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ABSTRACT

Standard procedures for teaching child management skills to parents may be inadequate for disadvantaged populations. The Parent/Child Early Education Program was developed to serve parents at risk of child abuse. Parent and child variables were measured at pretest in 41 families referred to this program. A profile of the families revealed that, in general, these families were single-female-headed households living on welfare support. Parents had an unstimulating, noneducational home environment for childrearing, more negative than positive parent-child interactions, a significant number of problems reported on the Child Abuse Potential Inventory, and a significant number of affective symptoms based on the Beck Depression Inventory. Children were described by their mothers as showing below average levels of adaptive behavior. The most common form of dropouts were no-starts who failed to attend sessions following the pretest assessment period. A discriminant function analysis of pretest data was conducted to determine which factors were the best predictors of finishing treatment. The results suggest that parents who are more likely to follow through with this form of training report more distress at pretest and show a more balanced ratio of positive to negative interaction with their children. In response to these client characteristics, a format for parent training has evolved which is tailored to the compatibility of the therapist, the extent of training/knowledge covered, and the target problems to address. (NRB)

Service Delivery Modifications in Behavior Therapy Programs for Families At-Risk for Abuse & Neglect

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Teaching child management skills to parents seeking assistance in controlling their child has become a widely accepted practice. Yet, the standard procedures may be inadequate in assisting less motivated and more disadvantaged populations. Such families may attend a program upon the recommendation of a protective service worker or court, and often do not maintain an interest in the program objectives if immediate and dramatic results are not forthcoming. Consequently, drop-out rates and treatment outcome failure rates with such families are often much higher than those for clinic-referred groups. The needs of this visible and at-risk group of parents and children have led to several modifications and supplements to parent training with this population.

The Parent/Child Early Education Program is a research project serving parents at-risk of child abuse. These parents pose many of the challenges to parent training that have surfaced in the literature: interfering life crises, over-dependency on social services, aversive social relationships, motivation and learning deficiencies, and multiple problems in child development and behavior. A profile of 41 families that were referred to the program (since 1981) is presented, which illuminates the demographic disadvantages among this population (see Table 1). In general, these families are single-female-headed households living on welfare support. These mothers have very young children, and have been under agency supervision for over 6 months (due to concerns related to the high-risk of abuse and neglect). We measured several parent

and child variables at pre-test to provide comparative data on treatment outcome, and these data will be used in the present analyses to compare families who completed treatment with those who declined to begin treatment (No Starts).

The next slide (see Table 1, cont.) presents a descriptive profile of parental functioning related to the parenting role. As shown, parents referred to the program can best be described as having a very unstimulating, non-educational home environment for childrearing (HOME score = 65% positive stimulation), and a ratio of proportionately more negative to positive interactions with the child (Parent-Child Interactional Index = 2.05 out of 4, with 4 being all positive and 0 all negative). Similarly, an index of demographic factors (in which a number from 0 to 4 was assigned to each the the 4 variables of income, months of supervision, child's age, and maternal education) was developed to reflect the degree of positive (i.e., above the mean of the sample) to negative (below the sample mean) demographic conditions. These parents report a significant number of problems on the Child Abuse Potential Inventory (M = 26), which places them in the At-Risk direction on this inventory, and a significant number of affective symptoms (M = 17), based on the Beck. Children in this sample were described by their mothers as showing below average levels of adaptive behavior (55%, where 100% represents full mastery of adaptive skills, e.g., language, social interaction). To provide a normative comparison for these data on child adaptive behavior, the Denver Developmental Screening Test was administered by a nurse who was familiar with the population and instrument, but who was unfamilar with the purpose of the study. This assessment indicated that, in general, children in the sample were functioning at an average of 5 months delay (compared to age-based norms). Observational data in the clinic and the home produced a mean compliance ratio (percentage of compliance to maternal

commands) of 72%, which is considered to be within the normal range for this age group. Finally, these children were reported on average to display 11 behavior problems (as rated by the mother), which is borderline between clinical and non-clinical groups of children.

The most common form of drop-out to our project we describe as the No Starts. That is, following a 2-3 week pre-test assessment period, these mothers failed to appear for their scheduled appointments at the university. After several unsuccessful attempts to re-schedule (including the arrangement of rides, babysitting, etc.), these Ss were classified as No Starts (very few actually could be considered "drop-outs," because they failed to attend at least 2 sessions). The next slide (see Table 2) presents a comparative analysis (using pre-test data) of Ss completing treatment and those not starting treatment. We were interested in seeing if we could predict subject attrition from the program based on pre-test findings, and to determine which factors were the best predictors of finishing treatment. A Discriminant Function Analysis was conducted, using group membership as the criterion and the 7 variables listed in Table 2 as predictors. The results of the analysis indicated that a mildly significant function was obtained ($\underline{x}^2 = 6.98$, $N = 41$, $df = 3$; $\underline{p} < .07$), in which only two variables (CAP and P-C Index) entered the equation. Subsequent univariate tests revealed that parents who completed treatment were observed to be functioning significantly more positively than the No Start group, and to report <u>more distress</u> on the CAP inventory. A trend was also shown for the Ss who completed treatment to be slightly more demographically advantaged, and to report slightly more distress on the Beck. Interestingly, no trends or differences emerged for any of the child variables: both groups were identical in terms of child compliance, reported behavior problems, and adaptive behavior. Missing data from the HOME and Denver measures from several subjects led to the exclusion of these findings

from the present analysis.

