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The Relationship Between Parental Sense of Competence and Parental Descriptions of Behavior and Treatment

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The Relationship Between Parental Sense of Competence and Parental Descriptions of Behavior
and Treatment

Dissertation Submitted to the
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In partial fulfillment of the
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In Clinical Psychology

by

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ABSTRACT

The Relationship Between Parental Sense of Competence and Parental Descriptions of Behavior and Treatment

By Rebecca Denning, M.A.

Although the literature has paid significant attention to treatments addressing externalizing behavior disorders, it has given less attention to the role of parental factors on treatment outcomes. This study used a qualitative methodology consisting of thirty semi-structured interviews with parents whose children had been in treatment for externalizing behavior problems for at least a month to examine how variations in parental sense of competence and self-efficacy are related to the ways in which parents describe their child's behaviors, their response to behaviors, their investment in treatment, and their attribution of treatment outcomes. Thematic differences between participants with high parental sense of competence and self-efficacy and those who scored low on these measures emerged in parental response to behaviors, use of resources, and investment in working to address behavior problems. Implications for future research will be discussed.

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INTRODUCTION

Although there is much emphasis in the literature on examining the efficacy of various treatment modalities (e.g. Bennett, Power, Rustain, & Carr, 1996; Brestan & Eyeberg, 1998; Chronis, Chacko, Fabiano, Wymbs, & Pelham, 2004; Conner, 2006; Daly, Creed, Xanthopoulos, & Brown, 2007; Farmer, Compton, Burns, & Robertson, 2002; Fossum, Handegard, Matinussen, & March, 2008; Hautmann, Hanisch, Mayer, Pluck & Dopfner, 2008), research has not examined how parental characteristics are related to parents' conceptualization of their child's behavior and treatment. In order for a child to receive treatment for externalizing behaviors, the child's parent or guardian must identify a problem that necessitates investing time and resources in treatment. Parents must then select a treatment modality and provider and take steps to initiate treatment. After treatment has begun, parents remain responsible for following through with treatment recommendations and monitoring treatment outcomes. Given this central role played by parents in identifying problems behaviors, initiating, and following through with treatment, it is important for clinicians to understand what factors are related to parental conceptualizations of their child's behavior problems and the treatment.

The purpose of this study is to explore how parental beliefs regarding competence and self-efficacy are related to the ways in which parents conceptualize their child's behavior and treatment. More specifically, the purpose is to consider how these characteristics are related to parents' description of their child's problematic behaviors, the amount of effort they invest into addressing their child's behaviors, and their conceptualization of the changes or stability they perceive in their child's behavior.

Externalizing Behavior Problems

Externalizing behavior problems are among the most common reasons children are referred for mental health services (Barkley, 2006; Gross, Sambrook, & Fogg, 1999). Attention-deficit/hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), and conduct disorder (CD) are particularly problematic because of the pervasiveness of the associated problems across multiple areas of children's daily lives. The behavioral symptoms that define these disorders are highly problematic and include antisocial behavior, aggression, and high activity levels (Goldstein, 1999). Additionally, children with these disorders are at risk for a variety of poor outcomes during adolescence and adulthood including school failure and early dropout, substance use and abuse, criminal activity, early parenthood, and unemployment (Farmer et al., 2002).

In response to the prevalence of externalizing behavior problems (3%-5% for ADHD among school-age children and 2%-16% for CD; American Psychiatric Association, 2000) and the severity of the associated difficulties, treatments addressing these behavioral disorders have received significant attention in the literature (Anastopolous, Phoads, & Farley, 2006; Barkley et al., 2000; Bennett, Power, Rostain, & Carr, 1996; Brestan & Eyeberg, 1998; Farmer et al., 2002). One of the most common treatments for externalizing behaviors is medication. For example, a meta-analysis of stimulant medication's effects on aggressive behavior in children found large effect sizes for stimulant medications on both overt and covert acts of aggression (Connor, Glatt, Lopez, Jackson, & Melloni, 2002). Additionally, stimulants appear to be efficacious in helping children control behaviors that are disruptive in the classroom, though there is less of an effect on measures of cognitive abilities and academic performance (Connor, 2006).

Psychosocial interventions are also empirically supported treatments for externalizing behaviors (Farmer et al., 2002). For example, training parents in behavior management strategies appears to be effective in reducing the frequency of disruptive behavioral problems (Brestan & Eyberg, 1998; Fossum, Handegard, Martinussen, & Morch, 2008; Kazdin & Wassell, 1999; Pelham, Wheeler, & Chronis, 1998). Additionally, behavioral interventions appear to contribute to improvements in other aspects of child, parental, and family functioning (Anastopolous et al., 2006).

Parents' Role in Treatment

Although research continues to examine the efficacy of various treatment modalities, less attention is focused on the role of parental factors related to treatment outcomes. Across treatment modalities, parents play a vital role in addressing their child's behaviors. They must first identify the existence of a problem. After classifying the behaviors as problematic, parents are then left with the decision of how to address the problem. The way parents conceptualize their child's behavior problems appears to better predict help-seeking actions than does the severity of the child's behavioral problems as rated by clinicians, teachers, or other observers (Morrisey-Kane & Prinz, 1999). If the parents decide to address the problem through formal treatment, they must, at a minimum, bring the child to the doctor's office or clinic. Factors such as the availability of a qualified therapist and the financial feasibility of the treatment can become overwhelming (Krain, Kendall, & Power, 2005). Parental work schedules, extracurricular activities, and child care arrangements also make attending sessions difficult (MacNaughton & Rodrigue, 2001).

Regardless of treatment strategy selected, parents are responsible for following through with the treatment after the session ends each week. Though pharmacological intervention

appears less time-consuming, for those who choose medication and whose child's behaviors respond to the medication, good treatment compliance is necessary for the maximum therapeutic effect. Some of the medications require that children take them two to three times a day, though extended release formulations are increasingly allowing for once a day dosing (Swanson, 2003). In addition, long-term monitoring of behaviors and reporting of adverse effects are also requirements of effective treatment. The timing of the dosing, the potential side effects, and the long-term treatment period make compliance an issue in clinical practice (Bennett, et al., 1996).

There are also challenges for parents who select behavioral treatments. The principles that underlie these programs require consistent application of the strategies in order to achieve success (Barkley, et al., 2000; Miller & Prinz, 2003). However, following through with these behavior management strategies at home can be difficult and may initially be stressful for parents and the family (Bennett et al., 1996; Friars & Mellor, 2007). These challenges can make continued involvement in treatment and consistent implementation of these strategies at home difficult. Johnston, Seipp, Hommersen, Hoza, and Fine (2005) found that among parents who had used behavior management techniques for their child, 18% were no longer using them. Nearly 25% of these parents indicated that they stopped using the techniques because they were too much work.

Additionally, parents are responsible for monitoring the behaviors and determining whether progress occurs as a result of treatment. Although standardized instruments such as the Behavior Assessment System for Children, Second Edition (BASC-2), Child Behavior Checklist (CBCL), and Conners' Rating Scales – Revised (CRS-R) are available to document the parents' observations, these instruments depend upon parental perceptions of the child's behaviors.

Regardless of treatment modality, utilizing resources and adhering to treatment for behavior problems places demands upon parents in terms of making decisions about how to address their child's behaviors, investing their efforts to address the behaviors, and monitoring outcomes of treatment. Therefore, it is important to understand how parental characteristics play a role in the diagnostic and treatment process. Two specific characteristics that may be related to the selection, involvement, and perception of treatment are parental sense of competence and parental self-efficacy.

Parental Sense of Competence

One parental characteristic that may be related to parents' conceptualizations of their child's behavior and treatment is parental sense of competence. Parental sense of competence is a broad way of describing feelings and beliefs about being a parent (Coleman & Karraker, 1997). Competence can be broken down into two factors. The first is parenting efficacy or beliefs about one's capabilities as a parent. The second factor is satisfaction or the degree to which parents feel frustrated or fulfilled in their parenting roles (Johnston & Mash, 1989). As a construct, parental sense of competence reflects a parent's perception of his or her parenting skills and satisfaction with the role of parent (Coleman & Karraker, 1997).

Parental Sense of Competence and Affect

Although the relationship between parental sense of competence and parents' conceptualizations of their child's behavior and treatment has not been examined extensively in the research literature, this characteristic has been shown to be related to other aspects of parental experiences and decision-making. For example, Hagekull and Bohlin (1990) found that parental sense of competence is related to parental reports of their affective response to the demands associated with raising children. Parents who reported a higher sense of parenting competence

felt able to cope in difficult parenting situations and reported less stress in the year after the birth of their child. Furthermore, sense of competence was a better indicator of parental subjective stress than was parents' perception of their child's temperament. The researchers concluded that parents with a high sense of competence believe they have sufficient parenting skills and thus experience less frustration and anxiety than those who have a lower sense of competence when making parenting decisions or engaging in parenting tasks (Hagekull & Bohlin, 1990).

