to take a break for a minute?" And he said, "Yeah, I'm gonna go to my room"….He can control it because he knows he's getting something for it. And inevitably that will just start being the norm for him. You do these charts for two or three weeks….It just becomes natural behavior.

Illustration: How skill encouragement can facilitate change in parenting practices.

Throughout their experience during and after the PMTO intervention, parents took advantage of their opportunities to attempt, appraise, and apply what they were learning about skill encouragement within their everyday lives. This section will illustrate how Betty (Participant #11), a divorced mother with two children, proceeded with this process while learning and implementing the strategy of charting.

Betty recalled that early in the PMTO intervention she had the opportunity to attempt the use of charts through home practice assignments. She said, "We started right out within that month of doing these charts and then trying things at home. And then [interventionist] would come back the next week and I'd report." Her initial appraisal of charting was positive as she found that they immediately worked to improve her children's behavior:

> When I first started doing this that was great. I was actually able to talk on the phone without being interrupted from a ten star chart. I mean, it's great and they learn real quick. [If] I'm good, I get a reward.

While Betty originally began applying the charting in the same way she had learned in sessions, she soon moved into other pathways of application. She explained, "We've been doing charts where they get a toy if they can give five consecutive days without hitting. Well, that's [son]'s. [Daughter]'s [chart] is five consecutive days without interrupting homework." Betty also decided to adjust the frequency with which she implemented charting. Although she now needs to use it less often, it is a tool available to her when needed. For instance, she explained how she plans to resume charting now that her son's father is moving away and her son has started acting out in response. She stated, "And just recently all this dad leaving came about so we're, in fact I'm getting ready to start a new chart this afternoon." In addition, Betty had also made some adaptations to charting to keep it effective. She explained, "At this point I will hang something up, like I drew a picture of a little dress because [daughter] outgrew all her play clothes." She then writes numbers, from one to five, alongside the picture and will require five consecutive days of good behavior from her children in order for them to earn the illustrated reward.

Through this cyclical process of reappraising and making adaptations to charting as needed, Betty has accomplished a very satisfying change in her parenting practices. Her final evaluation is overwhelmingly positive:

> I love the charts. They're great. They really give the kids incentive. And even little kids, because I've said we've been doing this for a year and a half. Even at four [son] would know, oh, at this point when I get all these numbers cut I'm getting this or we're gonna go here or go there. They know…. reward means reward. So it does work.

Limit setting. Learning about limit setting, also referred to as discipline, was another topic that was central to parents' experience in the PMTO intervention. This core component involves using negative, minor consequences in a structured fashion to discourage problem behaviors (Forgatch & Patterson, 2010; OSLC & ISII, 2006). Parents were usually implementing some form of discipline prior to their participation in the PMTO intervention. However, a main

theme that emerged from parents' interviews was how the limit setting strategies they learned in PMTO were an improvement upon what they had been doing. As one parent (Participant #11) recalled:

> There were days before I started this, and I felt guilty about it…. I gave him like 12 or 13 times out in one day. And that's what I did that whole day was give my son time out. Obviously it wasn't working…. That was right before we started therapy and then I started this and this is just so much better because you get training on how to deal with this so you don't do that to your family…. And you're not losing your mind and people's feelings aren't being hurt.

Elements of limit setting. In describing their experiences with limit setting in PMTO, parents discussed four key principles connected to this topic. They also described their use of the different limit setting strategies they had learned to implement in the intervention.

Actions have consequences. One principle of limit setting that parents identified in their interviews was the importance of helping children learn that their actions have consequences. Parents talked about how children need to understand that what they do will have repercussions. As one father (Participant #04) remarked, "It was mentioned such as opposed to asking them to stop, you know, suggesting that this will happen or this will happen." He recalled learning to use if-then statements in his family so that his children could better comprehend cause and effect. Another parent (Participant #20) explained how she went about implementing this practice, "You know I would explain the consequences to them if they did not comply. 'Alright, look, if you're not going to do this, this is going to be the result.'"

Giving children a choice. A related principle of limit setting was expressing to children that while they must face the consequences of their actions, they are also free to choose their behaviors. Parents were taught to pair a directive with information about the consequence that would occur for noncompliance. As one parent (Participant #20) put simply, "So he had that choice: Okay, do it, or go to time out." Many parents resonated with this idea. One mother

(Participant #11) commented, "You're still giving your child a choice to, oh, I can change my behavior now or I can just keep misbehaving and lose a privilege later on in the day. And I think that helps them build a stronger character…" Another mother (Participant #18) shared, "Even like giving them time to think about it and the chance to make their own decision….And it's two options. Do this or do that. I like that. That's stuff I never did before but I like it." Other parents liked this practice because it clarified that their children had control of their choices and made parents feel less guilty about enforcing consequences. For example, one mother (Participant #15) shared how her son had accused her of hurting his chances at a college scholarship because of a privilege that was taken away. This mother boasted, "And I didn't fall for it. I'm like, no, YOU caused yourself because you didn't do it. You're not blaming me."

Follow through with it. Parents also talked about the importance of being consistent with their limit setting practices. As one father (Participant #04) declared, "Consistency, I think, is the biggest thing. Being consistent with the rule, consistent with the consequence, and following through with it." Some parents disclosed how this was an important topic because they had not always followed through with the consequences they had given their children in the past. One mother (Participant #16) revealed, "My techniques before, I mean I would send him into his room or I would always do a grounding that I could never stick with. And I learned that also from PMTO. Never do anything that you can't stick with." One parent (Participant #17) reported how PMTO has empowered her to follow through with consequences, despite her daughter's violent behaviors:

> She kicks on that wall until she knocks my angels off the wall. And when I take the TV, the radio away….She'll go off kicking. That's a boot mark [showing me a bruise on her shin]…. But even if they get ahold of me or they break my stuff I still stick to it.

Amidst such challenges, parents realized that consistency was helpful to their children. As one mother (Participant #19) observed, "He really didn't want the power struggle kind of stuff…. So

I think it was just he was looking for some structure, some consistency. And he got it through the PMTO."

Short duration of punishment. The final principle of limit setting that emerged from parents' reports was that effective consequences often last for only a short period of time. This shifted the way many parents implemented consequences. As one parent (Participant #18) noted, "With the punishment part, you only punish him for a very small period of time, which is something that I never really realized." Another mother (Participant #08) described, "We were doing it more extreme like taking it away for the evening instead of just an hour or something like that. And I think it's better to do it in smaller increments…. I think little bits is more effective."

In general, parents agreed that limiting the duration of punishment was a sensible and effective strategy. As one mother (Participant #11) reasoned, "Why drag it that long? When punishment is over it's over. Here's what you did, you lost it, tomorrow is a new day. You can have it back. I mean, let's not begrudge it the whole week." Another mother (Participant #03) provided this account of the drastic difference this made in her family:

> I would do the whole week for a punishment, very typical for me. "Okay, you're just not gonna play that game for a week"….Wow, talk about escalating anxiety on high in the household. That was bad. And I didn't really put the two together, how bad that punishment was in my head. And in his world it was pretty horrible. But, doing a ten minute time out from a game, from a show he liked, I really, really, really liked. I was really impressed with that. Because I didn't really get the lip and the frustration and the anxiety from him for ten minutes. But yet, it proved my point, made him think.

Time out. One limit setting strategy that parents were encouraged to use was time out. While time out worked for some families, it was typically not the limit setting strategy of choice for parents because it appeared less effective than alternative strategies, particularly privilege removal. One mother (Participant #12) explained, "The privilege removal worked better, but the time out worked for me. I put her in the hallway and she had to face away from everybody and

each time she would talk or get up it was one minute added." Another parent (Participant #09) observed, "You send them to their room, I mean it does have an effect. But you start taking away things that they really love to do. That *definitely* has an impact."

Parents commonly reported two challenges trying to implement time out. First, it generally was not effective with older children. One mother (Participant #14) stated, "Well, it worked a few times. But because [daughter] is older, she's not gonna sit in a time out for ten minutes. She said, 'That's stupid, that's childish, I'm not a child!'" Another mother (Participant #20) scoffed at the idea of using time out with her teenager, "Consequences, as far as putting him in a corner or something like that – ridiculous. At his age, ridiculous!" Second, many parents had trouble finding an appropriate location in their home where they could place their child during time out. One mother (Participant #18) remarked, "Not having a good place to put him would be one [challenge]. Because there is really no place in here that's boring and safe." A father (Participant #13) pointed out, "The time out, not so much, because we have dogs, we have a baby, there's no way to separate her from anything. So it's just kind of a difficult thing to do." Another parent (Participant #07) described, "If I put them here [living room] then they're watching TV, if I put them in their bedroom I don't know what they're doing, and it's a small apartment, so if I put them over by the door…she's screaming, the neighbor can hear."

Privilege removal. Instead, the limit setting strategy parents found most practical and effective was removing a privilege. As one mother (Participant #20) discovered:

> Best, absolute best consequence that worked with him – revocation of the computer. Whoa! That was a bad one. 'Cause he is a computer fanatic. So revocation of the computer, that one was rough on him. So that one was the most effective out of anything.

Another parent (Participant #09) described:

> Today they lost their privilege to go to the roller rink because they couldn't get along. And that's the type of things that we use to change behavior. So we definitely use the take away – there is consequences - take away privileges. That's probably the biggest thing that we do to get them to behave.

Parents mentioned finding a variety of privileges they could remove that were unpleasant to the child, including TV, video games, cell phones, the computer, internet time, toys, or going to the swimming pool and other excursions. Only a few parents reported problems finding privileges to remove that made a difference with their children.

Other strategies. Parents remarked on two additional limit setting strategies, but to a much lesser extent than time outs and privilege removal. The first was the use of the "when-then" statement. Parents described the when-then statement as somewhat of a cross between a good direction and a privilege removal. In this strategy, the child is not allowed to experience a desired activity until a certain behavior is performed. One mother (Participant #16) instructed:

> If they make a mess and if it don't bother you, it's not harming them or putting them in danger, then just wait….Then if they want to go outside, they want a snack or something, you say, "Well, when you pick your mess up then you can have your snack."

The second additional limit setting strategy is assigning the child a work chore. One mother (Participant #03) described how if her son didn't complete one of his assigned tasks, "Then he had to go do his 10 or 15 minutes of raking the lawn or cleaning the kitty litter." Another parent (Participant #14) explained how her daughter can complete a work chore in order to shorten the duration of a privilege removal. For instance, "If she works sweeping, mopping the kitchen or helps me do dishes, those things, she can earn that back."

Illustration: How limit setting can facilitate change in parenting practices. This section provides an example of how Kim (Participant #19), a single parent with four children, attempted, appraised, and then applied the core component of limit setting within her family context.

Kim was very enthusiastic to be learning about limit setting in PMTO. She described her experience during her initial attempts with this strategy, saying, "You get pretty excited because even during the role play, and when we're talking about that, you're like, 'Oh wow, that was so easy. I can do that. I can go home and I can do that!'"

Yet, doubt soon began to creep in as Kim reflected on the pressures of single parenting and her concerns that she would make mistakes with the nuanced limit setting sequence:

> And so being nervous, like what if this doesn't work, what if I don't have the steps in order? Oh my gosh, this looks like a lot of stuff. How am I gonna go home and be like alright, step one, do this, step two..? Oh, it's too much!

She goes on to worry, "And that's how I think I'm gonna feel driving home. I'm like okay, what if I don't do it right? What if I don't do it right?" In this way Kim's appraisal of limit setting led her toward concluding that she would not be able to correctly implement this strategy. However, as soon as these thoughts began to emerge, Kim caught herself and reasoned, "You just have to think back, No, I'm gonna go in and I'm gonna say I'm gonna do this. I'm gonna do it right. I know how to do it. I know what to say. So just like changing your whole thinking." She explained that the encouragement of her interventionist played a big role in this reframing, saying, "And I could think of [interventionist] and she'd be like 'You got this!' If something doesn't go right, she's like, 'That's okay. We're gonna learn from that, we're gonna go on.'"

Subsequently, Kim applied limit setting with her son just as she had learned in PMTO. She found this application of limit setting to be highly effective (and somewhat amusing):

> He was funny. He only had to go to time out twice because he got that [time out] wasn't fun. But he did it. So the limit setting was okay, "I asked you to put your shoes away. Now I'm going to ask you again, if you don't do it you're gonna take a 10 minute time out." So I think at first, the first two times he [did not comply] was just to see, to test and see – Yeah right. You're not gonna send me to time out. I am ten. I haven't been to time out in forever. So I'm like, "Okay [son], that's a ten minute time out." And he's like, "What?!?" And he stood and I said, "That's 11 minutes, go to your room." So he went.

Kim found that she only had to implement time out twice and privilege removal once and now her son has been compliant. She has continued to retain this limit setting component in case it is needed, but reported she has not had reason to implement time out or privilege removal since.

Emotional regulation. The fourth content item that emerged from the data as a central facilitator of parents' process of change was emotional regulation. In PMTO, caregivers are taught methods for addressing their negative emotions and are encouraged to exercise positive or neutral expressions during most parenting interactions (Forgatch & Patterson, 2010). During the interviews, parents talked about emotional regulation in a discernably different way than giving good directions, skill encouragement, or limit setting. Parents placed greater emphasis on offering their perceptions of emotional regulation, described strategies for carrying this out, and went on to explain the role emotional regulation played in relation to the other PMTO topics.

Perceptions of emotional regulation. Four major themes emerged from the data related to parents' perceptions of emotional regulation: (a) emotional regulation is relevant, (b) emotional regulation is difficult, (c) PMTO assisted with emotional regulation, and (d) emotional regulation is helpful.

Emotional regulation is relevant. The majority of parents agreed that the topic of emotional regulation was relevant to their circumstances. Many found themselves struggling with this issue in their parenting efforts. One mother (Participant #15) explained, "Like I said, the kids like to draw us into the fights. And we get emotional, and then we're just like, Rrrrrr! 'Just forget it!' And they got their way." Some parents spoke of raising their voice or saying unkind things to their children during a conflict and then regretting it afterward. One parent (Participant #08) reported, "I would get so upset, and after I would yell at them I would feel

guilty. So then I'm trying to overdo what I just did or make up for what I just did." Another parent (Participant #19) admitted:

> I think [emotional regulation] is very helpful because in the heat of the moment, with anybody, it's hard to not be like, "Well, you're acting…" [implying an insult]. And I think it puts a lot of negativity out there. And then later, yeah, you would regret it…. You can't take that back. You can say you're sorry but that's gonna be stuck with them forever.

As a result, most parents agreed that covering this topic in PMTO was important. As one mother (Participant #12) shared, "That was the whole purpose of me doing the PMTO, was to help me keep my emotions controlled. And so that was an important thing."

Emotional regulation is difficult. While parents believed emotional regulation was an important skill, they also found it exceedingly difficult to accomplish. One mother (Participant #02) acknowledged, "Yeah, there's times where I don't even care and I just go off on 'em. But they get you to that point where you just can't take it anymore!" Another parent (Participant #01) described her experience trying to stay calm while her son was in and out of juvenile detention centers for drug use and theft. She expressed, "When it's that bad, it's very difficult to keep, you know, you're cool. And it's something that I struggle with every day. Just because there's so much anger and so much emotion just right below the surface." A different mother (Participant #03) described this experience trying to regulate her emotions when dealing with her son:

> That was hard. Yeah, because I was already stressed. I was out there above ten level. And, I had no more patience, I was drained of all patience. It's like I didn't have any, I didn't know what those were. So, that was extremely hard for me to do when I was angry at him, 'cause I just wanted to yell at him. I'm like, "Why are you being so disrespectful and rude!?! I'm just sick of it!" That's what I would want to yell at him.

PMTO assisted with emotional regulation. Despite these challenges, parents agreed that PMTO helped them to better master the skill of emotional regulation. One mother (Participant #16) explained, "The PMTO did help me stay calm, how she told me I had to breathe in and out if I was getting frustrated, but not to let him see. Just be calm about it. So that helped out a lot."