To sum these findings, the results of the discriminant function suggest that parents who are more likely to follow through with this form of training report more distress at pre-test (related to global aspects of personal functioning, as well as symptoms of discomfort and displeasure), and show a more balanced ratio of positive to negative interactions with their child. This finding is no surprise, in that it indicates that a certain degree of distress may be necessary to motivate the client to follow-through with training, and minimal competence may be necessary to facilitate their effort (as measured by demographic and interactional variables). It should be remembered, however, that these parents represent the most difficult population to serve, and any effort that helps to further determine the match between treatment and client needs represents an advance in service planning.

In response to these client characteristics, a format for parent training has evolved that differs on a number of procedural dimensions from previous approaches. The delivery of service to each family is tailored on three dimensions: the compatability of the therapist, the extent of training/knowledge covered, and the target problems to address. Within this framework, therapists instruct, model, and rehearse child management skills with each family in a manner that is most engaging and problem-focused. Parents conduct their own feedback by viewing videotaped sessions and critiquing their behavior (verbal, motoric, and physiological) with the therapist. Involvement of other service providers is restricted by consent, in order to reduce overwhelming demands. Living companions are involved in the program at the most active level possible. A problem-solving format is often adopted in order to meet the needs of the parent in a direct fashion, followed by more general skills training (refer to Service Delivery Modifications slide).

Table 1

THE PARENT/CHILD EDUCATION PROGRAM

Description of the Subject Population

(N = 41 at Pretest)

DEMOGRAPHIC

Variables	Mean	SD
Maternal Education	10.5	1.5
Family Income per year	$7,500	$1,213
Marital Status	All single females	
Maternal Age (years)	21.5	2.4
Target child's age (months)	20.3	5.6
Agency Supervision (months)	8.3	6.8
Number of children	1= 75%, 2= 20% 3= 5%	
Number of moves in past 2 years	3.5	2.1

Table 1 (Cont.)

PARENT DATA

Variables	Mean	SD
1. HOME Inventory	65%	12.3
*2. Parent-Child Interactional Index (Praise, Phys. Positive, Criticism, Phys. Negative)	2.05	.57
*3. Demographic Index (Income, Supervision, Child's age, Education)	1.27	.76
4. Child Abuse Potential Inventory	26.09	7.06
5. Beck Depression Inventory	16.86	10.02

CHILD DATA

1. Adaptive Behavior (WVAATS)	55.63%	24.25
2. Denver Developmental Screening Test	Average 5 month delay	
3. Parent Attitude Test or Eyberg Child Behavior Inv.	11.02 Problems	
4. Compliance Ratio	72.04%	29.32

* For each subject, a score of 0 is assigned to each of the 4 variables if their score is below the mean, and a 1 is assigned if above the mean (range from 0 (very low) to 4 (very high)

Table 2

Comparative Analysis of Pre-Test Data of Subjects Completing Treatment and Subjects Not Starting Treatment

	COMPLETED TREATMENT (N = 19)		NO STARTS (N = 22)	
Variables	M	SD	M	SD
I. DEMOGRAPHIC				
1. DemoIndex	1.47	1.17	1.05	.73
II. OBSERVATIONAL DATA (PARENT)				
2. Parent-Child Interactions	2.26	1.05	1.83	.99*
III. PARENT SELF-REPORT				
3. CAP Inventory	28.09	7.47	23.78	7.04**
4. Beck Depression Inv.	17.84	10.01	15.83	10.13
IV. PARENT REPORT OF CHILD				
5. Behavior Problems	11.47	5.82	11.28	4.74
6. Adaptive Behavior (%)	55.63	26.32	54.83	23.01
V. OBSERVATION OF CHILD BEHAVIOR				
7. Compliance Ratio (%)	73.53	29.69	71.67	29.43

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

SERVICE DELIVERY MODIFICATIONS

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* ADULT COMPETENCE *
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1. Poor Crisis Management (Avoidance, Poor Coping Methods) and Dependency on Social Agencies (e.g., low level of responsibility)

   Modifications:

   - Very gradual integration of parent into training (Passive role)
   - Focus on pleasant aspects of child behavior
   - Therapist monitoring of client's life events
   - beginning with very simple and concrete skills (e.g., attending)
   - home visits faded out over several sessions

2. Relationships (unstable, non-supportive)

   Modifications

   - limit amount of professional involvement
   - Develop therapist-client relationship
   - adjunctive therapies (e.g., marital)
   - social support groups

3. Motivation and Learning Abilities (e.g., short-term payoffs)

   Modifications

   - flexibility in establishing goals and progress (competency-based)
   - Videotaped feedback and self-correction

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* CHILD COMPETENCE *
****

4. Young target group (fewer reported problems, or very high-rate problems)

   Modifications

   - Focus on activities to strengthen child development
   - flexibility regarding goals of training: Less training of punishment techniques, more emphasis on qualitative interactions
   - Increased therapist involvement with child (e.g., modeling)

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* COMMUNITY AND AGENCY INVOLVEMENT *
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5. Lack of Shared Resources and Personnel

   Modifications
   - Caseworker attends sessions periodically
   - Agency and community professionals conduct support groups & services