Parental Sense of Competence and Parenting Behaviors

Parental sense of competence is also related to specific parenting behaviors. Parents who report a higher sense of competence report a greater breadth of knowledge regarding child development and are more likely to express flexible, less authoritarian child-rearing beliefs (Stoiber & Houghton, 1993). Additionally, higher ratings of parental competence are also associated with greater use of proactive techniques to handle child behaviors and less use of punitive responses (Stoiber & Houghton, 1993).

Parental Sense of Competence and Treatment

Research has also examined the relationship between parental sense of competence and retention in treatment. Addressing concerns regarding the problematic behaviors associated with externalizing behaviors requires considerable effort and persistence by parents. In an examination of factors that contribute to discontinuation of treatment, Friars and Mellor (2007) found that those who left a behavioral management training program for parents tended to believe that their child's behavioral problems were inherent to the child and not something that could be effectively controlled by parents. Parents who dropped out of treatment also indicated that they were overwhelmed by being held responsible for changing their child's behavior. These parents' beliefs and concerns reflect a lower sense of competence than do those of parents

who completed the program. Minimal expectations for improvement in their child's behavior and low perceived competence may contribute to a parent minimizing behavioral improvements and may promote premature dropout (Morrissey-Kane & Prinz, 1999). Those who perceive themselves as being less skillful and more easily frustrated are also more likely to withdraw from a difficult parenting situation (Mash & Johnston, 1983a).

In contrast, parents who completed the program felt that parenting strategies could help manage the problematic behaviors (Friars & Mellor, 2007). Parents who completed the program reported that although behavioral incidents still arose, they felt that they had acquired a repertoire of strategies for effectively handling their child's behavior. Consequently, these parents reported feeling less stress regarding the management of their child's behavior. The beliefs endorsed by the parents who completed the behavioral management program reflect a higher degree of perceived parental competence than do those who dropped out. Although able to recognize that management of the behavioral problems was ongoing, these parents noted improvements and persisted with the strategies introduced in treatment despite the difficulty of the parenting situation (Friars & Mellor, 2007).

Parental Self-Efficacy

A second parental characteristic that may be reflected in parents' conceptualizations of their child's behavior and treatment is parental self-efficacy. Parental self-efficacy refers to parents' expectations regarding their abilities to exercise a positive influence over their child's development and behavior and is derived from both specific knowledge and confidence in the practice of parenting (Coleman & Karraker, 1997). Parents with a high level of knowledge regarding child development and effective parenting practices score higher on measures of parenting self-efficacy than do those who have an inaccurate understanding of development and

parenting skills. Similarly, parents who have more confidence in their parenting skills score higher on measures of parenting self-efficacy than do those who express less confidence (Conrad, Gross, Fogg, & Ruchala, 1992).

Parental self-efficacy is the result of an ongoing, transactional process involving parents, their experiences, their behavior, and the ways in which they interpret their experiences and behavior (Bandura, 1997). As parents gain experience with raising children, their parental self-efficacy often increases (Weaver, Shaw, Dishion, & Wilson, 2008). Among parents of typically developing children, the age of the child correlated with the extent of parental self-efficacy, such that parents of older children felt more efficacious than did parents of younger children (Mash & Johnson, 1983b). The parenting experience gained over time provides the parents with evidentiary feedback that informs assessment of their parenting behaviors and skills.

However, the transactional process that shapes parents' self-efficacy allows for an interaction between a child's behavior and parents' beliefs about their abilities to effectively manage their child. High parental self-efficacy is associated with lower parental ratings of difficult behavior from their child (Raver & Leadbeater, 1999). Conversely, parents of toddlers who described their child as difficult had lower ratings of parental self-efficacy (Conrad, et al., 1992). Over time, persistence of behavior perceived as difficult can erode parents' assessment of their abilities. For example, parents of young hyperactive children did not differ from parents of young typical children in their ratings of self-efficacy. However, parents of older hyperactive children did not feel more efficacious than parents of younger hyperactive children (Maniadaki, Sonuga-Burke, & Kakouros, 2005). When compared to parents of age-matched typical children, parents of older hyperactive children reported significantly lower levels of perceived parenting self-efficacy. Furthermore, the perceived severity of child behavior problems was negatively

correlated with parental self-efficacy (Maniadaki et al., 2005). The interaction between a child's behavior and parents' beliefs is also supported by research showing that lower levels of parental self-efficacy when the child is two years old predicts higher rates of child problem behaviors at age four, even after controlling for initial levels of behavior problems (Weaver et al., 2008).

Environmental factors also play a role in this transactional process. Parental self-efficacy is related to environmental characteristics, such as a lack of perceived support from other caregivers. Mothers of young children who reported having another caregiver to help supervise their children and with whom they could talk through parenting decisions felt less overwhelmed by difficult parenting tasks and scored higher on a measure of parental self-efficacy (Lerkes & Crockenberg, 2002). Conversely, high levels of subjective stress and parenting as a young adult were associated with low parental self-efficacy (Lerkes & Crockenberg, 2002; Raver & Leadbeater, 1999).

Parental Self-Efficacy and Affect

Parental self-efficacy is related to parents' affective response to the demands associated with raising children. More specifically, parenting self-efficacy is significantly related to subjective experience of stress. Parents who report lower parental self-efficacy experience greater levels of stress related to parenting (Mash & Johnston, 1983b). Those with lower parental self-efficacy are also more likely to use passive coping skills such as ignoring, accepting, or avoiding the problems that contribute to the stress (Wells-Parker, Miller, & Topping, 1990).

Parental Self-Efficacy and Parenting Behaviors

Parental self-efficacy also is related to what parenting strategies are used, the effort that is invested in parenting activities, and the duration that these efforts will be maintained despite obstacles (Montigny & Lacharite, 2005). Parents with low self-efficacy seem to be less able to put parenting knowledge into action, become preoccupied with themselves, experience high levels of emotional arousal in challenging parenting situations, and do not show persistence in parenting tasks (Grusec, Hastings, & Mammone, 1994). Additionally, parents who feel that they are less able to control or influence their children's behavior and development are more likely to use coercive or abusive parenting strategies in challenging situations (e.g. Bugental, Blue & Bruzcosa, 1989; Teti & Gelfand, 1991). Among parents of preschoolers at risk for developing conduct problems, parental self-efficacy accounted for 22% of the variance in parental over-reactions and use of coercive parenting methods such as hitting (Bugental et al., 1989). High parental self-efficacy is associated with more competent parenting behaviors. Parents who report greater confidence in their ability to handle their child's behaviors are more likely to use flexible, authoritative, and non-punitive strategies in challenging situations (Teti & Gelfand, 1991).

Parental self-efficacy is also related to the ways in which parents interpret their child's behavior. Parents with high self-efficacy are likely to interpret child behavioral problems as a challenge that requires greater effort and application of parenting skills (Donovan, Leavitt, & Walsh, 1990). These parents are also more likely to persist in their efforts to address the behaviors. However, parents with low self-efficacy are more likely to perceive the behaviors as uncontrollable and therefore not brought about by parenting behaviors or strategies (Donovan et al., 1990). Parents with lower self-efficacy are more likely to attribute behavior problems as inherent to their child and stemming from stable and global characteristics (Maniadaki, et al.,

2005). When these behaviors become stressful or difficult to manage, parents with low self-efficacy feel less able to effect change and give up much more quickly when their efforts to address their child's behavior are met with resistance (Coleman & Karraker, 1997).

Finally, parental self-efficacy is related to the extent to which parents educate themselves about their parenting concerns such that those who rate themselves high in parental self-efficacy are more aware of the resources that exist and how to access those resources in response to their concerns (Spoth & Conroy, 1993).

Parental Self-Efficacy and Treatment

Parental self-efficacy is related to treatment for externalizing behaviors. Consistent parental engagement in the child's treatment often results in improved ratings of self-efficacy as the parents receive accurate information about the causes of their child's externalizing behaviors and are taught effective strategies for handling the behaviors (Miller-Heyl, MacPhee, & Fritz, 1998; Morrissey-Kane & Prinz, 1999).

Research has not fully examined the ways in which parental sense of competence and self-efficacy relate to other aspect of addressing behavioral concerns, such as how parents conceptualize their child's behavior, their own role in treatment, and changes or stability they perceive in their child's behavior. The present study will examine how parental characteristics of competence and self-efficacy relate to their conceptualizations of their child's behavior and treatment. Specifically, it will examine thematic differences between parents with high and low parental sense of competence and self-efficacy in the way parents describe their child's behaviors, the resources they use, their personal investment in treatment, and the way they describe changes in their child's behavior.