Another parent (Participant #02) mentioned how, "I can talk to [my children] calmer now then I could back then." Participant #14 reported:

> It has got me to think about things before I say them. It's gave me more emotional regulation. Where before I would tell her, "I want you to do this right now." And then she wouldn't do it and she'd cuss at me and yell. And I would say, "You're gonna do this right now!" And I end up yelling at her. It's taught me how to say those things without being stressed out, when you get that burning feeling in your stomach when you're yelling… It's really been helping me be a better parent.

Emotional regulation is helpful. Participants found that being able to better regulate their emotions was helpful to their parenting efforts. One mother (Participant #01) reported:

> If I kept my emotions in check he couldn't challenge me. As hard as he tried, I wasn't giving him a reaction…. He had to back down and he had to go pout somewhere else because I wasn't giving him what he wanted. So, I mean it does work, because then the kid is like "Whoa, what's going on? This is different. She's not in my face screaming."

Another mother (Participant #03) provided an example of how she was able to stay calm and handle a situation in which she feared her son was about to become violent toward her:

> I remember locking the door. Being in [my bedroom] for maybe 5 more minutes. I remember coming out, and he had sat down on the couch. And I looked at him calmly, but I was, you know, probably a good 10 feet away from him. I was really calm, and I said, "Look, violence is not allowed in this household." I had eye contact with him. And I said, "If you hit me, and you choose to go that route, I will call 911. I will press charges against you because you are not gonna be violent to me. You are not gonna hit anybody. That is inappropriate. It's not tolerated in this household, and I refuse to live like that." And then I just walked back in my room.

Some parents also mentioned that emotional regulation proved helpful to their children too. For example, Participant #03 went on to share that, "Wow, by me not yelling at him…. and being calm, it's amazing what it will do to an atmosphere, of bringing the calm to everybody…. I mean, he got calm. I mean, it's amazing – night and day, really."

Strategies for regulating emotion. Parents identified a number of strategies they used on their own or in combination with other tactics in order to help regulate their emotions.

Walking away. The most popular strategy parents reported employing was to walk away from the conflictual encounter. One mother (Participant #01) commented, "So learning how to walk away and not be confrontational was, it was hard. You know, but it helps and it still helps." Another parent (Participant #14) noted, "The walking away, that technique, more parents need to walk away, de-escalate. I learned how to de-escalate a situation by walking away..." Participant #02 also remarked how she now thinks to herself when her child is misbehaving, "You want to act like a little jerk? Go for it. Go for it. I'll walk away. And that's what I do. Now I'll walk away from situations."

Breathing strategies. Parents also described doing breathing strategies to help themselves stay calm. One mother (Participant #05) revealed, "If I'm really angry I don't talk to them at that moment…. I have to go and sit on my bed or sit in my chair and I have to just breathe. I have to concentrate on breathing and taking deep, long breaths, and I have to calm myself down." Another parent (Participant #14) expressed, "My experience has been good for me as a parent because I catch myself. If I catch myself yelling instead of asking and telling her…I sit there and I take a deep breath and think I gotta word this differently."

Other strategies. Less frequently, parents used other strategies to regulate their emotions. Some parents would count silently to themselves to remain composed. As one parent (Participant #11) explained, "It helps you to stay calm and focused, that's where the counting comes in." Other parents reported putting themselves in time out. In the words of one mother (Participant #20), "When I reached my frustration point, before I went berserk, I would say, 'Okay, mom's taking a time out. Bye-bye.'" Other parents reported they would just ignore certain instances of misbehavior or more generally take a step back and think before responding.

The role of emotional regulation. The final, and perhaps most significant, aspect of emotional regulation that emerged from the interviews was its role in relation to the other parenting strategies. Participants did not talk about emotional regulation as a discrete content item in parallel with giving good directions, skill encouragement, and limit setting. They did not provide extensive accounts of how they had attempted, appraised, and then applied this parenting skill. Instead, they experienced emotional regulation as a central element of their change process because of the way it was interconnected with the other parenting strategies.

Parents described how maintaining emotional regulation and staying calm helped them to implement the other parenting strategies. One parent (Participant #14) explained:

> Well, you give the good direction. You say, "[Daughter], put your dishes in the sink now please." And when she starts cussing at me or yelling at me, "I'm not gonna do it," or not compliant, "I'm playing my game", you take your deep breath and you count. I count to ten. I believe, yeah, it's ten. Then you tell them the good direction again.

Another parent (Participant #01) shared how emotional regulation helped her to improve the way she gave directions to her son compared to when she would not manage her emotions. She recalled, "It's still the tone in my voice that I would use. You know, it's not like sugar coming out. It's more like a demon coming out of my mouth." She went on to describe the change in her approach with the inclusion of emotional regulation, "Like instead of just shoutin' out a command, you know, actually like staying calm and walking up to him, and asking him to do something…. You know, instead of just shouting something out."

Conversely, parents found that utilizing good directions, skill encouragement, and limit setting better enabled them to remain calm in different situations. One father (Participant #06) explained how things changed for him once using good directions helped him and his wife to become more consistent. He disclosed, "I think by getting my wife and I to say the same thing, getting the response I wanted, I didn't need to raise my voice. I didn't need to get angry."

Another parent (Participant #12) explained, "Like the charting…. She knows you get told twice, possibly three times, if you don't do something you're losing the sticker. And once I'm done I don't get as angry. I just say, 'Okay, it's gone.'" Similarly, one mother (Participant #07) shared how she sometimes used an adapted form of time out to allow herself a moment to regroup:

> Sometimes [I have the children] just put [their] nose on the wall, just for a few minutes, to redirect the situation, to step back from whatever they were doing, to give me a minute to calm down, from like, "Oh my god, I can't believe they just did that."

In this way, emotional regulation both supported and was supported by the other content items.

Secondary content items. While giving good directions, skill encouragement, limit setting, and emotional regulation emerged as the content items central to facilitating parents' process of change in PMTO, the role of additional content items were mentioned.

Family problem solving. When asked about their experiences with family problem solving in the PMTO intervention, most parents did not acknowledge this core component as a major contributor to their process of change. Participants did not devote much time to this content item during the interview, and many parents acknowledged this was not a major focus for them during or after they completed the intervention.

The one aspect of family problem solving that some parents did discuss was initiating family meetings. As one parent (Participant #20) explained, "We started family meetings to put our concerns out on the table and work on them, all of us together." In some cases, it appeared that parents who held family meetings used this time to explain what they were doing in PMTO to their children. One mother (Participant #14) remarked, "I would set the family meeting and the paper up and I would say at this time we're gonna have a family meeting….We sat down and I talked to her….I explained to her the good direction." Other parents engaged in more general types of problem solving conversations during this time. Participant #11 expressed, "I find that is a good time to talk about things. And sometimes we really don't really come up with an answer,

or sometimes they have all sorts of answers that would be good if they would do them." However, many parents found that trying to find time to get together and hold a family meeting was difficult to do. One father (Participant #04) recalled, "We tried to do the family meeting thing but we never could get that off the ground because my schedule was just so unpredictable."

Even more rarely, parents would mention that talking about family problem solving motivated them to devise family rules. Yet overall, family problem solving did not play a large part in facilitating change in participants' parenting practices.

Monitoring. While parents agreed the concept of monitoring one's children was important, the overwhelming majority of participants did not consider this to be a relevant content item for them. Most often, parents reported they were already monitoring their children and did not benefit from the additional information or practice in this area of PMTO. One father (Participant #13) remarked, "It was just simply we didn't have a need for it because we already did it." Another parent (Participant #08) responded, "Oh, I'm big on that anyways. It wasn't anything new for me at all." Some parents reported that monitoring was not a consequential topic for them because their children did not require much supervision. It seemed that sometimes their children struggled socially and had limited interaction with other children. One mother (Participant #03) concluded, "[Monitoring] doesn't fall in my category unfortunately because my son will not go anywhere and he will not talk on the phone." Participant #07 reported a similar situation with her son, saying, "He doesn't play with peers a lot. And he'll be like, 'Oh, I like them but….I don't want them to come over.' He doesn't care. He is more the loner, so I don't have that issue having to monitor him." Other parents expressed that their child was too young for monitoring to be a highly relevant issue.

A few parents did find this topic to be helpful in making them more aware of the importance of monitoring or in helping them to improve the monitoring strategies they had been implementing. Yet overall, most parents did not report that covering the topic of monitoring in the PMTO intervention led to any significant changes in their parenting practices.

Summary and synthesis. The content of PMTO was a focal point for parents as they described their experiences in the intervention. In particular, they found that being exposed to good directions, skill encouragement, limit setting, and emotional regulation was central to generating change in their parenting practices. These content items were directly related to their process of change because it was these parenting strategies that parents attempted, appraised, and then applied on their way toward changing their parenting practices. Participants also described the elements of these parenting strategies that were significant to their process of change. While some content items within the PMTO intervention were not mentioned as particularly helpful topics, none of the content was found to impede parents' process of change. The role of the PMTO content in parents' process of change is depicted in Figure 4.1.

Findings of Focal Research Question B: The Method of Delivery of PMTO

The content of the PMTO intervention is characteristically taught using certain methods of delivery, also referred to as teaching strategies (Knutson et al., 2003). In this study, participants identified the teaching strategies that allowed them to most effectively learn the intervention material. The results indicated that the methods of delivery of PMTO helped to facilitate parents' process of change through the use of role plays, home practice assignments, troubleshooting, and the incorporation of visual aids. In this section, parents' experiences with and perceptions of each of these four teaching strategies will be presented.

Role play. Role play stood out during the participant interviews as the most striking method of delivery parents had experienced in the PMTO intervention. Some parents reported being unsure of role playing in the beginning and finding it to be somewhat awkward or unpleasant. One mother (Participant #01) explained, "Like they did role playing and then you know they would have us do it, which made me very uncomfortable. I mean I can talk to anybody but I don't like talking, like being in the center of something with people I don't know." Another mother (Participant #12) shared, "And that was the biggest thing that stood out for me. Because it was the most uncomfortable thing I've ever had to do, because they video tape it and you're doing all this role play stuff." Other parents found the experience much more amusing. One parent (Participant #14) described, "And then we role played. That was fun….And I'd sit there and laugh. And what was fun was that [interventionist] would say, 'Act like I'm [daughter]'….And practicing that really helped me and it was fun." Another parent (Participant #07) recalled, "It was funny – two adults role playing on camera."

Whether parents found role playing awkward or enjoyable, they certainly did not find it easy. Parents described how role playing was a lot of work and involved repeating the parenting strategies until they had learned them well. One mother (Participant #09) recalled, "She made us practice a hundred times a session on giving direction to the kids…. '[Son], pick up your coat now, please.' And it has to be that way. And if we deviated from that, we did it over again." Another parent (Participant #10) confirmed, "She definitely made you do the role play over and over until she decided okay, then you got it." One mother (Participant #11) had a specific morning ritual to prepare herself for role playing. She revealed, "Before [interventionist] would get here I would know that is what we were doing that week. I would drink a Red Bull, get ready. Because it is a lot of work."

Following this hard work, a clear theme that emerged from the data was that role play was effective in helping parents learn the parenting strategies of PMTO. One parent (Participant #14) remarked, "And then the role playing, I mean I think the role playing was good because it taught you what to do and taught you your tone of voice." Another parent (#20) confirmed, "Yeah, it did. It helped a lot. [Interventionist] really showed me a lot of really cool stuff with that. Helped me to understand his behavior a little better and helped me to deal with his immediate reactions better." Similarly, one mother (Participant #17) observed, "That kind of helped me a little bit with that standing up toward her type deal. Even though…you're trying not to laugh when you're doing it. But yeah, to me that helped me to keep [calm]." Even those parents who were initially uncomfortable with role playing agreed that it was an important teaching strategy once they realized how helpful it could be. One mother (Participant #12) explained, "It was uncomfortable, but it made you come out of that uncomfortableness and then it made you see how you can word things differently. So it helped you understand how to do it better." She went on to recommend the continued use of role playing in PMTO.

In particular, role playing was described as an exceptionally beneficial PMTO teaching strategy because it gave parents the opportunity to practice the skills and strategies they were learning before trying them at home. One mother (Participant #14) described, "And [interventionist] would sit there and we'd go through it step-by-step, and if I forgot something or got confused we'd say 'rewind' and then we'd start all over again. So that was really helpful." Another parent (Participant #19) explained:

> The role play was very helpful because when I would have a behavior at home with him I don't necessarily have time to replay all of that in my head. Okay, let me see, she said do this, then do this, then this. Well, I had already acted it out. I had role played it, so that made it easier to know what I was gonna do.

As another mother (Participant #11) disclosed:

> At first when I got started with this I thought, oh, role playing, that's so ridiculous! Why are we doing this? Okay, well now I know. Now I know why we're doing it. Because you do have to practice each step. Because you can't sit here and try to put this on your kid when you don't know what you're talking about. So you have to practice.

Participant #13 put it most succinctly, "You're not gonna learn how to do it if you don't actually do it."

Home practice assignments. After role playing each parenting skill in session, participants reported they would go home and begin to implement what they had learned with their children. One mother (Participant #09) described her experience carrying out the home practice assignment with a chart she had developed in session:

> We broke it down into steps in class. And then we took it home, we hung it up, and we practiced it. We went over it with the kids and she instructed. This is what we learned today. And this is what we're going to expect out of you. And we walked the steps. And then we practiced it…for weeks. It wasn't just one week and they can go on to something else. We took that same topic and we just kept working that particular series of events…

Similarly to role playing, participants expressed the importance of having the opportunity to practice the skills they were learning. Only now, they were practicing in their home environment. One mother (Participant #03) affirmed, "Absolutely. Practice. Because you're learning a whole new way of communication….I mean, you have to do it or you're gonna lose it and you're not going to change your household." Another parent (#14) agreed, "Practicing really helped. Coming home and doing it, being consistent really helped."

While home practice assignments in PMTO typically also include completing handouts, participants were less enthusiastic about this aspect of the teaching strategy. One mother (Participant #01) granted, "I kept [the worksheet assignment] in my head, but I didn't ever record anything, not really. Another parent (Participant #07) admitted, "It was probably one of those where she was like, 'Hey I have to give this to you.' And I was like, 'Yeah, just look at it, say I

did and please keep it so we don't waste the paper.'" Instead, the actual practicing of the skill was the element of the home practice assignment that made the difference to participants.

Troubleshooting. The troubleshooting conversations parents engaged in with their interventionist were another learning activity participants identified as significant to their process of change. Parents described how after going home and attempting a parenting strategy with their children they had the opportunity to come back and discuss their successes and challenges with their interventionist. One mother (Participant #20) commented, "We would go ahead and review how things went, and review how many setbacks we had, how many positive reactions that we had. And we could really see the progress." Another mother (Participant #10) reported, "And then we would come back the next week and then we'd have to tell her how we did and how it worked out. And we did that. We did quite a bit of that too." Participant #19 recalled, "She always wanted to know okay, did it work out? What did you see like maybe as a barrier?...Okay, how can we change this? Well, do you think this would work?... So there was always the opportunity for that."

During this process, interventionists could work with parents to help identify solutions to the problems and challenges they had faced trying to put the PMTO strategies into practice. For instance, one mother (Participant #03) remarked:

> [Interventionist] would have a different perspective on how to handle a certain situation or maybe on how I asked or how things got following through on. She would definitely reinforce and say well maybe next time you could approach it like this and you could get more results.

Another parent (Participant #15) talked about how she and her husband were struggling to find a solution to the problem of their son running away, but were able to successfully address this behavior after talking it through with their interventionist. In this way, troubleshooting provided parents with an opportunity to make adjustments to what they were doing. As one father

(Participant #13) explained, "It was helpful to have her come out every week 'cause if we did need to change something she would be right there." Another parent (Participant #09) recalled:

> We would go over that whole series of events from that week and what went well, what didn't go well. If one of us didn't give good directions, if one of us was not doing something quite right we discussed it and then we would practice it in class.