One hypothesis is that parental sense of competence and self-efficacy will relate to how the parents respond to the problematic behaviors. Specifically, parents who score high on measures of parental sense of competence and self-efficacy will be more likely to describe their child's behaviors as something they can address. They will be more likely to talk about their efforts to influence the behavior and will describe greater consistency and persistence in these efforts. Parents who score low on measures of parental sense of competence and self-efficacy will tend to believe their actions have limited effect on their child's behavior and will describe less consistency in their efforts to address these behaviors.

A second hypothesis is that parental competence and self-efficacy are related to the amount of time and effort parents put forth on obtaining the resources or treatment for their child. Those who score high on parental sense of competence and self-efficacy will describe spending more time and effort obtaining the resources or initiating the intervention. On the other hand, parents who score low on parental sense of competence and self-efficacy may describe spending less time and effort on obtaining resources or initiating intervention.

A third hypothesis is that parental sense of competence and self-efficacy are related to the amount of effort parents describe investing in addressing their child's behaviors. Those with high parental sense of competence and self-efficacy may describe more active involvement in their intervention or treatment. They may describe investing more time, energy, and effort into following through with the treatment. On the other hand, parents with low parental sense of competence and self-efficacy will describe being less actively involved in the intervention or treatment. They will describe less investment of time, energy, and effort into following through with the treatment.

Finally, parental sense of competence and self-efficacy is hypothesized to be related to the extent to which the parents assume responsibility for the changes or stability in the behaviors following the use of resources or interventions. Parents with high sense of competence and self-efficacy may talk about the change or stability in the behavior in terms of their efforts. They may be more likely to attribute the change or stability to their efforts. Parents with low sense of competence and self-efficacy may talk about the change or stability as resulting from something external to themselves. They are less likely to take responsibility for the change or stability in the behavior.

Method

Participants

Thirty parents or guardians of children between the ages of 6 and 11 who had been involved in treatment for externalizing behaviors for at least a month at a community mental health agency participated in the study. Of the respondents, nineteen were fathers, twenty-one were mothers, and seven were custodial grandparents. More than half of the sample ($n = 17$) had a household income of less than \$25,000 a year. Additionally, most of the parents in the households had less than a college education (mothers $n = 28$; fathers $n = 22$).

On the *Behavioral Assessment Scale for Children – Parent Rating Scales* (BASC-PRS), twenty-nine participants (96.7%) rated their child as clinically elevated on at least one externalizing behavior scale. Twenty-three (76.7%) rated their children as clinically elevated on the hyperactivity scale, nineteen (63.3%) rated their children as clinically elevated on the aggression scale, and thirteen (43.3%) rated their children as clinically elevated on the conduct problems scale. When asked about their child's diagnosis, twenty-eight participants reported that their child had a diagnosis of ADHD. Five participants reported a diagnosis of oppositional

defiant disorder, five reported disruptive behavior disorder, two reported depression, and one reported an anxiety disorder.

All of the participants were bringing their children for services at a community mental health center. Thirteen participants were obtaining medication only, six were receiving therapy only, and eleven were using a combination of medication and therapy.

Procedure

When the participants attended their regularly scheduled appointment with their case manager, therapist, or psychiatrist, they were introduced to the study. Those who indicated interest in participating met with a psychology doctoral graduate student who was also the primary investigator. The student reviewed the informed consent form with the participant and conducted an interview using a semi-structured format (see Appendix A). These interviews were audio recorded to allow for transcription and analysis. However, identifying information was removed from the transcripts. Following the interview, participants completed a demographic form and the Parental Sense of Competence Scale, which included a parental self-efficacy subscale. The interview and the accompanying forms were generally completed within 40 minutes. Participants were given a \$10 gift card to thank them for their time.

Measures

The Parental Sense of Competence Scale, which included a self-efficacy subscale, is a measure of parental sense of competence and parental self-efficacy (Johnston & Mash, 1989). Coleman and Karraker (1997) used factor analysis to provide evidence of the parental sense of competence scale's construct validity. The researchers also found good internal reliability

($\alpha = 0.70$). Other examinations of the scale have found internal consistency alpha coefficients of 0.75 for the satisfaction factor and 0.76 for the efficacy factor (Johnston & Mash, 1989; Rogers & Matthews, 2004).

Data Coding

Through the use of content analysis of the transcripts, seven themes and the categories within each theme were identified and defined by the researcher. The themes and categories into which the participants' responses were sorted were used as dependent variables in the testing of the hypotheses. The first theme was the description of the problem and the categories within this theme were use of diagnostic term and use of behavior description. The second theme was parental awareness of the impact of parental behavior on child's behavior and categories within this theme were expressed awareness and did not express awareness. The third theme was perception of need for consistency and the categories were described need for consistency and did not describe need for consistency. The fourth theme was perception of self as consistent. The categories within this theme were perception of self as consistent, perception of self as working on consistency, and perception of self as inconsistent. The fifth theme was perception of use of resources and the categories were limited use of resources and extensive use of resources. The sixth theme was amount of parental effort or investment in working to address behavior problems and the categories were high effort and investment and low effort and investment. The seventh theme was attribution of change or stability in behaviors since starting treatment. The categories within this theme were child, parent, other factors, combination of parent and child, combination of parent and medication, combination of multiple factors, and do not know how to attribute the behavior change or stability (see Appendix B).

The researcher transcribed the interviews. Although hypotheses were identified a priori, the thematic structure used to analyze the transcripts was extracted from the data by the researcher. These themes relate to the identified research hypotheses. The hypothesis that parental sense of competence is related to parental response to behaviors is addressed by four themes: parental awareness of the effect of parental response on their child's behavior, parental description of the problem, perception of need for consistency, and perception of self as consistent. The hypothesis that parental sense of competence is related to parental use of resources is addressed by the theme: parental use of resources. The hypothesis that parental sense of competence is related to parental investment in addressing behaviors is addressed by the theme: parental effort or investment in addressing behaviors. Finally, the hypothesis that parental sense of competence is related to the attribution of change or stability in behaviors is addressed by the theme: attribution of change or stability in behaviors since starting treatment (see Appendix C).

The researcher then sorted relevant passages from the transcripts into the established categories. Independent coders who held advanced degrees in clinical psychology and were familiar with qualitative methodology, although blind to the specific research hypotheses, then examined the transcripts and sorted the selected excerpts from the transcripts into the categories to establish interrater reliability. The independent coders did not participate in developing the thematic structure. The independent coders noted which excerpts they sorted into which categories (Appendix D includes complete instructions to coders). Cohen's kappa was used to examine the reliability of the independent coders' categorizations for the themes. All cells met or exceeded the accepted kappa of 0.80 (see Table 1). Discrepancies between the independent coders were examined and settled by using the student researcher's original categorization.

Results

Each theme was analyzed to determine whether there were thematic differences in the response categorizations of parents with high and low parental sense of competence and self-efficacy. For the five themes that contained two categories, Fisher's exact test was used as recommended by Maxwell and Delaney (2004) because it is a useful way to examine 2 (competence: low and high) \times 2 (categories specific to individual themes) tables with a small sample size and imbalanced cell sizes. Because five Fisher's exact tests were calculated, Bonferroni's correction was applied to reduce the likelihood of making a Type 1 error, which resulted in more stringent criteria for significance ($p < .01$).

A χ^2 was used to examine the relationship between the response categories and parental characteristics for the two themes that contained more than two categories. However, it is important to note that a χ^2 analysis is sensitive to sample size because the size of the calculated χ^2 is proportional to the size of the sample. Applying a χ^2 to small samples increases the likelihood of a type II error, or failing to reject the null hypothesis when the null hypothesis is false. Additionally, use of a χ^2 requires that each cell have an expected frequency of at least ten. Although corrections, such as the Yates correction, are possible, they are not always recommended because they impose a loss of power (Camilli & Hopkins, 1978). Such a correction was not applied to this data due to concerns about compounding the challenge of low power already imposed by a small sample size. Therefore, some caution is warranted in interpreting the analysis of this data.

In the following section, each of the emergent themes and categories are discussed in the context of the identified hypotheses. Each of the themes and identified categories are illustrated

using quotes from the interview transcripts. The excerpts from the transcripts were edited slightly for readability. However, the content was not changed.