Visual aids. Finally, participants described the importance of the visual aids that accompanied delivery of the PMTO intervention. In particular, the majority of participants expressed that it was helpful when their interventionist would write out key points or draw sketches during session on the giant post-it notes or portable easels he or she would bring to session. One mother (Participant #20) recalled, "She wrote everything down on the board and…then you know it really helped me to see the progress that we were making together." Another parent (Participant #14) expressed, "I liked that they wrote down so that I could see some of the things: What are some positive things? What are some rewards? What are some of the steps?" This mother went on to share how her interventionist had also used a drawing of a sandwich to help her better understand one of the parenting skills:

> [Interventionist] did this drawing [for] me with the giving the good direction. You put down what you want when you are building a sandwich is like she explained it. And she drew the bread, getting [me] to realize that I have to give a good direction. You have to say what you want, layer it.…She basically put it out that way. Which worked, because I actually understood that this is what we do when you give a good direction.

Participant #16 also provided an example of how using visual aids in session had been helpful to her. She explained:

> She would come with boards. She'd have different scenarios on them. She'd write down whatever we were learning that day, whatever technique, whatever we were gonna do we wrote it out. For instance she had me write a sentence out, like if I wanted to ask him to do something how would I do it. She had me right it out, *[Child], pick up your toys now, please.*

Participants also reported that it was useful when their interventionist would let them keep the sheets of paper they had written out during session and take them home as a reminder of

what they were doing. One parent (Participant #17) described what had been helpful to her, saying, "Letting me keep some of the papers. That way…until I got used to it I had something to refer back to." Another mother (Participant #07) provided a more detailed account:

> I don't know what the other parents did but I actually posted it…. So that piece of paper went right in the kitchen where I wash dishes…and then there was one that I put in the bedroom and I think there was one on the back of the bathroom doors….I liked it because it was a good reminder, because I felt in the beginning sometimes we talk about stuff, and I'd do good, she'd leave, and somewhere in the week I would completely forget, like what did we just talk about? So, it was, it was a good reminder for me and for the kids.

Many parents also found the formal PMTO handouts and the parenting binders they received to be beneficial. One mother (Participant #18) remarked:

> Well, in terms of helpful, I think all these little handouts are incredibly helpful. Her giving me this binder and all of these papers that tell me all the stuff we talked about, that's incredibly helpful because now I have my own little reference book. I love that.

Another mother (Participant #01) remembered really identifying with one of the pictures in the materials she received. She explained:

> It was how the pictures were of the mom who looks like a vampire or a monster. That hit home because that's how I always felt. And I know that's how my child saw me. Just angry, angry, angry all the time and lashing out. So that one helped.

Other parents found the handouts to be useful for helping them to remember what they had learned in PMTO. As one mother (Participant #08) acknowledged, "It helps me to remember, because I don't retain a lot. I have a hard time. I have to remind myself."

Summary and synthesis. The results of this study suggest that the method of delivery of the PMTO intervention worked to facilitate parents' process of change through the effective incorporation of role plays, home practice assignments, troubleshooting activities, and visual aids. When considered in the context of parents' process of change in PMTO, these teaching strategies serve important functions. In particular, parents' initial attempts to implement the intervention are promoted through in-session practice using role plays and in-home exercises

during home practice assignments. The results of these initial attempts and parents' related appraisals of the parenting strategies are then monitored and addressed during troubleshooting. During troubleshooting, interventionists highlight parents' accomplishments and help them to correct their mistakes, often through subsequent role playing and practice at home. In this way, these PMTO teaching strategies can ultimately help parents experience greater success with the intervention. This process is diagramed as part of Figure 4.1.

In addition, parents described the importance of visual aids in promoting their understanding of the PMTO intervention. No clear themes emerged from the data that described a method of delivery used in PMTO that impeded parents' process of change.

Findings of Focal Research Question C: Additional Characteristics of PMTO

Parents identified one additional characteristic of the PMTO intervention that affected their process of change. Namely, parents overwhelmingly described the important role of the interventionist in facilitating growth in their parenting practices. Throughout their interviews, participants described a number of clinical skills and professional qualities of their interventionist that allowed parents to more effectively learn the intervention material and practice PMTO with their children.

Primary roles. The three primary roles emphasized by participants were to (a) foster a strong therapeutic relationship, (b) provide support, and (c) offer encouragement.

Foster strong therapeutic relationship. It was clear from parents' reports that having a strong therapeutic relationship with their PMTO interventionist was critical for their success in the intervention. One parent (Participant #18) shared, "It's incredibly important that you get along with the person who is teaching you this stuff. Because if you don't get along with them…. parents aren't gonna want to listen. They're gonna be like, what does this idiot know?" Some

parents talked about the importance of feeling that "connection" or "clicking" with their interventionist. Another mother (Participant #08) explained, "We became friends at a certain level. I mean, not that we'd go out and do stuff together, but I felt like I was comfortable to talk to her and be honest with her…"

Participants also described elements that contributed to a strong therapeutic relationship. One parent (Participant #05) said, "I trusted her. I thought she was…funny. She was happy. She was encouraging. She was real. She would share about herself and things that she would do with her kids and things that she learned from her own experiences." Other participants mentioned the importance of being nice, patient, caring, and personable. In addition, parents also felt that sharing common experiences could promote a good relationship. In particular, parents in this study felt they connected particularly well with their interventionist when they were both parents. One mother (Participant #10) explained, "I would say with me and her it's because we both did have kids….And so I would say in that sense we did have a connection there." Another parent (Participant #11) agreed, "She's got kids. And I'm not saying somebody that doesn't have kids wouldn't understand that, it just makes it easier for me." Parents who participated in PMTO with a partner also tended to mention the importance of relating to each person when establishing a therapeutic relationship.

Provide support. Another key role of the interventionist that emerged from participants' reports was the importance of providing support to parents during the intervention. As one mother (Participant #03) shared, "I think just knowing that [interventionist] was there and she had the answers to get me through this step by step program was the tools I needed." Another parent (Participant #11) explained, "Every time I see her I can vent and talk to another adult, which I don't do very often." She went on to describe her relationship with her interventionist:

> Well, I would say that she's a professional coming in and presenting me with all these tools, but after all this time she has become a support system. Because I've really actually gotten to know her quite well and vice versa. So she's definitely a support person, because she's the one providing all this information. And if I have an issue come up, she's who I'd go to…

The importance of receiving support from the interventionist was an especially salient theme among single parents. One mother (Participant #19) described:

> I would kind of troubleshoot with her and say, "Hey, how does this sound?" Or I did make a chart and I took it to her first because I didn't have somebody in the home to say, "Well, will this work for us?"

Offer encouragement. The third major role of the interventionist, as experienced by participants, was to offer encouragement as parents learned and began to implement the intervention material. One mother (Participant #03) explained, "I think that you have to have those tools and you need somebody there weekly to help encourage you, because it is daunting." Another parent (Participant #19) described this aspect of the interventionist's role as, "very important because she's the motivator. She was the one that would be, 'You got this! That was awesome!' And I'm like, 'Really? Because that didn't seem so awesome.'" Parents shared how they needed this motivation during their participation in PMTO because it was hard work and discouraging at times. As one mother (Participant #20) described, sometimes a little encouragement could make a big difference:

> Whenever I had made a major leap in progress, [my interventionist would give me one of] those little funky little loopy things. Those were just so cute. I was like, "Yay! I got another one. Cool." And she encouraged me to make that progress, to continue, which was very positive motivation for me. Now that helped a lot because sometimes you just want to throw up your hands and go, oh, forget it! I can't take this shit anymore.

Additional qualities. Participants also mentioned additional interventionist qualities that played a role in promoting their success in the PMTO intervention.

Explain material effectively. Participants described that an important quality to have in an effective PMTO interventionist is the ability to explain the material effectively. One mother

(Participant #20) praised her interventionist, saying "She explained things so that I could understand very, very easily where she was going." Another parent (Participant #08) described how her interventionist presented materials at an appropriate pace and made time to focus on the areas she needed help with. She explained, "She didn't rush us. She didn't say, 'Okay, well this week we have to be right here.' You know, she was very good about troubleshooting those areas that we really needed and struggled in." Another mother (Participant #16) talked about how her interventionist explained things in a way that matched her learning style, explaining, "Because I learn more with demonstration and hands-on and she was more a hands-on, demonstration type person. So that's the reason it worked really well with her."

Be invested in helping families. Other participants expressed that having an interventionist who was invested in helping families made a difference in their experience of PMTO. One mother (Participant #11) perceived her interventionist as, "just really caring about her job. She's not doing it just to get a paycheck, she's doing it because she wants to help people. And that made it all the easier." Another parent (Participant #05) talked about her previous experience with other therapists in comparison to her current interventionist, saying, "They were very business-like, they were cold…. I felt like they didn't care. They were there to do the job and get out…. They weren't nice and warm and caring and sensitive. They weren't like her." This participant went on to describe the myriad successes she has experienced as a parent as a result of working with her current interventionist. Likewise, one mother (Participant #19) remembered how her interventionist was committed to being present in session and helping her navigate the challenges of parenting. She recalled, "She was very upbeat and when she came in you could tell she was really there. She was committed to being there….She was always positive and checked everything at the door and was there to just get me through that."

Present new ideas and information. Parents also spoke favorably about the role of their interventionist in being knowledgeable about PMTO and presenting them with new ideas and information. One mother (Participant #11) acknowledged, "It's nice to be able to talk to somebody who is a professional and knows how to do this." Another parent (Participant #20) recalled, "[Interventionist] was very, very helpful. She helped me come up with some really great new ideas, some new strategies in dealing with a child that had so many emotional issues….She gave me some fantastic new ideas, helped me brainstorm." Participant #08 said:

> She gave us some different views, different insight in the areas that made sense. Obviously, when you're frustrated and you don't know what to do and you're just feeling like you're not being the best parent, when you have somebody else come in and… help you fix the situation, that makes it better.

Demonstrate experience with PMTO. Parents believed that working with an interventionist with experience teaching and implementing the PMTO intervention was another factor that facilitated their process of change. One mother (Participant #09) stated, "If you're gonna teach it, you have to live it. So you're gonna have to participate. In order to teach it you have to go in and participate in these." A father (Participant #06) expressed his doubt that an interventionist without experience with PMTO would be able to handle the complexities of each case. He recommended, "I just would say that you would have to have somebody pretty experienced. You wouldn't want somebody right out the door trying to do this kind of stuff. It's too much going on. There's too many variables." One mother (Participant #11) reasoned that her interventionist had the experience she needed because she was familiar with all types of child behavior. In her words, "I don't know exactly how much training they've had, but they've had enough training where they're seeing every incident." Other participants valued working with an interventionist who was also a parent and had experience raising children and possibly even implementing PMTO with them. One parent (Participant #09) talked about her interventionist,

explaining, “She uses [PMTO] at home. And she also has a daughter with ADHD so she knew how to help us work the charts and modify things here and there [according] to [what] she had seen at home.”

Express confidence. Finally, parents felt reassured when their interventionist expressed confidence in his or her ability to help. For instance, as one mother (Participant #11) described, a confident therapist may be one who is, “very relaxed and comfortable with what she’s doing. She knows what she’s talking about.” Having a confident therapist made a big difference to parents. One parent (Participant #03) shared, “Just knowing she had the tools to fix my problem, and she was very firm in that belief. And she said there is hope for this situation and we can help you.” In her words, effective therapists “have to see that there is an end to the dark.”

Summary and synthesis. In addition to the content and method of delivery of the PMTO intervention, parents identified the role of the interventionist as a factor that was associated with their change in parenting practices. In particular, all participants in this study reported positive experiences with their interventionist. As a result, they were able to identify three primary roles and several additional interventionist characteristics that facilitated their process of change. Within the overall theory, it was indicated from parents’ accounts that the role of the interventionist facilitated their process of change indirectly, through association with the content and method of delivery of PMTO. In particular, interventionists were reported to help parents effectively learn and successfully practice the intervention material. This hypothesized influence is depicted in Figure 4.1.

Findings of Focal Research Question D: Engagement and Retention in PMTO

Engagement. As parents shared their experiences with the PMTO intervention, a striking feature of their accounts was often the background information they provided to explain their

engagement in the parenting program. The parents in this sample did not casually decide to participate in PMTO for purposes of family enrichment or to prevent problems from occurring in the future. Instead, the majority of parents shared their experiences of desperation and described how they were in urgent need of services. In particular, before beginning PMTO, parents recalled how they were facing acutely challenging circumstances and realized they had to seek help.

"Before I started all of this it was just chaos": Circumstances prior to PMTO. Many parents reported experiencing life events that were highly distressing to themselves and to their children prior to their participation in PMTO. As one mother (Participant #18) disclosed:

> So what happened was someone incredibly close to me, my ex-husband, …committed suicide. When that happened I lost control and just ended up going nuts, and I went into a mental institution. That is the first time in my son's life that I've ever not been there for him….So he flipped out because I was no longer there and his uncle-[figure] was dead.

Another mother (Participant #02) explained what her children were going through before she became involved in PMTO. She acknowledged, "They had major life [changes] – their dad walked out, my mom got sick and died, and the divorce was final. So, that all happened within not even a year." Similarly, Participant #11 remembered:

> Before I started all this it was just chaos. I had just got rid of their dad and everything….Within the same week I moved my mother out and their dad out….When all that first happened they knew it was different and things were crazy and up in the air and my son was really acting out a lot.

Parents often observed these major life changes precipitated negative behaviors in their children.

In addition, many participants' children were diagnosed with mental health issues that contributed toward their adverse behavior. Reports of children being diagnosed with ADD/ADHD were highly common. The parents in this sample also had children who were diagnosed with Oppositional Defiant Disorder, Bipolar Disorder, Schizophrenia, and various Pervasive Developmental Disorders. Another mother (Participant #08) described, "I had a son

who wished he wasn't alive and wished he was dead. So that really scared me as a parent. And he was young, he was probably 8…"

Whether as a result of the above circumstances or additional factors, children in these families had come to display behaviors that concerned their parents. One mother (Participant #10) reported how her sons were often afraid:

> They're still fearful from what they had and how they were taken. And so yeah, like today we went and picked up some chemicals. So I told them, "Take them, go put them in the car." But they won't go out the door. And when they're playing ball, if they can't see you, they won't stay there.

Another mother (Participant #03) was concerned that her son had become depressed because of the way he was isolating himself in his room.

It was common for parents to report that their children were manifesting more acute behavioral issues prior to their engagement in PMTO. One parent (Participant #20) reported that her son, "used to tear at his own face, rip out his own hair, and then he went to destruction of my walls. He's got a bad history of pulling knives on people, all kinds of craziness." Another parent (Participant #18) related how her son had been "kicking, biting, throwing stuff – just awful" which resulting in his getting expelled from kindergarten. A couple in the study reported one of the most extreme situations. The mother (Participant #05) explained, "I had to lock up a lot of stuff, you know, any scissors, knives, anything sharp that she could use. Because she was cutting herself and she was finding knives and scissors and stuff and trying to come after me." The father (Participant #04) confirmed, "[Daughter] would just have violent outbreaks to the point where a couple of occasions, my wife would actually lock herself into our bedroom. Her and [son] would go into our bedroom and [daughter] [was] trying to beat down the door."

Within these challenging contexts, parents felt overwhelmed and ineffective. One mother (Participant #01) described how she felt after struggling with her son and his behaviors for such a long time:

> I've spent years going to the bottom and climbing my way back up and going to the bottom and climbing my way back up and this last thing that has happened just kind of took me to the very, very rock bottom with how I felt about my son. And, I could give up.

Another participant (Participant #05) disclosed:

> There were times that I didn't even want to live anymore, and I just wanted to die. I felt like I failed and that I was the worst mother in the world with these kids and they didn't need me. I thought I was destroying them. I didn't know what was wrong, and I thought it was me.

Looking back on those times, participants often admitted they had made mistakes. One parent (Participant #03) acknowledged, "I did yell and that is huge, that's very wounding to a spirit." Another mother (Participant #11) shared how she had repeatedly punished her son, and remarked, "That's a lot of brow beating. 'Stay in your room, don't come out. Stay in your room, don't come out. You did this, you stay in your room.'" In addition, one parent (Participant #02) confessed:

> I would try to talk calm, but I was so exhausted and so I gave in. That was my biggest thing back then was I gave in so much. Because I just didn't care. I just wanted them to stop…and I didn't care about what it was doing because I just wanted the day to be over with. We made it another day. Because it was just like, it was insane.

"I didn't know what to do so I started doing this": Parent help-seeking leading to engagement in PMTO. During their interviews, parents recalled how they had come to the conclusion that they needed help with their parenting efforts. For some parents, this was somewhat of a logical decision based on shifting life circumstances. For example, one mother (Participant #09) had chosen to become a parent of two school-age children and recognized she could use assistance with this task, especially in handing their behavioral issues. She remarked, "I also know that when I started this class I needed help with that. In the sense that with no

parenting skills…learning how to deal with those issues. You know, not yelling to get what you want them to do." More commonly parents described how the challenges they were facing at home had reached a critical point and this led them to realize they needed help with parenting. One mother (Participant #02) reported:

> I can't even explain how bad it was. I mean we were beyond the point where it was just - I was just not gonna give up, because I would never give up on my kids - but to the point where I was just like somebody better help me because I don't know what else to do.

Another parent (Participant #03) observed:

> He was already 14. I mean, I believe that we were already at a full-blown situation, where somewhere prior I probably should have had more of a preventative action. But… I kind of thought day by day things would, I guess, get better. And we would have our good days but it was kind of like a rollercoaster. So, the rollercoaster was kind of speeding out of control so when I called I was pretty desperate. I don't really know what the one thing was that kind of tipped him over the edge to make him so out of control other than I just felt rage in him. And, he didn't know how to deal with his rage.

She eventually concluded, "I needed backup!" Participant #18 commented, "I feel like it was very out of control at some points in our house as far as screaming and yelling…I had to be the one to fix it or at least try to resolve some of the issues."

Many of the participants had been at this point before. Some parents reported how they had not been able to find services in the past. One mother (Participant #01) expressed:

> My son started having issues from preschool, and by time he was in third grade he was being kicked out and suspended for stuff. And I was screaming at the top of my lungs for someone to help me and there wasn't any of this.

Others explained how they had received services but they had been ineffective. As one mother (Participant #05) pointed out, "I just kept going to the doctor and going to the doctor and going to the doctor…. 'What is wrong? Something is wrong. Why is she behaving like this?'" The doctors responded, "Well, you need to discipline her." This mother had tried all the suggestions they had given her but without success. Another parent (Participant #03) replied:

> I had done traditional counseling with [child] when he was younger even.…They talk to you about your home life, what's bothering you, [and so on], and we'll see you in two weeks. Well in two weeks, you know, we're still critical. So I'm sorry, that ain't gonna help me!

Subsequently, the participants in this study had all gotten in contact with their local community mental health agencies and been offered the PMTO intervention. Some parents, like Participant #03 referred to above, were glad this was something different than they had experienced before. She remarked, "When I heard positive parenting, I knew that was for me." Other parents were somewhat skeptical of PMTO and benefitted from the more active engagement of their interventionist. As one father (Participant #06) reported, "I was expecting to be dragged to something….I was going in guns a'blazing. I'm like we all have problems, and I hate going to these classes where it's like telling me how wrong I was. [PMTO interventionist] didn't say that." Another parent (Participant #07) admitted:

> She was more working with me…[because] I'm the one that's running the boat here and if I'm all run amuck them it trickles down. So, that was weird at first, I felt like we didn't have a connection because I didn't understand why she was working with me and not working with him. But, it was what needed to be done and now…I found the connection to her.

However, the majority of parents described being immediately receptive to PMTO because they were inclined to try anything that could help. In the words of one mother (Participant #15), "We were at wits end. We didn't know what to do. So we were willing to try anything." Another parent (Participant #01) shared, "My wraparound coordinator told me about it and stuff so I thought yeah, I mean anything that could help me, you know, I am willing to do." Yet another mother (Participant #02) echoed this sentiment, "If somebody was trying to help me I was gonna suck in as much as I could because I had no one else to give me any direction." Participant #11 explained simply, "I didn't know what to do so I started doing this."

Retention. Once parents were engaged in PMTO, they remained in the intervention until completion because they saw that it was working. This was the straightforward and predominant theme that emerged from participants' accounts. As one mother (Participant #08) reported, "I kept doing it just because I needed to see some results and we were seeing results fairly quickly." Another parent (Participant #12) explained, "Because [daughter] and I were getting along. I mean we argued less and …our family was more functional." In the words of one parent (Participant #15), "To actually see the peace that comes along in the household, that was encouraging." Similarly, another parent (Participant #19) remarked that she continued participating in the PMTO intervention, "because I saw the results. And I saw that it was working. My house was calmer, it was smoother, it wasn't a fight getting somebody to do something." And as this mother (Participant #20) described:

> Not to say it wasn't tough following through with the practicing and things like that. It was tough at times because, well, my kids are not easy to deal with. They're very hard to deal with. But with [interventionist]'s help, with her strategies, with her showing me the progress that I had made with them, it really encouraged me to move on with it and continue and finish with it.

A few participants mentioned the role of their interventionist in encouraging their retention in PMTO. Sometimes the interventionist worked actively to motivate parents to continue with the intervention. As one mother (Participant #16) explained, "Just from what [interventionist] has told me, that she saw a dramatic change in a lot of kids from doing the PMTO…. And then I just always thought about that in the back of my head." Otherwise, some parents continued to attend their PMTO sessions because they had a pleasant relationship with their interventionist and appreciated the opportunity to talk and receive support.

Interestingly, a very small number of parents reported that PMTO had not worked in their families, yet they still remained in the intervention until completion. These parents continued with the intervention because they were committed to learning and trying new things to help

their children, even if conditions were not improving at the present time. One mother (Participant #01) shared:

> I knew I had to do everything I could to try to see what would happen….to get as much as I could out of it for my kids…. I didn't know what would happen over the next years, whatever, you don't know what's gonna happen. But I knew I had to do what I had to for my kids because they are, they are it.

Summary and synthesis. The parents in this sample reported facing a variety of challenging circumstances prior to their participation in PMTO. These experiences led to the realization they needed assistance with their parenting efforts, at which point parents sought help and became engaged in the PMTO intervention. Once exposed to the intervention, this sample of parents remained in PMTO and completed the intervention primarily because it was working for them and their families. In this way, it appears that retention in the intervention was associated with parents' appraisals of its effectiveness. The role of engagement and retention in parents' overall process of change in PMTO is illustrated in Figure 4.1.

Findings of Focal Research Question E: Resistance in PMTO

The main finding that emerged regarding parents' experiences of resistance in PMTO was this sample of participants did not experience much resistance. When parents were asked if there was anything about their experience in PMTO that made them upset or frustrated, half the sample was specific in stating there was not. Some other parents expressed difficulties or challenges they faced while implementing PMTO in response to this question. While these may have been frustrations, they did not clearly lead to resistance on the part of the parent. For instance, one mother (Participant #16) expressed, "In the beginning it was kind of frustrating, which is normal. Because it's something new for him. But overall I liked it a lot." Other parents reported being initially uncertain about certain aspects of PMTO. Specifically, some parents reported feeling awkward about participating in role plays or were initially uncertain about the

idea of breaking child behaviors down into steps. During data analysis, these responses were found to fit better within other categories, and were presented in other sections of this chapter.

Overall, only about one quarter of participants reported discernable manifestations of resistance during their interviews. These responses coalesced around a shared concern that one or more of the parenting strategies being presented in PMTO would not work. As one mother (Participant #02) explained, "Yeah, it was helpful. It was. I can see that now. Back then, no. Not at all. I was just like 'Really? Seriously, you want me to do this? This ain't gonna do anything!'" Another mother (Participant #19) expressed, "I was concerned when she said, 'Okay, we're going to do time out." I'm like, 'Really?!? He's ten. Like who uses time out?'" A father (Participant #13) described his reaction after learning about giving good directions and being told that at the beginning of the intervention he would not enforce any penalty for noncompliance. He recalled, "In the beginning…what I thought was, Um, like how is this gonna work? If there is no correction, what do you do? If it doesn't work, you just forget about it? What's the point of that?" One parent (Participant #01) in particular went into detail about her discomfort practicing giving good directions because she was certain her son was too old for this strategy to work. Her account suggests her refusal to believe that giving good directions would be effective with her son was a tactic she used to protect herself from getting her hopes up and then being disappointed once again, a theme common to her parenting experience. In her words:

> It just brings up a lot of emotion too. Like what she would have us [do], to walk up and say, you know, "Pick that up please and put it in your room." Or, "Put it in your room please" or however you're supposed to say it. It made me feel uncomfortable because like inside I knew that would never work, you know, for me. So like it just was stupid. Like, I'm not gonna do this. It's not gonna work anyway so why would I be doing this? But then it was like when I would do it, it would just bring a lot of emotion up because I wish it would work.

There were two additional experiences reported by parents that appeared relevant to the topic of resistance. First, one parent expressed resistance to the idea of engaging in a parent

training intervention when she perceived her child was the one that needed counseling. She remarked, "I was a little skeptical at first. I didn't really know…I was more looking for counseling just for [son] more or less just to help him kind of work through his issues. I was not real happy about that." Second, one mother described a situation in which her interventionist seemed to perceive her as resistant, and kept insisting that she implement time out with her son because the interventionist was certain it would work, even when the mother reported it was ineffective. This mother reported being head-butted, bit, kicked, and screamed at by her son while trying to enforce time out before her interventionist would accept that privilege removal was a better option. While atypical, each of these accounts raised important issues to consider regarding parents' experiences of resistance in the PMTO intervention. These will be addressed in Chapter 5.

Summary and synthesis. Overall, the parents in this sample did not report much resistance to the PMTO intervention. The one theme of resistance that did emerge stemmed from parents' doubt that the parenting strategy they were learning at the time was actually going to be effective. In this way, resistance to the PMTO intervention appeared related to parents' appraisal process, particularly their perceptions of whether or not what they were learning would work when implemented in their life context. This relationship is illustrated in Figure 4.1.

Chapter 5: Discussion

Child mental health disorders are a significant public health issue in the United States (U.S. Public Health Service, 2000). Approximately 15 million children in this country have a diagnosable mental health condition, but only about one in three of these children receive treatment (Kazdin, 2008). This study sought to address this problem by investigating the evidence-based parent training intervention known as PMTO. The PMTO intervention is one particularly well-supported treatment approach capable of alleviating child behavior disorders (Forgatch & Patterson, 2010; SAMHSA, 2011). Yet, there is a need to better understand how this intervention promotes change (Patterson & Forgatch, 2010). Increased knowledge of the process of change experienced by parents exposed to PMTO could inform further adaptations of this intervention as well as other evidence-based parent training interventions. The objective of these research efforts was to continue improving the services available to families and ultimately help reduce the distress associated with child behavior disorders.

The purpose of this study was to develop a grounded theory describing the process through which parents' experiences in the PMTO intervention led to change in their parenting practices. To accomplish this, individual interviews were conducted with parents who had successfully completed PMTO in a community mental health services setting. Qualitative data analysis was performed using a grounded theory approach and resulted in the development of a theory that explains this process of change based on the experiences and perceptions of PMTO reported by parents. The contributions of the PMTO intervention content, its method of delivery, and the role of the interventionist are described in this theory. The influence of parents' experiences of engagement, retention, and resistance were also incorporated.

This chapter will feature a discussion of the study findings. It will begin by reviewing the utility of the Doss framework for studying change applied in this investigation. Next, it will consider the findings of each research question in relation to current PMTO scholarship and propose implications for intervention delivery and continued study. This chapter will go on to discuss the findings within the broader context of research on evidence-based parent training interventions. Finally, the strengths and limitations of this study will be presented along with recommendations for future research and practice.

The Utility of Applying the Doss Framework for Studying Change

According to Doss' (2004) framework, change is conceptualized to occur in three sequential domains: The change processes occurring in therapy lead to change mechanisms that occur outside of therapy and then result in ultimate therapy outcomes. This study was primarily concerned with exploring and identifying change mechanisms resulting from exposure to PMTO that led to change in parenting practices. This framework proved helpful for identifying and organizing the change processes that were identified in this investigation.

This study identified a number of therapy change processes that took place during PMTO sessions and helped lead to subsequent improvements. Therapy change processes are specific actions and activities that the interventionist performs while delivering the treatment (Doss, 2004; Mckay, 2007; Nock, 2007). Study findings suggested it was important for therapists to cover the PMTO topics of good directions, skill encouragement, limit setting, and emotional regulation in session with clients. Clients found it most helpful when the interventionist helped them to practice these strategies using role play, home practice assignments, troubleshooting, and by incorporating visual aids. The role of the interventionist was also implicated as a therapy

change process, and participants described the importance of having a therapist who provided support, offered encouragement, and fostered a strong therapeutic relationship.

This study also identified some behaviors and perceptions of the PMTO participants that helped bring about change. These are referred to as client change processes (Doss, 2004; McKay, 2007; Nock, 2007). The engagement context played an important role because in most cases participants were seeking help and remained receptive to the material presented throughout the intervention. Participants' appraisals of the effectiveness of the intervention may have also been an important change process because positive appraisals fostered retention in the intervention and further change, while negative appraisals were linked to resistance.

Despite its usefulness, the Doss framework was also somewhat limiting because thinking about change in terms of three sequential components, as presented in the framework, did not provide a high degree of correspondence with the experiences of participants. For example, participants reported their experience of change to be much more fluid and circular than what is described in the framework. The process of change experienced by parents was also more complex and implicated contextual variables and other factors as integral parts of this process. In addition, parents reported experiencing change as much more of an active process than what appears to be depicted by this framework. Therefore, the Doss framework is useful for structuring the study of change and helping to interpret research results, but it fails to capture the full extent of the change process experienced by participants in this study.

Discussion of the Findings in Relation to PMTO Scholarship

Process of change in PMTO.

Parents' efforts to attempt, appraise, and apply. The findings of this study revealed that parents' experiences in the PMTO intervention led to change in their parenting practices through

their efforts to attempt, appraise, and apply the intervention material. The first step parents described in their process of change was to attempt the parenting strategies they were learning, initially in session and then at home with their children. The second step, appraisal, took place as parents continually evaluated their experiences with the intervention to determine if it was working and fit with their worldview. During the final step, parents applied what they were learning in PMTO by either maintaining implementation, adapting the strategies, using PMTO as a backup, or setting the skills aside.

What stands out about this process is that parents do not passively absorb the PMTO intervention material based on external assurances that it is important or effective. Instead, parents actively engaged in attempts to try out the intervention, appraise whether or not the intervention worked for their family, and then applied it accordingly. In some ways, identifying these steps does not seem extraordinary – it almost seems to be common sense that parents would want to try out PMTO and see if it works for their family before they are willing to change their parenting behaviors. Yet this process may be in danger of being overlooked during intervention delivery, especially in the case of evidence-based interventions.

In the case of PMTO, researchers and practitioners connected to the intervention know that outcome studies have found PMTO to be an efficacious and effective intervention. By the standards of the scholarly community, most people would agree that PMTO works. However, demonstrating a significant effect size in a research study and making a noticeable difference in the life of one parent are far from the same thing. Therefore, the process of attempt, appraise, and apply calls attention to the importance of the individual experience of each parent who is participating in the PMTO intervention. It is important that interventionists work with every

parent to find ways for them to experience success throughout each phase of this process of change.