Hypothesis 1: Parental Sense of Competence Relates to Parental Response to Behaviors

The emergent theme regarding the use of diagnostic labels versus behavioral description was thought to relate to this issue in that parents who use labels without explanation or representative understanding may be more disengaged from the causal patterns of the behavior than parents who provide in-depth descriptions of behavior. Such disengagement may be related to the parental response to problematic behavior. Similarly, parental awareness of the effect of their response their on child's behaviors, perceived need for consistency, and the perception of self as consistent in parenting responses would also reflect greater understanding and investment in the process of behavioral change and were thought to be reflective of characteristics of parents high in self-efficacy and competence. Of these themes, differences in the response categorizations emerged only for parental description of response to problematic behaviors.

Theme: Description of Problem

Parental description of problematic behaviors is the first emergent theme that relates to the hypothesis that parental sense of competence relates to parental response to their child's behaviors. It was hypothesized that parental sense of competence and self-efficacy would relate to thematic differences in how parents describe their child's behavior problem. This hypothesis was derived from research that suggests parental self-efficacy is related to the way parents conceptualize their child's behavior problem. However, the hypothesized differences were not found in this study. Parental sense of competence was not related to how parents described their child's behavior problems ($p = 0.552$, Fisher's exact, one-tailed). Parents tended to provide behavioral descriptions of their child's behavior problems. Twenty-seven parents described their

presenting concerns by providing descriptions of the behaviors they found challenging. Thirteen of these parents had high parental sense of competence and fourteen scored low on these measures. Three parents described their presenting concerns using diagnostic labels. One of these parents had high parental sense of competence and two scored low on a measure of this characteristic (see Table 2 for response categorizations and parental characteristics).

Category 1: Use of behavioral description. Responses in this category emphasized a description of the problematic behaviors that prompted treatment. Although the parents may mention their child's diagnosis, they also provided an explanation of the behaviors. For example, one parent elaborated:

My child has ADHD. Um... Just uncontrollable energy. He couldn't focus in school for more than a minute or two on each project. Even on his graded papers when he'd bring them home, like the first ten answers would be correct and all the rest of them would be absolutely wrong because, after a certain amount of time, he couldn't focus on what he was doing. At home he was very, very hyper, acting out, driving his brothers crazy, driving me crazy, you know. Couldn't really get himself to go to sleep at night because he was up forever. He was never violent or anything like that. Just uncontrollable energy is the best way to describe it.

Some of the responses focused on specific behaviors that parents found challenging or overwhelming to handle. For example, one participant mentioned that when her child "gets upset, he will head butt the truck. I felt like it wasn't normal." Other parents described more general concerns such as "not listening," "not minding," "acting up," "aggression," having "outbursts," and "being a bully." One participant commented that her son has "severe behavioral issues with discipline and respecting authority." Another participant noted that her child has

“trouble getting along with others.” Several parents also listed stealing, lying, or destroying property as behaviors that prompted treatment.

In addition to the behaviors they believe indicated their child needed services, some parents identified a situation that exacerbated the behaviors. One participant commented that her child had “been through all kinds of things and needed somebody to work with him and help him.” Another observed, “things got a little worse when their mother left.” One participant described the behavior problems that she noticed develop following changes in her family:

Their mother got killed a year ago and their daddy got incarcerated. It’s been traumatic and caused problems. He’s got problems at school. He talks too much, gets up too much, doesn’t want to listen to his teachers. He’s not abusive or anything, he just don’t listen. He likes to run his mouth. He wants to do things when he wants to do them.

Whether the description focused on general behavioral concerns, specific behavior problems, or situations that exacerbated a problem, all of the responses sorted into this category describe behaviors the parents find challenging.

Category 2: Use of diagnostic term. When asked what behaviors prompted their interest in treatment, some parents listed their child’s diagnoses. In these responses, the diagnostic term seemed to be assumed to explain the problem to the interviewer. For example, one parent described the problematic behaviors as being “his ADHD, ODD, intermittent explosive disorder. He has outbursts a lot. He’s very hyper. Very extremely hyper.” Although the parent characterized the child’s behavior as hyper and stated that he has outbursts, the response emphasized the diagnostic label as explaining what prompted treatment.

Similarly, when asked about the behaviors that prompted the family to seek services, another participant depended upon the child’s diagnosis for her explanation:

Well, he was diagnosed with ADHD and put on medication years ago, but he started developing ticks and his other doctor took him off the ADHD medication and put him on another one. This whole school year, he's done really bad in school and that's just not him. I think it was where he just wasn't focused because the ADHD was there.

Although this parent mentioned concern over the child's academic performance, the focus of the description of the problem was on the diagnosis. The parent did not talk about specific behavioral concerns or specific parenting situations that were challenging, but instead emphasized that managing the disorder has been challenging.

Theme: Awareness of the Effect of Parental Response on Child's Behavior

Parental sense of competence was significantly related to how parents describe their response to their child's behavior ($p = 0.009$, Fisher's exact test, one-tailed). Overall, eight parents described an awareness of the effect of their response on their child's problematic behaviors. Seven of these parents scored high on measures of parental sense of competence and one scored low on these measures. Twenty-two parents did not describe the relationship between their reaction and their child's behaviors. Seven of these parents scored high on measures of parental sense of competence and fifteen of these parents scored low on the measures. Parents with high sense of competence were more likely than those who scored low on these measures to describe an awareness of the effect of their parental responses on their child's behavior (see Table 2 for response categorizations and parental characteristics).

Category 1: Expressed awareness. When asked about their response to their child's behaviors that they had identified as being problematic, some parents tended to describe both their efforts to address their child's behaviors and their child's reaction to their efforts. These parents identified a connection between their response to their child and their child's behaviors.

One participant noted, “It took a lot of trial and error to figure out what the problem was and what the best way to handle it might be.” Another responded, “When she gets that upset, I put her in time out to give her time to cool down. When she is calm, I let her come out and we talk about it.”

Additionally, some parents believed it was important to help their child see the connection between their behavior and their parent’s response to the behavior. One parent explained, “He doesn’t like time out and he hates it when you take something away. He’s learned that I give him consequences for his behavior.” Another noted, “I think it’s really important for them to know what to expect and what the consequences are.”

Category 2: Did not express awareness. Although some parents described the effect their response had upon their child’s behaviors, others did not express their awareness of the relationship. These parents described their effort to address their child’s behaviors, but did not talk about the effect that their efforts have on their child’s behavior. Their description of their effort often focused on themselves rather than on the effect of their response on their child’s behavior. For example, when asked how she usually responds to her child’s behaviors, one parent listed her actions but does not talk about the effect of these actions on the child or the child’s response to the consequences:

I either take something away, like his Xbox or something like that. I tell him to go to his room until he calms down or can treat me with respect, come out, and talk to me. I try to do something like that because I’m not going to scream and holler. I pick and choose my battles.

Another participant explained, “I yell, which isn’t always the best. Try to take away stuff: Xbox, PlayStation. Make him stay in or go to his room.” A third participant responded,

“When she acts up, I make her go to her room or sit on the couch. Sometimes I give her a spanking or don’t let her play.” Although all of these participants listed their reactions to their child’s behavior, they do not identify a connection between their response and their child’s behaviors.

Theme: Perception of Need for Consistency

Parental perception of need for consistency is the third emergent theme that relates to the hypothesis that parental sense of competence relates to parental response to their child’s behaviors. However, the hypothesized thematic differences did not emerge in whether parents describe a need for consistency. Parental sense of competence was not related to whether parents’ responses were categorized as describing a need for consistency ($p = 0.132$, Fisher’s exact, one-tailed). When talking about their response to their child’s behaviors, twelve parents described a need for consistency. Eight of these parents scored high on measures of parental sense of competence and four of these parents scored low on these measures. Eighteen parents did not describe a need for consistency. Seven of these parents scored high on measures on parental sense of competence and eleven scored low on these measures.

Category 1: Describes need for consistency. In talking about their response to their child’s behaviors, some of the parents brought up a need for consistency in how they address their child’s behaviors. One participant alluded to the importance of consistency, “Once I’ve said I’m going to do something I have to do it.” Other parents referenced the role that consistency or lack thereof plays in their child’s behavior. For example, a participant stated, “Once I say that’s what will happen, I stick with it because he has to know that I will.” However, another participant identified consequences of being inconsistent, “I don’t really give up. I can’t. It might make it worse.” The parents may have described their own behavior as

inconsistent, but see this as being problematic. One participant commented, “It’s hard to be consistent like I should.” Another noted, “There are times I’m not consistent. I fail at that, and I know she needs consistency.”