During the attempt phase, parents often reported feeling anxious or awkward as they began implementing the new PMTO techniques they were learning. It may be important for interventionists to anticipate and normalize these reactions. At the same time, interventionists can provide encouragement and positive reinforcement to highlight the areas in which parents are doing well. These clinical skills - normalizing, focusing on encouragement, and reinforcing positives – are expressly encouraged among PMTO interventionists and factor into their competent adherence to the PMTO model (Knutson et al., 2003). Study findings also emphasized the important contributions of role play during the attempt phase as well as other teaching strategies that allow parents to practice new behaviors in a supportive environment where they can experience success. Role play and other active teaching strategies are a hallmark of the PMTO approach (Forgatch & Patterson, 2010; Knutson et al., 2003).

During appraisal, interventionists should focus on ensuring every parent is able to experience success with the intervention. In order to do this, interventionists can help structure experiences where parents can implement PMTO effectively. This can be accomplished by making sure parents feel prepared and confident before practicing new skills at home, by setting small goals and focusing on small successes, and by preparing parents to anticipate and work through any obstacles they may face.

Interventionists should also monitor parents' initial responses to each intervention component for signs that it might diverge with their worldview. For example, some parents might perceive that the focus on positive reinforcement and incentives violates their beliefs about parental authority and child obedience. In these cases, interventionists may be able to find

agreement with parents on common parenting goals both parties want to work toward (e.g., you want your child to comply and positive reinforcement is an effective method for teaching compliance). Otherwise, interventionists may consider reframing certain aspects of the intervention or collaborating with parents to make adaptations to the way the skill is applied.

As parents described their experiences in the application phase of the change process, four different pathways emerged. This suggests that successfully applying the PMTO intervention may look different across parents or across various intervention material. The first pathway was to maintain implementation of the parenting strategies in the manner parents had learned in the intervention. In comparison, some parents benefited more from the second pathway, adapting the strategies of PMTO to better fit their life contexts.

Many of these parents found that making minor alterations to the parenting practices made them more effective or allowed them to remain operational over time. This adaptation pathway is interesting because it shows that even when parents may no longer be implementing the parenting strategies of PMTO with fidelity to the original model, exposure to the intervention was still helpful for informing their parenting methods and triggering change in their parenting practices. There is some indication that adapting the parenting strategies is an expected aspect of integrating PMTO into one's parenting efforts. As Forgatch and DeGarmo (1999) have written, "A key assumption was that each mother would tailor these procedures to fit her child's needs. Presumably, each mother would apply the newly acquired skills to child problems that concerned her and develop her own sequence of application" (p. 720). Yet, one danger of making adaptations was that some participants were now implementing parenting practices that appeared similar to what they had learned in the intervention, but violated an important premise of the model. For instance, one mother shared how her kids responded better to her directions when she

gives them after breaking down and beginning to cry. While this practice seemed to work for her, it was negating the importance of emotional regulation on the part of the parent. In order to promote successful adaptation of PMTO, interventionists can use their expertise to help parents modify intervention components in ways that still embody the principles of the strategy while helping them avoid dangerous PMTO mutations.

Another pathway of implementation was to use PMTO as a backup when the conditions warranted it. A relevant finding from this study was that parents often noticed positive changes in their children's behavior after implementing PMTO for a short time and did not feel it was necessary to rely heavily on them after that. Over time, many of these parents had moved into the fourth pathway of application described in this study and had been able to entirely set aside the PMTO strategies because their children showed lasting improvements in behavior. Interventionists should realize that for some parents, reducing or terminating their use of PMTO strategies is an indicator of success with the intervention (Kazdin, 2008).

There were only a few parents in this study who did not report considerable success with the PMTO intervention in changing their children's behavior and had subsequently stopped implementing the PMTO strategies. From the interview data collected if was not clear if this lack of success was the result of overwhelming contextual factors, weak coaching by the interventionist, or some other reason. The parents themselves seemed to attribute the lack of improvement to the severe and chronic behavioral issues exhibited by the children. They did not seem to expect one parenting intervention to solve their problems.

Taken together, parents' process of attempting, appraising, and then applying the intervention material in different ways according to what they found to work best for their family poses interesting implications for the training model of PMTO. In particular, the PMTO

intervention may better equip parents to manage child behavioral problems by shifting from prescriptive efforts toward a more principle-driven model. For example, instead of emphasizing a specific way of constructing and evaluating a behavioral chart, it may be more productive to spend time teaching parents about the principles that form the basis for skill encouragement in PMTO. In this way, when parents change how they practice skill encouragement in their families over time, it is more likely they will retain the key elements of the strategy even if they adapt their methods of implementation. Providing parents with a solid understanding of the principles behind the PMTO parenting strategies may ultimately enable them to continue implementing PMTO over time in ways that embody the fundamental aspects of the intervention model while still providing flexibility to modify the specific parenting techniques when the need arises.

To conclude this section of the discussion, I need to present one final, exceedingly significant recommendation for PMTO that emerged from the data. During the interviews, parents emphasized the need for some type of booster session component to be added to the PMTO intervention. Parents reported that as time elapsed, they recognized areas where they were losing effectiveness because they were having troubles remembering a PMTO strategy. They also encountered new situations after completing the intervention, often as their children grew older. As a result, parents overwhelmingly agreed that having access to some form of a booster session or opportunity to refresh their skills would be advantageous.

When asked what kind of booster session-type activity would be most helpful, two different suggestions received widespread support. Many parents agreed that being able to schedule additional sessions with a PMTO interventionist in the future would be beneficial. In this format, parents could receive one-on-one attention similar to their original experience in PMTO and could re-work some of the content areas they were unable to remember. Parents

would also have the opportunity to discuss ways of implementing the intervention within their current context, after family arrangements had shifted or children had matured. A few of the parents in this study had actually engaged in this type of "refresher" course with their interventionist and found it very useful.

The other widely endorsed format involved establishing some type of ongoing PMTO support group for parents who had participated in the intervention. The key advantage of this group was that parents could share their experiences with others who understood what they were going through. They could then receive feedback based on the challenges and successes experienced by other parents in the group. In this way, participants felt they would benefit from the collective experiences of the group and be able to learn from others who were implementing the intervention in the real world with their children.

Of course, many other booster session variations are possible, and it would be important to assess the advantages and disadvantages of implementing any one of them. Still, parents' calls for some form of continued support for implementing PMTO were clear throughout the interviews. I promised them I would highlight this as a main implication of the research study.

Life contexts. Another significant contribution of this study was the way in which parents were able to identify multiple life contexts that influenced their experiences in PMTO. The importance of accounting for context in planning and delivering the PMTO intervention has informed the design and delivery of previous PMTO studies (Forgatch & Martinez, 1999; Forgatch et al., 2005). Thus, the role of each of these contexts is important to consider when continuing to adapt and disseminate PMTO among various populations.

Family context. Participants in this study identified how being in a two-parent, divorced, single, or other caregiver context affected the way in which they were able to implement PMTO

within their family. Participants in two-parent families stressed the importance and challenges of maintaining consistency across parents. Helping parents to develop a united parenting front is a key consideration of the PMTO intervention (Forgatch & Patterson, 2010; Knutson et al., 2003). While many parents in this study confirmed that PMTO did help them become more consistent as a couple, intervention activities addressing this issue may need to be enhanced to promote a more uniform experience across participants.

Participants who were divorced reported increased threats to consistency because they were often parenting in conjunction with an ex-spouse or together with a new step-parent. Single parents, all mothers in the study, felt the pressures of being solely responsible for the caregiving. The experiences of these divorced and single parents are interesting because PMTO has been adapted for recently separated single mothers and stepfamilies and has demonstrated successful outcomes when applied with these populations (DeGarmo & Forgatch, 2005, 2007; Forgatch & DeGarmo, 1999; Forgatch et al., 2005; Forgatch et al., 2009). This suggests two implications. First, when disseminating PMTO in community contexts, it is important that interventionists are aware and have access to different adaptations of the PMTO intervention so they can infuse them as needed into their work with parents. And second, the PMTO intervention must remain open to refinement as parents in various family constellations voice the challenges they face.

Finally, some parents in this study received caregiving assistance from their own parents. In these instances, parents expressed that it was difficult because these additional caregivers were not familiar with PMTO and could not implement similar parenting strategies with the children. An interesting area of future exploration in PMTO may be to investigate ways of simply yet effectively transmitting basic information about PMTO to other caregivers in a family.

Employment context. Participants in this study described how their employment outside the home often limited the amount of time they were able to spend with their children and made it difficult to implement PMTO. Some aspects of PMTO can be particularly time intensive, such as charting or convening regular family meetings. In addition, after not seeing each other all day, parents and children may want to enjoy some time together away from the structured strategies of the intervention. The parents in this study who were most successfully managing this contextual stressor seemed to be those who adjusted their timeline for implementing the intervention strategies. Therefore, interventionists coaching parents who work during the day could show them to use charts that focus on shaping behaviors the child performs at night after the parent gets home (e.g., brushing teeth before bed) or in the morning before work and school (e.g., get backpack ready). The same strategy could apply for parents working other shifts. Overall, given the necessity of employment for many parents and the time pressures it introduces, interventionists must be sensitive to this life context and be willing to troubleshoot and find ways of implementing PMTO that work for employed parents.

Financial context. The majority of parents in this study were dealing with significant financial strain. While some parents reported this made it difficult to afford the incentives and rewards used to reinforce positive behavior in PMTO, other parents found ways to address this issue. In particular, the key seemed to be finding relevant yet inexpensive rewards to offer to children. Parents in this study sometimes allowed their children to do crafts, took them to the park, or spent extra one-on-one time with them. Yet finding effective incentives is not always easy and often requires creativity and extra time in session to discuss and revise possible incentive options. Interventionists may be able to better support parents facing financial challenges by setting aside extra time in PMTO to work through this issue.

Resulting improvements. In this study, participants described their experiences in the PMTO intervention leading to change in their parenting practices. They also went on to describe additional improvements they observed within themselves as parents, in their children's behavior, and in their family relationships. These findings relate in exciting ways to current research being conducted on the PMTO intervention.

One improvement parents described was how participating in PMTO had helped them as a parent. In particular, parents described how they experienced increased confidence and self-assurance as a result of the intervention. This is in line with one of the chief aims of PMTO, to empower parents in the use of more effective parenting strategies (Forgatch & Patterson, 2010). Yet, the identification of these improvements in positive internal states (i.e., confidence, self-assurance) suggests an important complement to current PMTO research which has mainly focused on decreases in maternal depression. Work by Patterson and colleagues (2004) has shown that participating in PMTO was associated with decreased depression outcomes in mothers, even before any changes in child behavior were observed. The current study confirms it is important to also include measures of mastery and parental efficacy in studying this effect (Patterson et al., 2004).

Including variables that track positive internal states may also shed light on a current mystery within PMTO research. In work by Forgatch and colleagues (2009), mothers who participated in PMTO demonstrated significant improvements in several areas of financial well-being relative to mothers who did not participate in the parenting intervention. However, the researchers were unable to explain these effects based on the changes mothers had experienced in their parenting practices, their reductions in depression, or in their children's behavior (Forgatch et al., 2009). Instead, this study suggests that improvements in parental confidence and

self-assurance may be implicated as potential change mechanisms. This hypothesis is supported by parental reports of how the success they experienced in PMTO had given them confidence to generalize the skills they were learning to other settings. For example, one mother shared how she now gives more specific and assertive directions at work because of the increased self-esteem and confidence she attributed to PMTO.

A second improvement parents described was how PMTO had led to positive changes in their children's behaviors. Parents had noted progress in both the internalizing and externalizing behaviors of their children. Observing improvements in child behavior as a result of improvements in parenting practices goes in line with the body of research behind PMTO, as "studies are consistent in declaring that changes in parenting produce changes in child outcome (Patterson, 2005, p. 28).

The potential relationship between these improvements in how parents view themselves and the behaviors they observe in their children is particularly fascinating. In particular, these data suggested there may be a reciprocal relationship between the two, where improvements in parental confidence were promoting changes in child behavior, and changes in child behavior were leading parents to feel more confident with what they were doing. PMTO scholars have been working hard to uncover the sequences of change following participation in the PMTO intervention. To date, studies have found that participation in PMTO leads to improvements in child behavior which brings about reductions in maternal depression (DeGarmo et al., 2004). These reductions in maternal depression have actually been observed at multiple time points following the intervention, sometimes before changes in child behaviors (Patterson et al., 2004). Furthermore, changes in both internalizing and externalizing behaviors have been demonstrated

following parental participation in PMTO, with internalizing behavior mediating changes in externalizing behavior (DeGarmo et al., 2004).

In many ways, this study aligns with these previous quantitative investigations. For instance, it described improvements in child behavior and parent internal states following participation in PMTO, and confirmed changes in both internalizing and externalizing child behavior. In addition, this study suggests that exploring parental confidence as a variable in addition to parental depression, and examining if improvements in parental confidence mediate changes in child behavior may be fertile areas for future study.

The final improvement resulting from PMTO described by parents was positive growth in family relationships, particularly the parent-child relationship. Enhancements in sibling relationships, parental relationships, and overall family cohesion were also evidenced less frequently in the data. The idea that changes in one parent can lead to changes in other members of the family is consistent with a family systems perspective, and has recently become the focus of study in PMTO research (Forgatch et al., 2009; Patterson et al., 2004). Taken together, these findings suggest that recognizing the interconnected nature of family relationships and exploring how changes reverberate throughout the family system over time following participation in PMTO could be rewarding new frontiers for research.

Content of PMTO. Of all the intervention content parents were exposed to during PMTO, four topics emerged as the most salient in their change experience: good directions, skill encouragement, limit setting, and emotional regulation. Participants described how their efforts to attempt, appraise, and apply these parenting strategies allowed them to generate change in their parenting practices. They also described elements of each of these content items that helped to facilitate these changes.

Good directions. Learning to give good directions was the most prominent aspect of PMTO for parents and was described as having the most influence on their parenting practices. This is an interesting finding given that using good directions is not officially a core component of the intervention, although it is considered an essential parenting tool for promoting skill encouragement and limit setting (Forgatch & Patterson, 2010). Similar to what is described in the PMTO literature, parents found that giving good directions led to almost magical improvements in the cooperation and compliance of their children (Forgatch & Patterson, 2010; Knutson et al., 2003). Yet even as parents progressed through the program and were introduced to the core components of the intervention, they maintained that giving good directions, as an independent parenting skill, was critical to the changes they were seeing in their children's behavior.

Parents identified numerous elements of good directions that guided their use of this parenting skill, including using "now, please," getting the child's attention, and being simple and specific. These align with the principles of giving good directions taught in the intervention, and suggest that parents found these features to be not only useful but memorable. However, parents did not mention one important principle of giving effective directions: identifying the goal behavior and telling children what to do, as opposed to what not to do (Forgatch & Patterson, 2010; OSLC & ISII, 2006).

The topic of good directions is recognized as an important parenting tool in PMTO, and is taught toward the beginning of the intervention because it is considered a foundational skill (Forgatch & Patterson, 2010). The findings of this study confirm its importance and support the usefulness of teaching good directions near the start of parents' participation in PMTO. Yet, the consistently positive emphasis parents placed on this skill may suggest that it deserves an even more pronounced role in the intervention. If nothing else, this content item should be valued for

the unique contribution it can make toward helping parents improve child behavior in additional to the ways in which it provides support to other parenting components. This is a particularly important point to emphasize when training PMTO interventionists, as there is a risk that clinicians will overlook the importance of this tool when first being exposed to the intervention. This study also confirmed the relevance of several principles inherent in giving good directions while pointing out one element (i.e., focusing on goal behavior) that may require extra emphasis.