Category 2: Do not describe need for consistency. Although some parents talked about a need for consistency when asked about their response to their child’s behavior, their consistency in their response, whether their response works, and their beliefs about why it does or does not work, others did not. For example, when asked whether they always respond to their child’s behaviors in the ways they identified earlier in the interview, one participant acknowledged, “We tried a little bit of everything, honestly.” Some of the parents did not mention consistency or the results of being consistent or inconsistent. When asked about why they believed their current disciplinary methods were not working, one participant responded, “I think it’s because she wants to do what she wants to do and she’s self-centered. If she doesn’t get her way, she has a fit.” Similarly, another participant believed that her efforts to address her child’s behaviors were not working because “he’s just uncontrollable.”

Theme: Perception of Self as Consistent

A fourth emergent theme that relates to the hypothesis that parental sense of competence relates to parental response to behaviors is whether parents perceive themselves to be consistent. However, hypothesized thematic differences did not emerge. A chi-square was used to examine the frequency of the categorizations of parents’ responses. The number of responses categorized as reflecting the parents’ perception of themselves to be consistent, working on their consistency, or inconsistent was not significant, $\chi^2(2, N = 30) = 3.00, p = .223$. Overall, fifteen parents perceive themselves as consistent. Eight of these parents scored high on a measure of parental sense of competence and seven scored low on the measure. Five parents described themselves as

working on their consistency. Four of these parents scored high on a measure of parental sense of competence and one scored low on the measure. Ten parents perceived themselves as being inconsistent. Three of these parents scored high on the measure and seven of them scored low (see Table 2 for response categorizations.)

Category 1: Perceive self to be consistent. In talking about their response to their child's behaviors, parents talked about "doing the best we can" to be consistent. One parent emphasized, "I can't give up" and described anticipated consequences of inconsistency, such as making the behaviors worse. Another parent talked about the challenges of being consistent, "I'm pretty consistent. It's hard sometimes, especially when we're at a family's house, but I try. I know consistency is important." Another noted that the situation in which the behaviors occur affected her ability to be consistent:

Which [consequence] we use really depends on the situation. If she was playing too rough, I would take away the toy or make her sit on the couch. If she was doing something really bad, I might spank her. Usually, we just send her to her room or make her sit on the couch and calm down.

Category 2: Perceives self to be working on consistency. These participants described themselves as working on their consistency in their response to their child's behaviors. Several parents mentioned "trying hard to be consistent." They may have acknowledged that being consistent was hard or that they sometimes struggled to be consistent. One parent concluded, "It's important to be consistent and patient. I work really hard on that. It's hard at times, but I really do work on that."

Several participants also brought up working on their consistency at the suggestion of a mental health professional involved in their child's treatment. For example, one participant

commented, “I try to be pretty consistent about it, which is something I’ve talked to the therapist about.”

Category 3: Perceives self to be inconsistent. These parents described themselves as being inconsistent in their response to their child’s behaviors and did not identify this as something they were working to improve. They frequently acknowledged that their response varied or that they discontinued their efforts quickly. For example, one parent acknowledged:

It doesn’t take long before I give in. With her the way she is, I have a stressful moment and give in too easy. I know I give in too easy, but it’s stressful and I don’t do well with that. I don’t last long. She’ll start throwing a tantrum or tell me I don’t love her and I give in. I’m soft hearted like my mom.

Another participant (mother) explained:

I almost always put her on the couch when she does something wrong or acts up, but it depends on what I’m trying to get done as to how many times I’ll chase after her and put her back on the couch. I know I need to be consistent, but it’s so hard.

Hypothesis 2: Parental Sense of Competence Relates to Use of Resources

The hypothesis that parental sense of competence would be related to the amount of time and effort parents put forth in obtaining resources or treatment for their child is addressed by the emergent theme: parental use of resources.

Theme: Perception of Use of Resources

Parental sense of competence and self-efficacy were related to the extent to which parents describe utilizing resources ($p = 0.015$, Fisher’s exact, one-tailed). When asked specific questions about resources they may have used since becoming concerned about their child’s behaviors, eight participants described an extensive use of resources. Seven of these parents

scored high on the measure of parental sense of competence and one scored low on the measure. Twenty-two participants described a limited use of available resources. Eight of these parents scored high on a measure of parental sense of competence and fourteen scored low. Parents with a high sense of competence and self-efficacy were divided in whether they described an extensive or limited use of resources. However, parents with low sense of competence and self-efficacy frequently described a limited use of resources.

Category 1: Extensive use of resources. These parents described putting forth extensive effort in utilizing resources to address their child's behavior problems. Although all participants were taking their child for mental health services, parents who described an extensive use of resources often talked about actively using their child's service provider as a source of information and taking an active role in their child's treatment. For example, one parent described extensive discussions with the child's doctor about possible treatment options:

His doctor went over with me all the different types of things we could do. I was really concerned because a lot of the medications they used to have for hyperactivity literally were medications that zombified your child. I didn't want to go the medication route at first. I wanted to try something else. But really, from what his doctor explained, that really was the only way to get it under control, especially at his age. When he was first diagnosed, he was five or six and just starting out in school. He had to be held back one grade because of his ADHD, and when it became that much of a problem and I knew it was affecting his school, then I decided to go the medical route. I talked to his doctor and we put him on medication that wouldn't be dangerous or turn him into a completely different person.

Other parents described frequently discussing the effectiveness of the medication with their doctor. For example, one parent described her role in working with the doctor:

We spend a lot of time talking about his meds and changing his meds. You really have to pay attention to how the meds are doing and the doctors have to be willing to listen. And not all doctors do. Every kid is different.

In addition to their active involvement in their child's mental health treatment, parents describe investing significant time in seeking out information from a variety of resources. One parent talked about looking through books at the library and working closely with his child's teachers:

I talked to the teachers about her behavior. I actually worked pretty close with some of her teachers there until I got a grip on things. They've been good to her. They've also been patient with me. They've spent a lot of time helping me and working with me.

Parents often described their use of resources as an "ongoing process" that they either engaged in regularly to continue to seek out information or returned to as the behavior changed or a question arose. One participant explained, "when I have a chance to go and read some more information or when something is going on with him and I'm not really sure why, I'll go see what information I can find."

Category 2: Limited use of resources. These parents described putting forth limited effort in utilizing resources to address their child's behavior problems. All participants were taking their child for mental health services, whether medication, therapy, or a combination of the two. However, some parents' description of their interaction with the mental health staff suggested that they assume a limited role in treatment. They did not seem to contribute much to the treatment planning or to use the professional as a source for information or suggestions.

Parents described using one or two types for resources, but their description of their efforts suggested limited effort in seeking out information or reading through materials. Additionally, their descriptions were not specific about the information they gathered or about the specific resources they used. For example, when asked what resources she had investigated since becoming concerned about her child's behavior, one participant described briefly using the Internet to "look up different signs and symptoms, but nothing major." When asked for clarification on what websites she may have visited, she stated, "I just put ADHD in, or intermittent explosive disorder, things like that." Although she was not able to estimate how many websites she may have browsed, when asked about how much time she had spent looking through the websites she responded, "I know one week I spent just about every other day on there looking up signs and symptoms of different things." This participant denied considering using other resources for information. Another participant described briefly "looking on the Internet, but that's about it. I just browsed. I didn't do in-depth."

A couple of parents mentioned that they were unaware of what resources existed or how to appropriately access them. For example, one parent mentioned that she "didn't know there was anything until starting [treatment] and they gave me some." Another commented, "There's not that much. People think there are resources, but there isn't. I don't see them."

Additionally, a few parents expressed concerns about whether the information that they could find was helpful or valid. For example, one parent stated, "I look at a lot of websites, but you never know what's good." Another commented, "It's so slow and frustrating that it's not worth it. I've never found anything that has been helpful."

Hypothesis 3: Parental Sense of Competence Relates to Investment in Addressing Behaviors

The emergent theme that addressed the third hypothesis is: amount of effort or investment in addressing problematic behaviors.

Theme: Amount of Parental Effort or Investment

Parental sense of competence was significantly related to parents' descriptions of the amount of effort or degree of investment in addressing their child's behavior problems ($p = 0.013$, Fisher's exact, one-tailed). Based on a reading of the entire interview transcript, the interviews with parents who have a high sense of competence and self-efficacy were more likely to be categorized as reflecting a high amount of effort. The interview with parents who have a low of competence and self-efficacy were more likely to be categorized as reflecting a low amount of effort or investment. Thirteen parents were categorized as putting forth great effort or being highly invested in working to address their child's behavior problems. Ten of these parents scored high on a measure of competence and three scored low on the measure. Seventeen parents' responses were categorized as reflecting minimal effort or investment in working to address their child's behavior problems. Five of these parents scored high on the measure of parental sense of competence and twelve of these parents scored low on the measure.