Skill encouragement. Parents identified skill encouragement as another content item that was central to their experience in PMTO. Skill encouragement is a core component of PMTO that involves using token incentives and more structured incentive programs, such as a star chart, to reinforce positive behavior (Forgatch & Patterson, 2010; Knutson et al., 2003). Study findings revealed that parents were practicing each of these methods and found them to be helpful. Some parents did report trouble finding effective incentives because of unrealistic expectations on the part of the child or the cost associated with implementing an incentive program.

Within the skill encouragement component, the idea is for parents to use incentive programs to structure common, more involved behaviors such as setting the table, and to use token incentives for immediate reinforcement when outside the home (Forgatch & Patterson, 2010). This distinction was not clear in parents' reports. Instead, parents tended to start off implementing both approaches to encouragement and then adapt their application based on which method they found to be most practical and effective in their household.

Parents also identified additional elements of skill encouragement that played a role in their experience with this core component. The categories that emerged from their accounts – practicing positive reinforcement, breaking it down into steps, and teaching new behaviors – demonstrate parents' understanding of the guiding principles and goals of this parenting strategy.

It is significant that parents demonstrated such insight into practicing skill encouragement with their children because this component is central for structuring successful experiences for their children and fostering positive parent-child relationships.

Overall, the findings of this study confirm the central role of skill encouragement in the PMTO intervention. Parents seem to understand and appreciate this core component, although they might benefit from additional attention aimed at identifying effective incentives. This is especially relevant when working with families with lower socio-economic status and others facing financial pressures because of the cost sometimes associated with incentives. Interventionists need to carefully attend to this issue and lead these families in identifying creative solutions. Otherwise, parents may surrender their use of important elements of skill encouragement due to limited financial resources.

Limit setting. Learning about limit setting, another core component in the PMTO intervention, was also considered by parents to be central to their process of change. A key theme that emerged in the data was that parents considered the limit setting strategies taught in PMTO to be an improvement upon what they were already doing. They did not feel they were undermining their current methods of discipline, nor did they discount them as just more techniques amidst a sea of discipline recommendations.

Parents discussed four key elements of limit setting: actions have consequences, giving children a choice, follow through with it, and short duration of punishment. These categories demonstrate that parents have a strong understanding of many of the principles of limit setting. Still, other key aspects were not mentioned. For instance, PMTO recommends that parents maintain a ratio of five positive interactions to one negative, leave adequate physical distance when assigning consequences, and allow the issue to rest once the limit setting encounter is over

(Forgatch & Patterson, 2010). These principles of limit setting are central to the intervention because they help parents teach children what is not allowable in a manner that protects the quality of the parent-child relationship.

Parents reported using two primary methods of limit setting: time out and privilege removal. In PMTO, parents are taught a highly structured sequence for setting limits that results in a time out if the child does not comply. Privilege removal is then introduced as a supplementary practice to be used when children refuse to go to time out (Forgatch & Patterson, 2010). However, the parents in this study generally did not practice limit setting in this way. Parents commonly reported facing challenges when trying to implement time out, and concluded that privilege removal was more effective. As a result, privilege removal was the limit setting strategy of choice for parents in this study.

In this way, the limit setting component of the intervention constituted a situation in which most parents applied PMTO by adapting the method to better fit their life context. Yet while the actual methods were altered, these adaptations often maintained many principles of appropriate limit setting taught in PMTO. This suggests that future adaptations of PMTO may benefit from placing less emphasis on teaching conditional limit setting sequences and focus instead on providing parents with a solid understanding of the principles of limit setting. This may provide parents with a more solid foundation as they go forward and adapt this strategy to best fit their family circumstances.

Emotional regulation. The fourth and final content item that emerged as a central contributor to parents' process of change was emotional regulation. In this study, parents described their perceptions of emotional regulation and provided examples of strategies they used in order to to help regulate their emotions. More importantly, they went on to express how

emotional regulation was interconnected with the other parenting strategies. Regulating their emotions helped parents to implement good directions, skill encouragement, and limit setting just as implementing these other strategies helped parents to regulate their emotions.

In the PMTO literature, emotional regulation is mentioned as "an important yet seldom described supporting component for PMTO" that is often covered as parents practice the limit setting sequence (Forgatch & Patterson, 2010, p. 166). And while it is assessed as a supporting parenting practice when fidelity to the PMTO model is being evaluated (Knutson et al., 2003), it is not often emphasized in PMTO scholarship. However, the experiences of the participants in this study underscore the central role of emotional regulation in facilitating their process of change in parenting practices. This suggests that increased attention should be given to the role of emotional regulation in PMTO and that future intervention efforts ensure it is not just included to augment the limit setting component, but is emphasized throughout the intervention.

Additional content items. The findings related to two additional content items, problem solving and monitoring, are notable primarily because they were not particularly significant to parents' experiences in PMTO. This was unexpected because they are both core components of the intervention. Parents suggested that if these topics were presented toward the end of the intervention they may have already been so occupied with implementing other strategies that problem solving and monitoring were overlooked. In addition, some parents reported that monitoring was not relevant because of the younger age of their child. It may be that as children transition toward adolescence, parents will identify monitoring to be a much more salient issue. It is also possible that interventionists' fidelity to these parts of the model was diminished for some reason and parents were not adequately exposed to these topics. However, another possibility is these core components do not fully match the needs of parents who participate in

PMTO in community mental health contexts and may need to be adapted to become increasingly relevant to this population. This is a highly important area for continued research.

Salient content items and previous PMTO research. It is interesting that the four content items identified as central to parents' experiences of change in PMTO do not fully align with the core components of the intervention. In fact, only two of the five core components emerged as salient topics (i.e., skill encouragement, limit setting). The other two topics (i.e., good directions, emotional regulation) are considered to be PMTO support skills. These observations may be important to consider alongside previous PMTO research.

A main variable in PMTO outcome research, positive parenting practices, has been operationalized as a composite of four parenting practice indicators: skill encouragement, positive involvement, problem solving, and monitoring (Forgatch et al., 2005; Patterson et al., 2004). Yet only one of these indicators, skill encouragement, was identified as a major content item leading to change in parenting practices in this study. Other research has focused on the problem solving outcome, likely because observational data based on problem-solving exchanges has been shown to be a reliable predictor in PMTO studies (DeGarmo & Forgatch, 2004; Patterson, 2005). However, family problem solving was not one of the core components highlighted by parents in this study.

It is notable that the PMTO indicators being used to measure and to demonstrate positive changes in parenting practices are not the same parenting strategies participants in this study reported were most helpful to them in the intervention. It is possible the content items parents reported as facilitators of change in this study serve as precursors of change to the parenting practices being measured in quantitative PMTO research. In fact, learning to give good directions is believed to promote skill encouragement and limit setting (Forgatch & Patterson,

2010). And, good directions, skill encouragement, and limit setting have been identified as strategies parents learn in PMTO in order to teach their children compliance (Forgatch & Martinez, 1999). It is also likely that improved ways of evaluating positive involvement could lead to a better appreciation of this core component. While the interview guide for this study included probes to explore positive involvement, participants' accounts of this component were ambiguous. At the same time, it may be useful to consider that the indicators of change currently being used in PMTO research do not closely reflect parents' actual experiences, and could be improved. These modifications could lead to exciting new insights in this area of study. Of course, the current study would need to be expanded and replicated before calls to re-examine established methods of PMTO outcome research would be in order.

Method of delivery of PMTO. Study findings showed that participants identified certain PMTO teaching strategies were most effective in helping them learn the material. Engaging in role plays and home practice assignments helped parents to begin practicing the parenting strategies and applying them at home. Troubleshooting gave them a chance to process their experiences and find ways to achieve greater success. In addition, parents reported their learning was enhanced when their interventionist used visual aids.

Role play. Role play stood out to parents as the most memorable learning activity they engaged in during PMTO. This was not surprising given that role play is a central feature of PMTO's active teaching strategies and is used extensively throughout the intervention (Forgatch & Patterson, 2010; Knutson et al., 2003). Parents' original reaction to role playing was often somewhat negative as they reported feeling awkward and uncomfortable with this approach to learning. In addition, parents pointed out the demanding nature of role play and how they often had to repeat a skill more than once before mastering it.

However, most parents eventually came to accept role playing as an effective way to learn how to implement the PMTO parenting strategies. In particular, parents valued role play because it allowed them to practice the parenting tools they were learning and gain confidence before implementing them at home. This finding is in line with the scholarship on role play in PMTO. In particular, Forgatch and Patterson (2010) have written how role play facilitates practice with an interventionist so that skills learned in PMTO can be generalized to the home environment. However, these scholars also expected that role play would benefit parents by allowing them to understand different situations from the perspective of the child. Yet, this was not a theme that emerged in the data.

Overall, study findings confirm that role play should be considered a central method for delivering the PMTO intervention. Despite its demanding and awkward nature, parents felt it was central to their experiences of success with the intervention. When introducing role play, interventionists should be sensitive to the fact that many parents may feel uncomfortable participating at first. Interventionists can seek to normalize this response. Yet, according to the participants in this study, interventionists should also proceed with the role playing exercises because they will ultimately benefit the parent. In addition, interventionists should be aware that role play is a valuable tool for addressing areas where parents need improvement, and should consider using this strategy as a means of soft correction when needed.

Home practice assignments. Parents also described how home practice assignments constituted an important PMTO teaching strategy. Not much is written about home practice assignments in the scholarly literature on PMTO, although their significance is demonstrated throughout the implementation manuals and parent handouts (e.g., OSLC & ISII, 2006). Parents valued home practice assignments for the prompting they provided to practice the parenting

strategies they were learning at home with their children. Although home practice assignments often included a written component, parents did not find this portion of the homework to be nearly as relevant. Future scholarship on PMTO should more carefully consider the role of home practice assignments, and study findings suggest this teaching strategy should continue to be used in the intervention. Placing more emphasis on active practice activities and less on completing handouts may further increase parents' appreciation of these homework activities.

Troubleshooting. Troubleshooting was another element that was mentioned frequently by parents but is not covered as often in PMTO scholarship. Specifically, parents appreciated the opportunity to discuss their successes with their interventionist and to share their challenges and work toward finding solutions. In this way, troubleshooting enhanced parents' experiences of success in the intervention. This activity may have also helped to foster a strong therapeutic relationship as parents came to believe their interventionist cared how they were doing and was willing to set aside extra time to help them in areas they were struggling. In the PMTO literature, troubleshooting is most often referred to as a component of session structure. Each PMTO session generally begins with a debrief of the home practice assignment from the last week, which includes efforts to troubleshoot (Forgatch & Patterson, 2010). This study suggests that troubleshooting may deserve recognition as a more central activity critical for promoting change in the PMTO intervention. In particular, troubleshooting may be essential with families facing difficult life contexts so these parents can find ways to experience success using the PMTO strategies amidst challenging circumstances.

Visual aids. The final method of delivery emphasized in parents' accounts was their interventionist's use of visual aids. During the interviews, it was common for parents to spontaneously mention how it was helpful when their interventionist wrote out key points or

drew sketches on a large sheet of paper during the session. Some participants even took these materials home and found them to be useful reminders of what they had talked about. This emphasis on visual aids was a particularly unexpected finding of this study. While PMTO intervention materials strive to incorporate useful illustrations, using visual aids in the manner described by participants is only a minor portion of one aspect of the active teaching skills PMTO interventionists seek to use (Knutson et al., 2003). However, it has become somewhat of an established practice to write on large post-it notes during PMTO training and intervention delivery. It is informative that participants resonated so much with this practice, and their experiences suggest that PMTO teaching activities may benefit from a more formal incorporation of this use of visual aids. Participants also described benefiting from the handouts and parenting binders they received. This finding helps confirm the importance of continuing to supply these materials to parents.

Role of the interventionist in PMTO. Parents only identified one additional characteristic of the PMTO intervention that affected their process of change: the role of the interventionist. The interventionist was the face of PMTO from parents' perspective and was critical to many of their experiences in the intervention. To be effective in this position, participants advised that interventionists must foster a strong therapeutic relationship, provide support, and offer encouragement.

The importance of a strong therapeutic relationship was central to parents' accounts. This is not surprising, given that the therapeutic relationship is recognized as a common factor of therapy that has demonstrated a moderate and consistent relationship to therapy outcome (Lambert & Barley, 2001; Martin, Garske, & Davis, 2000; Orlinsky et al., 2004). PMTO scholars have also emphasized the importance of establishing a strong therapeutic relationship with

parents early in the intervention (Forgatch & Martinez, 1999). Many clinical skills necessary for fostering this type of relationship are among the clinical process skills interventionists must practice to maintain fidelity to the intervention (Knutson et al., 2003). In fact, focusing on encouragement and support are specifically listed as a clinical process skill important to PMTO (Knutson et al., 2003). This aligns directly with what participants reported that interventionists need to do.

In this same way, many additional qualities that participants described regarding the role of the interventionist help to establish the therapeutic relationship and are clinical process skills relevant to the PMTO intervention. They are also important ways in which interventionists help to provide guidance in working with parents through PMTO. These include being able to effectively explain the material, showing investment in families, and demonstrating experience with PMTO. Overall, study findings highlight the central role of the interventionist and confirm the importance of establishing a strong therapeutic relationship. The experiences of participants also indicated that the clinical process skills characteristic of PMTO help to cultivate this important bond.

Engagement and retention in PMTO.

Engagement. Parents' descriptions of how they became engaged in the PMTO intervention highlighted the challenging circumstances they were facing prior to PMTO. Their accounts featured experiences of family dissolution through divorce or death and dealing with the effects of child mental health conditions that were often severe. Many parents were also facing financial strain. Overall, it is important to recognize that participants in this study were encountering multiple stressors and confronted with serious child behavioral problems. Within this context, parents struggled to manage the adverse behaviors their children were exhibiting

and often began to feel overwhelmed and ineffective. They ultimately decided they needed assistance with their parenting efforts and sought out services. They were subsequently offered the PMTO intervention through their local community mental health agency.

These findings on engagement are interesting to consider in light of the Oregon delinquency model that informs PMTO (Forgatch et al., 2009). Part of this model delineates how challenging contexts can lead to disrupted parenting which can result in child antisocial behaviors. Contexts such as divorce, poverty, and other stressors are implicated in this process. There is a high degree of correspondence between this model and the experiences reported by participants in this study before their engagement in PMTO. However, instead of continuing on this path leading to deviant child behaviors, parents in this study sought help and received the PMTO intervention. Unfortunately, the data did not provide a clear picture as to why this sample of parents made the choice to seek services whereas other parents do not. This decision point is important to explore in further research on engagement in the PMTO intervention.

Another key finding was that the participants in this study were not highly selective regarding their treatment approach; they were distressed, seeking help, and willing to try what was offered to them. This rather indiscriminate process of engagement was unexpected. Instead, this research question set out to uncover specific factors of PMTO associated with engagement in the intervention based on the premise that once these factors had been identified they could be honed in order to bolster future engagement efforts. Instead, these study findings implicate a different type of engagement strategy. Based on the experiences of this sample of parents, it appears that one straightforward approach for increasing engagement in PMTO is to increase dissemination of the intervention and make it available to more parents. While this should not

constitute the entirety of its engagement strategy, this may be an important point to consider when seeking to increase engagement in the PMTO intervention.

***Retention*.** The main finding regarding retention in the PMTO intervention is that once engaged, the participants in this study reported remaining in the intervention until completion because they believed it was working. This finding is especially significant given the severe child behavioral issues and high levels of stress parents were facing, because in spite of these challenges, parents were still able to experience PMTO as effective. A few participants also mentioned the role of their interventionist in encouraging their retention.