Category 1: High effort or investment in working to address the behavior problems.

Based on these parents' responses to the interview questions, it was clear that they have taken an active role in working to address their child's behavior problems. They described giving careful thought toward identifying the problem, why it occurred, and how it could be best addressed. They often described giving careful thought to the selection of treatment modality or the resources used.

They described themselves as actively involved with treatment, whether through regularly discussing treatment and monitoring progress with the mental health professional or by working with the service provider to develop their strategies for addressing the behaviors at home. Additionally, they tended to describe making changes in their response to problematic behaviors as a result of suggestions they received during treatment or information they obtained from resources. One participant, for example, explained:

I have talked to the therapist because I would like some help with them. I feel like a drill sergeant. All three of the kids will gang up on you because that's what they've learned to do, but I hear myself screaming and yelling and I don't like that. So I have asked them to help me learn to do things better. They've helped me and have been giving me ideas here.

Another parent described working on being more consistent at the suggestion of the therapist:

We're sticking to it more than what we would usually. Before we would just kinda let him go do whatever. Now it's sticking to it and making him do what you want him to do. We talked about it here [at the community mental health center] and then we noticed a difference. Even if he's having an outburst, if you make him do it, he's eventually going to do it. He's going to know he has to do it. If you just say okay you don't have to do it, he ain't never going to do it.

The parents seemed to feel a responsibility for addressing the problems and bringing about change. Some parents described having greater patience in dealing with their children and others emphasized the importance of learning and implementing new strategies.

Category 2: Low effort or investment in working to address behavior problems. Based on these parents' responses to the interview questions, it seemed that they have taken a less active role in working to address behavior problems. The parents tended to describe less persistence in their disciplinary efforts. For example, one participant stated, "sometimes it works pretty good. Sometimes it doesn't. When it doesn't work, I can't get my stuff done." When asked about how long she persisted she responded, "a couple times – until I get mad."

Several parents in this category mentioned frequently missing or forgetting appointments with their service providers. One participant explained her belief that therapy was not yet yielding changes in her daughter's behavior because "we've missed some appointments so maybe it will still help. Maybe it just hasn't had time to work."

The parents also tended not to be involved in working with the mental health staff working with their child or to be using them as a source of information or ideas. Instead, they were dismissive of the ideas or resources that had been presented to them. Some parents described passively relying upon the recommendations of the doctor or therapist for treatment options.

Generally, the parents did not seem to take responsibility for addressing behaviors or contributing to treatment. The parents tended to express beliefs that the factors responsible for their child's behavior are beyond their personal control, such as the effect of medication, their child's temperament or effort, or a specific situation. One participant explained:

It all depends on what mood he's in. There are some days when he's just totally in his mood. He gets in those moods. I might as well talk to an ant. It's in his head and that's the way it's going to be.

Hypothesis 4: Parental Sense of Competence Relates to Attribution of Change or Stability

The a priori hypothesis that parental sense of competence and self-efficacy may relate to the way parents understand the change or stability in their child's behaviors was addressed by the theme: attribution of change or stability in behavior since starting treatment.

Theme: Attribution of Change or Stability in Behaviors

A chi-square was used to examine the frequency of the categorizations of parents' responses. The frequency of the categorizations were not significant, $\chi^2(2, N = 30) = 10.00$, $p = .350$. Two parents attributed the change or stability to their own efforts. One of these parents scored high on parental sense of competence and the other scored low on the measure. Three parents attributed the change to other factors, such as the effect of medication or a situation. Two of these parents scored high on the measure and one scored low. Three parents attributed the change or stability to a combination of their efforts and those of their child. One of these parents scored high on the measure and the other scored low. Seven parents attributed the change or stability to a combination of their own efforts and the medication. Four of these parents scored high and three scored low. Eleven parents attributed the change or stability to a combination of multiple factors. Six scored high on the measure and five scored low. Finally, four parents did not know how to attribute the change or stability. One of these parents scored high on the measure and three scored low (see Table 2 for response categorizations and parental characteristics).

Category 1: Parent only. Responses in this category identified the parents' efforts as being the primary reason for the change or stability in the child's behavior since starting treatment. One parent mentioned that she was "learning more" about how to handle her child's behavior and felt that her efforts to do so were impacting her child's behavior. Another parent

believed that her efforts to address her child's behaviors helped "a tremendous amount. I'm the only one who provides that stability and discipline."

Category 2: Other factors. Parents in this category identified an external factor such as medication or therapy as being the biggest reason for the changes or stability in their child's behavior. For example, one parent described her belief that "with the medication, her brain's more balanced than it was." Another parent noted:

It's like he's a completely different person on and off his medication. It's the medication.

I used to think it was me, but we went through all those options and there wasn't anything

I was doing that was helping or hurting the situation. On the medication, it's a lot easier.

One parent attributed the stability in her child's behavior to her lack of consistency in keeping her therapy appointments, though she remained optimistic that it would help. She stated that the reason her child continued to have difficult behaviors was because "she needs psychological help."

Category 3: Combination of parent and child. Parents' responses in this category attributed the changes or stability they perceived in their child's to themselves and their child. For example, one parent believed:

It probably has to do with the stuff we do at home. A good bit of it has to do with him too, possibly because he's feeling more comfortable and safe at home. He doesn't seem to feel the need to have as much control anymore.

Another parent commented:

I play a role – apparently I haven't found the right thing to do with her. I think it has a lot to do with her. I don't know why she doesn't want to listen and would just as soon fight us, but that's the way she is.

Category 4: Combination of parent and medication. These parents' responses identified both their efforts to address their child's behaviors and the effects of the medication as being significant factors in the change or stability in their child's behaviors. For example, one participant noted, "The medication helps a lot and also I know a lot more about how to deal with things and help him more." Another parent explained, "What we do at home wouldn't be nearly as effective without his medication. I think it's really a combination."

Category 5: Combination of multiple factors. Parents' responses in this category named multiple factors as contributing to the change or stability in their child's behavior problems. For example, one parent attributed the change to "having someone outside everything for him to talk to," her own efforts to "be there and be positive," her son's efforts to "think about things and make better decisions about his behavior," and the situation with his stepmother. Another parent believed that her child's medication, therapy, and her own efforts to "be more consistent once I say no" have resulted in her son's behavior changes.

Category 6: Don't know how to attribute change or stability. Four parents did not know how to attribute the change or stability in their child's behavior. In each case, the parent responded "no" or "I don't know" to the questions of "Why do you think these changes have occurred?" "How much do you think it has to do with what you're doing?" "How much do you think it has to do with your child?" and "How much do you think it has to do with other factors?" One participant added, "I don't know why things aren't getting better. If I did, I would do something about it."

Discussion

Although the literature has emphasized examination of the efficacy of treatments for externalizing behavior problems, it has not extensively considered how factors endogenous to the

parent may be related to treatment. Given the central role parents play in initiating and following through with treatment, it is important for clinicians to understand what factors are related to parental conceptualizations of their child's behavior problems and treatment. This study utilized a qualitative methodology consisting of thirty semi-structured interviews with parents or guardians whose children had been in treatment for externalizing behavior problems for at least a month to examine whether parental sense of competence and self-efficacy are related to the ways in which parents describe their child's behaviors, their response to the behaviors, their investment in treatment, and their attribution of treatment outcomes. Upon examination of the interview transcripts, seven themes emerged that address the identified hypotheses.

The hypothesis that parental sense of competence relates to parental response to behaviors is addressed by four of the emergent themes: awareness of the impact of parental response on child behaviors, description of the problem, perception of the need for consistency, and perception of self as consistent. However, response categorizations differed for parents with high and low parental sense of competence in only one of these themes: awareness of the impact of parental response on child behaviors. Parents with high sense of competence were more likely than those who scored low on this measure to describe the effect their behavior has upon their child and recognize a connection between their response and their child's behavior. Some parents also mentioned needing to help their child understand the connection between their behavior and the parents' response.

In contrast, parents with a low sense of competence and low self-efficacy did not talk about the connection between their response and their child's behavior. Their descriptions of their response to their child's behavior frequently involved listing possible consequences, but did not emphasize an attempt to help their child understand the connection between behaviors and

the parental response. This is consistent with previous research suggesting that these parents feel less able to control or influence their child's behavior (Donovan, et al., 1990). If parents do not believe that their response affects their child's behavior, they are more likely to give up quickly when their efforts to address their child's behaviors are met with resistance (Coleman & Karraker, 1997).

The expected thematic differences did not emerge in parents' descriptions of their child's behavioral problems. When asked what behaviors brought them to the mental health center, parents responded either by using diagnostic labels or by providing descriptions of the problematic behaviors. Maniadaki et al. (2005) concluded that parents with high self-efficacy are likely to interpret child behavior problems as a challenge that requires greater effort and application of parenting skills and those with low self-efficacy are likely to perceive the behaviors as inherent to their child and stemming from stable, global characteristics. It was hypothesized that parents' descriptions of their child's behavior problems would reflect these differences in conceptualizations. However, the hypothesized differences did not emerge. One reason for this may be that the phrasing of the interview prompts led parents to respond in a particular way. For example, the language parents used to describe their child's behavior problems was shaped by the interview prompt: "I was hoping you could tell me what behaviors caused you to be interested in coming here [for treatment]". The use of the word "behaviors" may have encouraged parents to provide behavioral descriptions. Although three parents focused their response on their child's diagnosis, more parents might have done so if not specifically asked to talk about the behaviors.

Expected thematic difference did not emerge in whether parents described a need for consistency in their response to their child's behavior nor did they emerge in whether they

described themselves as consistent. Some parents described the importance of consistency and the consequences of being inconsistent. However, other parents did not identify consistency in their response to their child's behaviors as affecting their child's behaviors. Parents also varied in how consistent they believed themselves to be with some expressing strong beliefs in their ability to be consistent and others acknowledging that being consistent is very challenging for them. Several parents also describe working on their consistency, either on their own or with the help of a professional.

Previous research has not examined the relationship between parental sense of competence and self-efficacy and consistency in parental responses. However, research has suggested that parental sense of competence and self-efficacy are related to the amount of persistence parents demonstrate in difficult tasks (Coleman & Karraker, 1997; Grusec, Hastings, & Mammone, 1994). Although this study did not find a significant relationship between parental sense of competence and self-efficacy and consistency, the data were likely impacted by the relatively small number of participants in this study, which limited the power to detect differences in the frequencies of categorizations due to low cell sizes. Although it is also possible that parents' responses to the prompts about their consistency were affected by the face-to-face nature of the interview and an attempt to present themselves in a particular way, the clinical setting of data collection may have minimized this possibility as parents are accustomed to talking about their parenting behaviors with their service providers.

The hypothesis that parental sense of competence and self-efficacy would be related to the amount of time and effort parents put forth in obtaining resources or treatment for their child is supported by the response categorizations for parents with high and low parental sense of competence. Some parents described an extensive use of resources, often including having

lengthy conversations with service providers about treatment options or spending extensive time searching for and reading through information pertaining to their child's behaviors. Many of these parents noted that their use of these resources was ongoing and something they depended upon when questions arose or their child's behaviors changed.

Other parents described a limited use of available resources. Although they were taking their child for mental health services, they did not describe using the service providers as a resource or attempting to access other sources of information. Some parents cited concerns about whether the information was accurate and others dismissed the resources as unhelpful. Still others stated that they were unaware that resources exist.

Although parents with a high sense of competence and self-efficacy were divided in whether they described an extensive or limited use of resources, parents with low sense of competence and self-efficacy frequently described a limited use of resources. This is consistent with past literature that found parental self-efficacy to be related to the extent to which parents educate themselves about parenting concerns (Spoth & Conroy, 1993).

The third hypothesis was supported by thematic differences in how invested parents described themselves as being in their child's treatment, with some parents assuming a very active role in working to change the behaviors and other parents taking a less active role. The interviews with parents who have a high sense of competence and self-efficacy were more likely to be categorized as reflecting a high amount of effort. Parents often described giving careful thought to the selection of the treatment modality and the resources used. They also tended to describe themselves as actively involved with their child's treatment through regular discussions of the treatment with the service providers. Several parents also described working with the service provider or utilizing other resources to develop their strategies for addressing the

behaviors at home. Overall, these parents seem to feel a responsibility for addressing the problems and bringing about change.

The interview with parents who have a low sense of competence and self-efficacy were more likely to be categorized as reflecting a low amount of effort or investment. These parents described taking a less active role in working to address their child's behaviors. Several parents mentioned frequently missing or forgetting appointments with their service providers. When attending sessions, the parents tended not to be as involved in discussing their child's treatment and progress with the service providers and did not seem to view them as a source of information or ideas. Instead they tended to be dismissive of the ideas or resources that have been presented to them or unaware that the resources exist.

Although previous research has not specifically examined how parental sense of competence is related to the amount of effort parents expend or the degree to which parents are invested in treatment, it has found that parents with low parental sense of competence tend to hold minimal expectations for improvement in their child's behavior problems and prematurely withdraw from treatment (Morrissey-Kane & Prinz, 1999). The current finding that parents with low sense of competence and self-efficacy describe themselves as less invested in treatment is consistent with existing research.

Finally, the a priori hypothesis that parental sense of competence and self-efficacy may relate to the way parents understand the change or stability in their child's behaviors was addressed by the theme: attribution of change or stability in behavior since starting treatment. Parents differed in their attribution of changes or stability in their child's behavior following treatment initiation. Some parents attributed the changes or stability to external factors such as medication and others attributed it to a combination of their efforts and the medication, a

combination of their efforts and their child's efforts, or a combination of multiple factors. A few parents struggled to explain the reason for the changes or stability. However, categorization differences were not found for parents with high and low sense of competence. These results were likely impacted by the combination of a high number of potential categories (seven) and low number of participants (thirty).

Discussion of Clinical Implications

These results suggest that parental sense of competence and self-efficacy are factors that clinicians should be cognizant of when working with parents of children with externalizing behavior disorders. Although formal assessment of these characteristics can be conducted, the results of this study imply that an informal assessment is possible by listening to the subtleties of the language that parents use to talk about the issues related to their children. Parents with high and low sense of competence and self-efficacy differ in terms of how they understand their response to their child's behaviors, the extent to which they make use of available resources, and their investment in working toward addressing their child's behavioral problems.

Parents with a high sense of competence and self-efficacy have characteristics that may be a strength they bring to treatment. These parents are more likely to view their response to their child's behavior as reciprocal. In talking about their response to their child's behavior, they may describe an effort to determine "the best way to handle it" and may adjust their response based on the effect it has upon the child. These parents recognize that their response to their child's behavior impacts future behavior and talk about the importance of helping the child "know what to expect." This understanding is an underpinning of behavior management training that these parents may grasp more easily.

Parents with high sense of competence and self-efficacy are also more likely to be invested in addressing their child's behavior problems, which may be reflected in the extent to which they utilize existing resources and in the role they take in their child's treatment. These parents are likely to seek out information from the available resources. They may describe "working pretty close with some of [their child's] teachers," for example. They are likely to view their use of resources as an "ongoing process." They are also more likely to actively involve themselves in discussing the treatment and progress with the mental health professional. If they have chosen medication for their child, for example, they may "spend a lot of time talking about the meds" with the prescriber and "paying attention to how the meds are doing." Similarly, they may seek information from the clinician about "how to do things better." This predisposition to assume an active role in addressing their child's behavior problems may facilitate their adherence to treatment recommendations and help ensure their retention in the treatment program.

Although high parental sense of competence and self-efficacy can be viewed as a strength upon which treatment can build, low parental sense of competence and self-efficacy may present challenges that need to be considered by clinicians as potential targets for therapeutic change. For these parents, the language they use to discuss issues related to their child's behavior may reflect beliefs about their efficacy and competence as parents that would suggest they are more likely to see their response to their child as not influencing their child's behavior, to make a limited use of available resources, and to limit their investment in addressing their child's behaviors. These differences in how they talk about issues related to their child's behavior have implications for clinical practice that can be explored in future research.

For example, the concept of parental sense of competence may provide a framework for conceptualizing and working with parents who do not seem to understand the relationship between their parenting response and their child's behavior, who make limited use of available resources, and who take a passive role in their child's treatment. The use of cognitive techniques such as restructuring can play an important role in helping parents establish realistic expectations for treatment, conceptualize the problems, and shape involvement in treatment (Friedberg & McClure, 2002). Additional research is needed understand how clinicians might intervene with parents with low sense of competence. For example, research could examine whether cognitive-behavioral techniques might be used to target the specific beliefs that reflect a low sense of competence.

Examples of such beliefs were evident in the interviews for this study. For instance, in talking about how she handles her child's behavior, one parent minimized her abilities by concluding, "I don't do well with that. I don't last long." Similarly, a parent expressed her belief that she could not affect her son's behavior when she explained, "there are some days when he's just totally in his mood... I might as well talk to an ant. It's in his head and that's the way it's going to be."