An implication stemming from these results is that interventionists could help to retain parents in the intervention by structuring opportunities for them to experience success with the strategies of PMTO throughout the course of their participation. This underscores the importance of troubleshooting with clients and making mid-week phone calls to assess how things are going at home and suggest modifications as needed. Although PMTO research to date has not placed a large emphasis on issues of retention, the practice of delivering PMTO places a focus on parent empowerment, pre-correcting when difficulties are anticipated, and helping parents to see their strengths and positive behaviors (Forgatch & Patterson, 2010; OSLC & ISII, 2006). In this way, the findings of this study highlight the importance of the focus that PMTO is already placing on promoting parents' mastery of the skills and strategies being presented.

Study data suggest some additional practices that may further enhance parents' opportunities to recognize the intervention is working for their family. For instance, parents talked about how keeping track of their child's behavior on charts or some other form of visual aid throughout the intervention helped them to see the progress they were making. It is also possible that asking the family to perform a structured task at the beginning of the intervention

and then at later stages may demonstrate to parents the successes they are achieving. Such an experience was salient to the couple who was able to observe their children were no longer hiding under the table during their post-intervention assessment. And finally, parents in this study suggested that it may be important to tell families that some difficulties may be expected in the beginning as they try these new strategies at home. Other parents may benefit from knowing this is a normal reaction to the introduction of new parenting practices and is not a sign that PMTO is doomed to be ineffective with their children. To the contrary, such growing pains may be seen as indicators that growth is in fact occurring.

Resistance in PMTO. Parents in this study reported very little resistance to the PMTO intervention. This is interesting given the struggle/work-through hypothesis operating in PMTO, where parents displaying initial increases in resistance that subside by treatment termination are believed to achieve better outcomes than those experiencing low resistance throughout therapy (Forgatch & Patterson, 2010; Patterson, 2005; Stoolmiller et al., 1993). However, parents in this study reported little resistance throughout therapy combined with satisfactory change outcomes. This may suggest that certain teaching strategies, such as those identified by participants as facilitating their process of change, are able to promote positive outcomes while avoiding parental resistance. For example, role play is thought to minimize resistance (Patterson, 2005).

It is also possible the parents in this study did manifest resistance to the intervention, but either did not recall these experiences after their resistance had dissolved, did not want to report these experiences, or described them in a way that was not coded as resistance. Notably, some parents described discomfort with role playing and certain principles of skill encouragement that may have been indicators of resistance but were coded into other categories during data analysis. It is also possible this sample of parents was biased toward very little resistance because only

those parents who had completed the intervention were eligible for the study. It is likely that parents who experienced more prominent resistance to the intervention would have dropped out.

The one theme related to resistance that was captured in the data referred to parents' doubts that certain intervention strategies would work for their family. This suggests structuring opportunities for parents to experience success in the intervention may be helpful for addressing resistance. Yet, it is clear further research is needed to more thoroughly understand this area.

Two additional points of discussion are needed to fully address parents' accounts of resistance. First, one mother expressed displeasure that she was asked to engage in treatment when her son was the one needing the help. This type of objection to parent training is anticipated in PMTO, and interventionists are advised to engage parents through emphasizing they are their children's best teachers and the key to helping their children succeed (Forgatch & Martinez, 1999; Forgatch & Patterson, 2010). Yet, research has demonstrated that children with disruptive behavioral disorders may benefit from direct treatment in addition to parent training (Webster-Stratton & Hammond, 1997). At the end of treatment this parent still felt her son needed professional help with his anger. Therefore, it may be wise to work hard to engage and retain these families in PMTO while also remaining open to making additional referrals when needed.

Second, there was one troubling report where a mother felt pressured to continue to try and implement time out with her son, even though it was leading to extreme instances of escalation, because her therapist insisted that this technique should be working with a child his age. While certainly not a representative experience, this case serves as an important reminder that sometimes what may be perceived as parental resistance is actually an indication that more individualized attention is needed. Fortunately, this parent continued to participate in PMTO

despite the challenges she faced and was eventually able to work with her interventionist to determine that privilege removal was a more effective limit setting strategy with this child.

Examining Study Findings within the Broader Research Context

There is a great need to better understand the experiences of parents who are receiving treatment through evidence-based parent training interventions, and qualitative research studies can make a significant contribution to this area (Levac et al., 2008; Spitzer, Webster-Stratton, & Hollinsworth, 1991; Webster-Stratton & Spitzer, 1996). In particular, this study focused on examining the process of change experienced by parents in one such intervention. The importance of augmenting quantitative data with qualitative insight in the study of change processes has been recognized for some time (e.g., Spitzer et al., 1991), yet quantitative studies continue to dominate this area of research. Therefore, this methodologically rigorous, qualitative study can offer several important contributions to the larger body of research examining the processes of change taking place in evidence-based parent training interventions.

Process of change. Many findings that emerged from the main research question in this study serve to strengthen the current knowledge base on parents' process of change. By establishing the attempt, appraise, apply framework, this study can provide a structure for identifying similar experiences reported by parents in other qualitative studies. For example, Petra and Kohl (2010) reported that parents in their study found some of the parenting techniques presented to by useful while finding others less so, and parents proceeded to select the techniques that best worked for them. This illustrates a process of attempt, appraise, and apply occurring in another parent training intervention context. Similarly, Levac and colleagues (2008) observed their parents "deliberately adopting a number of new parenting strategies that were helpful in their interactions with their children" (p. 84).

The work of other scholars aligns with the finding that parents apply what they are learning from the intervention in a variety of ways. Work by Spitzer and colleagues (1991) uncovered a process they labeled as "making the shoe fit." When parents engaged in this phase of change they worked to adapt what they were learning to fit their family context. Their findings went on to reveal that parents who did not make these adaptations experienced less success with the strategies (Spitzer et al., 1991). These reports corroborate what parents in this study were explaining as they engaged in the adapt pathway of application. Furthermore, writing by Kazdin and Rotella (2008) demonstrates a high level of convergence between their experiences and the parents in this study who described how they used PMTO as a backup and then were eventually able to set aside the skills as their children demonstrated improvements in their behavior. These authors provide the following description of Kazdin's parent management training approach:

> The program you'll set up for changing your child's behavior works like a frame you place around a growing plant to train it up straight and healthy. The plant is better behavior, and once it can stand on its own, you'll take down the frame. You will not be awarding points or keeping track of rewards forever. In fact, most parents find that such concentrated interventions take effect quickly and can be largely discontinued after a relatively short time, like a month or two. The intention here is that you build the frame of this method around your child's changing behavior, but once the desired behavior takes deeper root and gains in vigor, you quickly scale down the frame and then take it down entirely. (Kazdin & Rotella, 2008, p. 5)

Taken together, these findings suggest that the pathways of application described in this study may be shared by participants in other evidence-based parent training interventions.

Additional study findings regarding the process of change add further support to other qualitative research outcomes in the field. For instance, other parents have reported that whether or not support is received from one's partner factors into their ability to implement new parenting strategies (Stewart-Brown et al., 2004). A similar theme was revealed in this study and shed light on the impact of the family context. Study findings also bolster parents' reports of the positive results they have experienced as a result of participation in a parent training

intervention. In particular, participants across studies substantiate improvements in parental confidence, child behaviors, and parent-child relationships (Levac et al., 2008; Patterson et al., 2005). Finally, comparing the findings of this study to other research further supports the importance of adding a booster session component to parent training interventions, particularly if parents are exposed to multiple contextual stressors that are likely to threaten the effective implementation of core parenting skills (Patterson et al., 2005; Stewart-Brown et al., 2004).

The findings of the main research question also expand the current knowledge base concerning the process of change in evidence-based interventions in significant ways. First, it articulates a process of change featuring parents' efforts to attempt, appraise, and apply intervention material, highlighting the intentional nature of these efforts and the cyclical progression of this process. These findings deviate markedly from other change processes that have been identified through qualitative research (Spitzer et al., 1991) and may suggest important differences occurring between parents in an individual intervention utilizing active teaching methods compared to one using videotapes in a group setting. Second, this study describes several life contexts that influence parents' experiences of change in an evidence-based parent training intervention. Identifying the effects of different family contexts, employment contexts, and financial contexts is an important contribution. Finally, this study provides qualitative data indicating that parents experience changes in themselves, their children, and their family relationships after participating in a parent training and that these outcomes may in fact be associated with one another.

Content, method of delivery, and role of the interventionist. Study findings related to intervention content, method of delivery, and the role of interventionist also make important contributions within the broader research context. Most significantly, certain content items are

beginning to emerge as important across studies of parenting training interventions, and this study helps strengthen these findings. Parents commonly reported that learning new parenting skills such as giving clear commands, providing tangible rewards, focusing on praising positive behaviors, using time out, establishing consistent discipline, remaining calm, and managing their anger have been helpful aspects of the parenting intervention (Levac et al., 2008; Patterson et al., 2005; Petra & Kohl, 2010). In addition, the results of a meta-analytic review of program components that were associated with the effectiveness of parent training interventions found that components that helped parents foster positive interactions with their children, practice time out, and be consistent were associated with larger effect sizes than programs not including these components (Kaminski et al., 2008). These findings correspond powerfully with the content items identified as important in this study: good directions, skill encouragement, limit setting, and emotional regulation.

Several findings regarding method of delivery and the role of the interventionist also compare favorably with existing research. Similar to this study, the value of having a workbook to refer to at home has been expressed by participants in other interventions (Petra & Kohl, 2010). Meta-analysis has also demonstrated that program components which require parents to practice new techniques with their own children are associated with larger effect sizes in both parent and child behavioral outcomes (Kaminski et al., 2008). Regarding the role of the interventionist, themes of encouragement, support, and offering new ideas emerged as common between this study and others (Levac et al., 2008; Patterson et al., 2005).

Looking at these findings, it appears this study also has a great deal of potential in expanding understanding in the field related to the specific methods of delivery that help parents to experience change in parent training interventions. As important intervention content

continues to be identified, it is equally important that researchers begin to specify the teaching practices that are the most successful in conveying this information and encouraging parents to practice new skills. This study has suggested the central function of role plays, home practice assignments, troubleshooting, and visual aids in facilitating this process. Interestingly, the importance of role play was not confirmed in a recent meta-analysis (Kaminski et al., 2008). This appears to be an area ripe for further study.

Engagement, retention, and resistance. Parents' reports of engagement, retention, and resistance can also help to inform the broader research context. Similar to the themes emerging from this study, parents in other parent training interventions also described having difficulty managing their children's behavior, acknowledging there was a problem, and then identifying the need for assistance on the way to becoming engaged in a parenting intervention (Patterson et al., 2005; Spitzer et al., 1991; Stewart-Brown et al., 2004). Across studies some parents also reported feeling uncomfortable and intimidated with role playing (Patterson et al., 2005), although most parents in the current study moved past their original misgivings.

Overall, when the findings of engagement, retention, and resistance from this study are compared to other research on evidence-based parent training interventions, it is clear much work remains to be done. While parents described very remarkable experiences of engagement in this study, more research is needed to identify practical strategies for increasing engagement in these types of interventions. With regard to retention, interesting differences exist between the findings of this study and the strategies for retention implied elsewhere in the parent training literature. While other studies identify the importance of being alert to parent learning preferences or the availability of child care or transportation assistance (Patterson et al., 2005; Petra & Kohl, 2010), this study found that parents were motivated to continue in an intervention

when they perceived that it was working. This finding should be explored further, and if confirmed, could result in critical new suggestions for structuring therapy in a way that allows parents to experience successes early and often in the intervention in order to promote greater retention.

And finally, the relative lack of resistance reported by parents in this study makes it difficult to contribute much to the literature in this area. The only discernable manifestations of resistance centered around parents' concerns that intervention strategies would not work for their families. It may be that helping parents experience success at the outset of the intervention may be indicated here as well. Yet, other qualitative research has offered greater insight into parents' experiences of resistance (Spitzer et al., 1991). What this study suggests is the body of literature on factors leading to resistance in evidence-based parent training interventions would benefit from continued qualitative investigation among parents who have experienced resistance and possibly even dropped out of the intervention.

Strengths and Limitations of the Study

The current study was characterized by a number of strengths. It addressed a critical gap in the research on evidence-based parent training interventions by contributing a much-needed qualitative perspective to studying the process of change. It further combined the principles of CBPR and the grounded theory approach, which provided a rigorous methodology for developing a theory describing the process of change taking place in PMTO by privileging the experiences of parents who had participated in the intervention. This was the first study to employ this type of research design in examining the PMTO intervention. The findings of this study are therefore highly relevant for informing this area of scholarship. For instance, the data suggested an overall process of change experienced by parents that was influenced by multiple

life contexts and facilitated by various intervention content items, methods of delivery, and interventionist roles. There is a high potential the theory developed in this study can provide new insights that will inspire continued research and the advancement of understanding into the processes of change taking place within evidence-based parent training interventions.

At the same time, study findings should be considered in light of several limitations. As a qualitative study, the findings presented here are not intended to be widely generalizable. Instead, it is expected that other scholars may apply the study findings after acknowledging the unique contextual anchoring of this research. In particular, the theory developed in this study was based on the experiences reported by 20 parents and primary caregivers living in a restricted geographical area in the Midwestern United States outside of highly urban or rural settings. The study sample consisted of all Caucasian parents, and this lack of racial diversity is important to consider when interpreting the findings. In addition, only parents who completed PMTO were eligible for the study. Confirmation of study findings using broader sampling frames and additional research methods would considerably strengthen the transferability of the results.

In addition, the experiences reported by this sample of participants precluded certain aspects of study research questions from being fully explored. First, this study sought to identify various factors that both facilitated and impeded parents' process of change in PMTO. However, participants did not frequently report experiencing impediments to their process of change related to the content, method of delivery, or additional characteristics of the intervention. Likewise, the lack of resistance reported by participants in this study limited exploration of this research question. It is likely this may have resulted from restricting the study sample to those parents who completed the PMTO intention. A more thorough examination of issues of resistance to PMTO and impediments to change may be possible by relaxing this eligibility

criterion. In particular, a study focused solely on parents who drop out of PMTO before completing the intervention is highly needed.

Another limitation of this study is the possibility that all participants were not thoroughly exposed to every aspect of the PMTO intervention. Care was taken to protect against this concern when planning the study. Specifically, to be eligible to participate, parents had to have completed the PMTO intervention. This criterion helped ensure that every participant was exposed to the entire PMTO intervention, because learning about each core component and practicing each strategy is a requirement for completion. However, PMTO interventionists may not have maintained fidelity to the model or may have prematurely designated a case as complete before parents had mastered each of the components. It is worth speculating this may have been a reason the content presented at the end of the intervention (i.e., problem solving, monitoring) was not as relevant to parents as the topics covered in the beginning. Future research could coordinate observational data or fidelity of implementation ratings with the qualitative reports of parents to better confirm participants are sufficiently acquainted with each element of PMTO.

Other limitations were also present. For instance, this study only captured the experiences of parents related to the PMTO intervention. A more comprehensive understanding of the change process may result from integrating the reports of parents, interventionists, and other family members. The researcher also acknowledges that her preconceptions and personal biases likely impacted the research findings. While several precautions were taken to limit these effects, the grounded theory approach does not assume these influences can be completely set aside. Finally, this study faced many challenges in applying the CBPR approach and fell short of the standard of equal participation it seeks to promote. The most significant obstacle to greater collaboration was

the acute time demands faced by all parties, although geographical distance and not having a precedent in place for conducting research with community members also presented challenges.

Recommendations for Future Research

The results of this study suggest several directions for future research. First, research is needed to substantiate and refine the theory developed here with larger, more diverse samples of parents. It would be valuable to extend this research using a mixed methods approach where parents participate in repeated assessments and interviews during and after their participation in PMTO to more systematically capture how their process of change takes place over time. The theory developed in this study would also benefit from including the experiences of parents who did not complete the PMTO intervention so that more insight into issues of engagement, retention, and resistance could be incorporated. A follow-up study examining many of the same research questions among a sample of parents who dropped out of the intervention would be highly informative.

In addition, the theory developed here can be used to generate hypotheses to test in further quantitative investigations of the change processes operating in PMTO. For example, research has demonstrated that exposure to the PMTO intervention leads to changes in parenting practices, which in turn bring about improved child outcomes (Forgatch & DeGarmo, 1999; Martinez & Forgatch, 2001). This study suggests certain aspects of parents' exposure to PMTO that may be facilitating these changes in parenting practices. It would be very interesting to investigate if the intervention factors identified as important by parents in this study, such as giving good directions, learning about emotional regulation, and participating in role plays, do in fact emerge as change processes operating in the PMTO intervention when examined using quantitative methods.

Ultimately, this line of research could suggest adaptations to the PMTO intervention that may help make it more effective when applied in community settings. If further research corroborates the findings of this study, it would be informative to test the comparative effectiveness of adaptations of PMTO that incorporate the factors suggested by parents in this study versus the standard intervention. For instance, adaptations of PMTO could shift the emphasis of the intervention more toward focusing on good directions, skill encouragement, limit setting, and emotional regulation, could incorporate more practice and troubleshooting opportunities that help parents apply the intervention effectively in their life contexts, and could add a booster session component as a follow-up to the intervention. Some adaptations may be more indicated in certain populations. For instance, adaptations of PMTO targeting populations with low socioeconomic status may benefit from placing greater emphasis on troubleshooting so that challenges associated with limited access to resources and related stressors could be better addressed. Other adaptations meant for parents of older children should also consider if the problem solving and monitoring components prove more relevant for these families.

Furthermore, future research in this area could benefit from examining the processes of change taking place across multiple evidence-based parent training interventions. The similar and contrasting change processes that emerge could lead to a better understanding of how changes in parenting are facilitated and how parents can more effectively enhance their parenting practices to help their children experience better behavioral outcomes. Such efforts may lead to exciting future possibilities for helping more parents experience greater success in evidence-based parent training interventions.

Recommendations for the Practice of Family Therapy

Several recommendations for the practice of family therapy stem from this study. Overall, this study highlights that evidence-based parent training interventions can be a very relevant tool for family therapists to utilize in the treatment of child behavior disorders. Many families seek therapy for problems with child behavior, and therapists should be familiar with these interventions. Knowledge of these approaches will allow family therapists to make informed clinical decisions as to whether or not they should incorporate this type of approach into their treatment plan. This study helped to contribute to the continued refinement of one such evidence-based intervention therapists can use to help treat child behavioral problems.

The findings of this study suggest certain parenting material and intervention strategies that can help inform treatment with families experiencing child behavioral problems. For instance, parents may benefit from learning specific parenting strategies in therapy. Family therapists should consider if helping clients to make specific and respectful requests to their children, encourage positive behaviors, set clear and consistent limits, and work to regulate their own emotions would be helpful in meeting their treatment goals. Therapists may also want to incorporate role play activities and the use of visual aids into their work and consider assigning homework that prompts clients to practice new behaviors outside of session. This study should also emphasize to family therapists the importance of helping parents experience success as a means to fostering retention in treatment. In addition, it should serve as a reminder of the critical importance of working in accordance with the life contexts of families.

Finally, this study suggests certain therapist characteristics that may help to promote change when working with parents. Overall, parents highlighted that a solid therapeutic relationship is essential to their process of change. They went on to describe how receiving

support and encouragement from their interventionist was critical. At the same time, participants valued when their interventionist demonstrated knowledge about parenting practices, clearly explained strategies to parents that could lead them to successful outcomes, and expressed confidence in his or her ability to help families. These accounts indicate that family therapists may best serve parents by taking a stance that is highly collaborative and respectful while also grounded in their expertise. Parents wanted an interventionist that was willing to work with them and did not tell them how to parent. Yet, they needed a therapist who demonstrated expertise in order to trust him or her past the initial feelings of awkwardness and discomfort. Ultimately, a therapeutic stance combining the role of expert with a commitment to collaboration may best help parents embrace new parenting skills and achieve the goals they are seeking.

Conclusion

This study set out to examine the process of change taking place in an evidence-based parent training intervention. By applying a qualitative research approach, it has resulted in the development of a grounded theory that describes the process of change taking place in PMTO, based on the experiences and perceptions of parents who completed the intervention. The findings of this study suggest recommendations for the practice of family therapy. They can also inform further adaptations of PMTO and other evidence-based parent training interventions to help continue to improve the services available to families in community settings. These efforts hold great promise for reducing the distress associated with child behavior disorders. In the words of one mother from this study (Participant #11):

> That's why I am so grateful for this. Because this whole program has saved my house, and my sanity, and my little boy's, and definitely my little girl's. I mean my whole household is affected. So this has really turned it all around.

APPENDICES

APPENDIX A:

Study Consent Form

Exploring Change Processes in Parent Management Training - the Oregon Model (PMTO)

Consent Form

Purpose of the Study:

We are conducting this study to learn about your experiences in the parenting program known as Parent Management Training – the Oregon model (PMTO) that you participated in. For instance, we are interested in learning from you about the things that were helpful to you as a parent and things that were not as helpful about this program. We will use the information to gain a better understanding of how this program can lead to changes in parenting practices. The overall goal of this study is to help improve the parenting program [PMTO] so that it can be more helpful to families. This study is being led by Kendal Holtrop, a doctoral student at Michigan State University, under the advisement of Dr. Rubén Parra Cardona. It is being conducted in partnership with researchers from Michigan State University, the Michigan Department of Community Health, and your local community mental health agency. If you would like, we can provide you with a summary of the study findings once it is completed.

What Your Participation Would Include:

You are being asked to participate in one individual interview which will last approximately 1 to 1½ hours. You may choose to participate in this interview at your home, at a location in the community, or on the campus of Michigan State University. This interview will focus on exploring your experiences with the parenting program [PMTO] in which you participated. For example, you will be asked questions about how different aspects of the program were helpful or not helpful to you. This interview will be audiotaped. By audiotaping your interview we can make sure we have a complete record of the answers you provide. You cannot participate in this study unless you agree to have your interview audiotaped. In addition to the interview, you will be asked to complete an informational questionnaire about yourself and your experience in the parenting program [PMTO]. You will receive $25 as compensation for your time and effort participating in this study.

You are being asked to participate in a research study about services you have already received; this study will not provide you with any form of mental health service. If you feel you are in need of mental health treatment you are encouraged to contact your local community mental health agency.

Privacy and Confidentiality:

Your confidentiality will be protected to the maximum extent allowable by law. The only time in which it would be required to break confidentiality is if you report any child abuse or abuse of elderly persons or if state that you are going to harm yourself or someone else. The only people with access to your research data will be Kendal Holtrop and Dr. Parra-Cardona. In addition, the MSU Human Subjects Protection Program may have access to your data in the event of an audit. The recording of your interview will be labeled with an ID number, and only Kendal Holtrop and Dr. Parra-Cardona will have access to the list linking your name to your interview. Neither the interventionist you worked with nor anyone else at your local community mental health agency will have access to this list. Your confidential information will be stored in a locked file in a locked office or on a password protected computer in a locked office at Michigan State University. We will keep all data associated with this research project for three years after the project is closed, during which time it will be stored in a locked file in the principal investigator's office.

The findings of this study will be reported to many people and organizations. Research results may be reported to people at Michigan State University, the Michigan Department of Community Health, your local community mental health agency, the Institutional Review Boards monitoring this project, and others in the academic community. When the results of this study are presented and published, pseudonyms will be used and any identifying private information will be modified or omitted to protect the identity of participants.

This consent form was approved by the Social Science/Behavioral/Education Institutional Review Board (SIRB) at Michigan State University. Approved 02/14/11 – valid through 02/13/12. This version supersedes all previous versions. IRB # 10-1274.

Your Rights to Participate, Say No, or Withdraw:

Participation in this research study is completely voluntary. You may say no to participation or you may change your mind and decide to stop participating at any time with no negative consequences. You may also choose not to answer any question that you do not want to answer. Your participation will have no affect on your ability to obtain services at your local community mental health agency, and no one at your local community mental health agency will have access to the record of who participated in this study and who did not.

Potential Risks and Benefits:

There is a risk that you might experience some discomfort while participating in this study. For instance, you might feel slightly uncomfortable reporting certain demographic information or talking about some of the experiences you had with the parenting program [PMTO]. Please remember that your confidentiality will be protected and no one besides Kendal Holtrop and Dr. Parra-Cardona will be able to match your name to your answers. In addition, you may always choose not to answer a question that makes you uncomfortable and you may decide to stop participating in this study at any time without penalty.

You may experience benefits from participating in this study. We expect that you might appreciate having the opportunity to talk about your experiences and to provide feedback about what was helpful to you and not helpful about the parenting program [PMTO]. You also might experience a sense of empowerment and satisfaction from helping to improve the parenting program [PMTO] so that it can be more helpful to more families.

Contact Information for Questions or Concerns:

If you have concerns or questions about this study, such as scientific issues, how to do any part of it, or to report an injury, please contact the researchers directly:

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In addition, if you have any questions or concerns about your role and rights as a research participant, would like to obtain information or offer input, or would like to register a complaint about this research study, you may contact, anonymously if you wish, Michigan State University Human Research Protection Program at 517-355-2180, FAX 517-432-4503, or e-mail irb@msu.edu, or regular mail at: 207 Olds Hall, MSU, East Lansing, MI 48824.

Documentation of Informed Consent:

Please provide your signature below if you voluntarily agree to participate in this research study.

_____ _____

Signature Date

You will be given a copy of this form to keep.

This consent form was approved by the Social Science/Behavioral/Education Institutional Review Board (SIRB) at Michigan State University. Approved 02/14/11 – valid through 02/13/12. This version supersedes all previous versions. IRB # 10-1274.

APPENDIX B:

Study Interview Guide

Semi-Structured Interview Guide

Introduction:
A number of weeks/months ago you participated in a parenting program, through [COUNTY] County CMH, called PMTO. I am here because I am interested in learning about this program so we can make it as useful as possible for parents and other people who take care of children. In particular, **I would like to hear about your experiences with this program**. I want you to know there are no right or wrong answers – the most helpful information is when you provide your honest opinions and personal experience. Your name will not be tied to any of the answers that you provide. Also, please feel free to interrupt, ask questions, or provide feedback on what I am asking at any point during the interview.

Grand Tour Question #1: *General*
Will you please begin by talking about the experience you had in the parenting program with [Interventionist]?

Probes:

- Do you think that your experience with the parenting program helped you to change or improve you parenting practices, or not?
    - What was it about the parenting program that helped you to do this?
    - Which aspects of the parenting program were not helpful to you?
- What encouraged or motivated you to keep going to the parenting program? (***retention***)
- What point in time in the program or what in particular convinced you that it would be valuable to stay in the program? (***engagement/retention***)
- What aspects of the program made you upset or hesitant to stay in the program or to try and change your parenting practices? ***(resistance)***

Grand Tour Question #2: *Content*
Please tell me about how the topics that you talked about in the parenting program [PMTO] helped you, or did not help you, with your parenting practices.

Probes – *Core Components*:

- One topic covered in PMTO is ***skill encouragement***, where you provide incentives to your children to help teach them positive behavior. How did learning about this topic help you, or not help you, with your parenting practices?
- Another topic covered in PMTO is ***limit setting***, where you use mild consequences like time out or work chores to discourage negative behavior. How did learning about this topic help you, or not help you, with your parenting practices?
- Another topic covered in PMTO is ***monitoring***, where you supervise your children and keep track of where they are, who they are with, and what they are doing. How did learning about this topic help you, or not help you, with your parenting practices?
- Another topic covered in PMTO is ***problem solving***, where you solve disagreements, negotiate rules, plan family activities, work out problems, and decide on positive and negatives consequences for behavior. How did learning about this topic help you, or not help you, with your parenting practices?
- Another topic covered in PMTO is ***positive involvement***, where you give your children loving attention and spend time together doing fun things, provide support for learning new behaviors with your help, communicate with the school to ensure success, etc. How did learning about this topic help you, or not help you, with your parenting practices?

Probes – *Support Skills*:

- You may remember that one skill you learned about in this parenting program [PMTO] was ***giving good directions***, where you practice giving simple, clear and specific directions to your child. How did learning about this topic help you, or not help you, with your parenting practices?
- Another skill you learned about was ***behavioral tracking***, where you take notice of when your child is behaving well. How did learning about this topic help you, or not help you, with your parenting practices?
- Another skill you learned about was ***emotional regulation***, where you learn ways to stay calm when disciplining your child or with communicating with your child. How did learning about this topic help you, or not help you, with your parenting practices?
- Another skill you learned about was ***communicating*** with your child, where you practice active listening and speaking skills. How did learning about this topic help you, or not help you, with your parenting practices?

Probes – *Other Content*

- Were there any topics in particular that specifically influenced your participation in the program? (***engagement/retention***)
- Were there any topics in the PMTO program that made you upset or frustrated or that made you reluctant to change your parenting practices? (***resistance***)
- Are there any ***additional topics*** that you think would have helped you more with your parenting practices that were not covered in the PMTO program?

Grand Tour Question #3: *Method of Delivery*

Now I would like to ask you some questions about the way the parenting program [PMTO] was delivered. Please tell me about how the way in which you learned things in the program helped you, or did not help you, with your parenting practices.

Probes:

- How did learning through ***role plays*** help you, or not help you, with your parenting practices?
- How did the ***home practice assignments*** help you, or not help you, with your parenting practices?
- How helpful was having the opportunity to review the parenting skills that you were learning with the therapist? For example, how to improve the use of charts or time out once you had started to use them at home? ***(troubleshooting)***
- How did the PMTO sayings or phrases, like "parents are their children's best teacher" help you, or not help you, with your parenting practices? ***(raps)***
- Was there anything specific about the way PMTO sessions are delivered that influenced your participation in the program? (***engagement/retention***)
- Was there anything about how the PMTO program was delivered that made you upset or frustrated or that made you reluctant to change your parenting practices? (***resistance***)
- What did you think about the ***length*** and ***number*** of sessions?
- How would you feel about the option of attending a ***booster session*** where you could come back to review and ask questions about what you learned in the program?

Grand Tour Question #4: *Additional Characteristics*

What else about the parenting program [PMTO] helped you, or did not help you, with your parenting practices?

Probes:

- How important was the role of your interventionist for you?
- How did the unique qualities of your interventionist (***therapist characteristics***) help you, or maybe not help you, with your parenting practices?
- How did your ***relationship with your interventionist*** help you, or maybe not help you, with your parenting practices?
- How did the ***learning environment*** of the parenting sessions help you, or not help you, with your parenting practices?

Grand Tour Question #5: Context of Use

As you were learning about all of these different parenting skills in the parenting program [PMTO], what was it like to practice using them at home in your daily life?

Probes:

- What successes did you experience using the skills at home with your children?
    - How do you explain the reasons for your successes?
- What challenges did you experience using the skills at home with your children?
    - How do you explain the reasons for facing these challenges?
- How did these experiences influence how you felt about the parenting program? (e.g., ***engagement/retention*** or ***resistance***)
- Earlier you told me that _____ helps you with your parenting [refer to other people involved in parenting listed on Information Form].
    - What was it like to learn about these parenting skills and use them with your children when _____ was also/not learning about these skills with you?
    - How did learning about these parenting skills and using them with your children influence your relationship with _____?
    - Did your interventionist talk with you about what it was like to learn about these parenting skills and use them with your children when _____ was also/not learning about these skills with you?
        - YES → What was helpful, or maybe not helpful, about talking with your interventionist about this?
        - No → Do you think it would have been helpful to talk with your interventionist about this?
- How do you think your job/career influenced your experience using the parenting skills with your children?
- How do you think your financial situation influenced your experience using the parenting skills with your children?
- What other factors in your life influenced your experience using the parenting skills with your children? Can you please provide an example of this?

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