Other examples of beliefs that reflect a low sense of competence and may need to be addressed in treatment include parents' attribution of their child's behaviors to factors beyond their influence or control. For example, one parent concluded that the reason for her child's behaviors is because "she needs psychological help." This suggests the parent externalizes the responsibility for addressing the behaviors. Another parent attributed responsibility for changing behaviors to her child when she noted, "she wants to do what she wants to do and she's self-centered. If she doesn't get her way, she has a fit." The parent did not seem to believe that there

was an alternative to giving in to her daughter. Similarly, another parent concluded, “he’s just uncontrollable” and attributed the responsibility for the behaviors to the child.

Limitations and Direction for Future Research

There are a number of limitations associated with studies of this type. First, this study used a sample size of thirty participants whose children had been involved with treatment for externalizing behavior problems for at least a month, which imposes several limitations on the generalizability of this data. The length of time for which children had been receiving treatment likely varied considerably, though this information was not collected. How this may have affected the parents’ use of resources, investment in treatment, and attribution of behavior change or stability is unknown and may be an interesting area for future research.

The small sample size and use of one site to recruit participants also resulted in a lack of variability in household income and parental education level, both of which may be related to the parents’ knowledge of existing resources and ability to access those resources. This imposes limits on the generalizability of the data; however, it also is a strength of the study. Participants in this study tended to have a low to moderate mean household income and limited education. This population is not typically accessed by research, though this population is representative of the consumers of community mental health services. Understanding how parental sense of competence and parental self-efficacy relate to parents’ conceptualizations of their child’s behavior and treatment among this population is a useful addition to the existing literature.

Qualitative methodology was a useful way to explore how parental sense of competence and self-efficacy relate to parents’ conceptualizations of their child’s behavior and treatment. Because qualitative research methods are used to investigate subjects in the context in which they occur (Bogdan & Biklen, 1999), it allowed for a practical understanding of how those with

high and low competence and self-efficacy differ in their description of their response to their child's behaviors, their use of resources, and their investment in treatment which has clinical implications. Although a useful way to obtain this information, the use of qualitative methodology also imposes limitations on this study. Although the interviews were conducted using a pre-set, semi-structured interview format, the nature of the interview allowed for variability in follow-up questions. Whether parents were asked follow-up questions and how these questions were worded depended upon the individual interview. Additionally, the rapport between the participant and the interviewer may have influenced the interview. It is also possible that social desirability affected participants' responses. However, the interviews were conducted in a clinical setting in which the participants were accustomed to openly discussing the issues related to their child's behaviors. Additionally, the variability of the parents' responses did not suggest that participants were extensively restricting the nature of their responses or the extent of explanation they provided.

Using a quantitative methodology in future research to examine how parental characteristics relate to their decisions regarding treatment for their child's behavior problems and their perception of treatment outcomes may add validity to the current findings. For example, research might consider whether parental sense of competence and self-efficacy prior to treatment relate to treatment outcomes as assessed by both parents and treatment providers. It would also be interesting to examine whether parental characteristics influence the treatment modality parents select to address their child's behavior problems.

The methodology used imposed an additional limitation in that parents were categorized into a high or low group according to their scores on the Parental Sense of Competence Scale and the self-efficacy subscale. These categories were created in order to examine the thematic

differences and to gain a preliminary understanding of whether the parental characteristics are related parents' conceptualizations of behavior and treatment. However, parental sense of competence and efficacy are not dichotomous, but exist on a continuum. They are also likely to be multi-dimensional rather than unitary. The results obtained in this study may have been affected by applying the categories. Additional research may be able to examine the relationship without imposing these categories.

Future research should also consider whether the parental characteristics are related to mental health professionals' perception of the problem, parental response to behaviors, investment in treatment, and treatment outcomes. Additional questions might include: Do parents' ratings of their sense of competence and self-efficacy relate to clinicians' assessments of the parental characteristics? Do the parental characteristics impact the way clinicians conceptualize the problem or approach treatment? Do the parental characteristics affect parents' and clinicians' perception of the rapport in the relationship? Is it possible to intervene in the area of parental sense of competence and self-efficacy in a way that would enhance treatment outcomes? Given the central role parents play in their child's treatment, it is important that future research explore how parental characteristics affect various aspects of treatment.

Conclusion

In conclusion, this was a preliminary exploration of how parental sense of competence and self-efficacy relate to the ways parents' description of their child's problematic behaviors, their understanding of their role in addressing their child's behaviors, and their conceptualization of the changes or stability they perceive in their child's behavior. Parental sense of competence and self-efficacy were related to parents' description of their response to their child's behavior as either reciprocal or unidirectional, their perception of their use of resources, and their description

of the amount of effort or investment in working to address behavior problems. The parental characteristics were not related to the way in which they described their child's behavior problem, their perception of the need for consistency, their perception of their parenting behavior as consistent, or their attribution of the changes or stability in behavior since starting treatment. The tendency for parents with a low sense of competence and self-efficacy to see their response as unidirectional, make limited use of resources, and have a lower investment in addressing behaviors is notable and suggests potential areas for intervention in clinical work.

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Table 1. *Reliability of Independent Coders' Categorizations*

Theme	Category	Interrater reliability
Description of problem	Use of diagnostic terms Use of behavioral description	$\kappa = .84$
Awareness of the impact of parental behavior on child's behavior	Expressed awareness Did not express awareness	$\kappa = .83$
Perception of need for consistency	Describes need for consistency Does not describe need for consistency	$\kappa = .86$
Perception of self as consistent	Perceives self to be consistent Perceives self to be working on consistency Perceives self to be inconsistent	$\kappa = .89$
Perception of use of resources	Limited use of resources Extensive use of resources	$\kappa = .84$
Amount of parental effort or investment in working to address behavior problems	High effort/investment Low effort/investment	$\kappa = .86$
Attribution of change or stability in behaviors since starting treatment	Child only Parent only Other factors (e.g. medication, therapy, situation) Combination of parent and child Combination of parent and medication Combination of multiple factors Don't know how to attribute behavior change or stability	$\kappa = .87$

Table 2. *Frequency of Categorization of Parental Characteristics*

Theme	Category	High parental sense of competence/ self-efficacy	Low parental sense of competence/ self-efficacy
Description of problem	Use of diagnostic terms	1	2
	Use of behavioral description	13	14
Awareness of the impact of parents' behavior on child's behavior	Expressed awareness	7	1
	Did not express awareness	7	15
Perception of need for consistency	Describes need for consistency	8	4
	Does not describe need for consistency	7	11
Perception of self as consistent	Perceives self to be consistent	8	7
	Perceives self to be working on consistency	4	1
	Perceives self to be inconsistent	3	7
Perception of use of resources	Limited use of resources	8	14
	Extensive use of resources	7	1
Amount of parental effort or investment	High effort/investment	10	3
	Low effort/investment	5	12
Attribution of change or stability in behaviors since starting treatment	Parent only	1	1
	Other factors	2	1
	Combination of parent and child	1	2
	Combination of parent and medication	4	3
	Combination of multiple factors	6	5
	Don't know how to attribute	1	3

Table 3. *Results*

Theme	Category	Fisher's exact	χ^2
Description of problem	Use of diagnostic terms Use of behavioral description	$p = 0.552$	
Awareness of impact of parental behavior on child's behavior	Expressed awareness Did not express awareness	$p = 0.009$	
Perception of need for consistency	Describes need for consistency Does not describe need for consistency	$p = 0.132$	
Perception of self as consistent	Perceives self to be consistent Perceives self to be working on consistency Perceives self to be inconsistent		$\chi^2 (2, N = 30) = 3.00,$ $p = .223$
Perception of use of resources	Limited use of resources Extensive use of resources	$p = 0.015$	
Amount of parental effort or investment	High effort/investment Low effort/investment	$p = 0.013$	
Attribution of change or stability in behaviors since starting treatment	Child only Parent only Other factors (e.g. medication, therapy, situation) Combination of parent and child Combination of parent and medication Combination of multiple factors Don't know how to attribute		$\chi^2 (2, N = 30) = 10.00,$ $p = .350$

Appendix A

Script for Interview

Good afternoon (morning), I am Becky Denning from Marshall University. I'd like to talk with you about a research project I'm conducting regarding behavior problems in children. May I take a few minutes of your time to explain the project?

(Parent response)

We are interested in understanding how parents think about the problem behaviors and how they view treatment as being helpful or not helpful. If you agree to participate, I will ask you to fill out a couple of questionnaires regarding your child's behavior and your thoughts about the behaviors. I would also like to do a short interview to give you a chance to talk about some of the issues further. I would like to tape the interview so I can refer back to it later. After I have transcribed the interview, it will be erased from the tape and neither your name nor your child's name will be attached to it in any way. The whole process should take about an hour or so. I want to make it clear that you do not have to participate and that your decision to participate or not will have no impact on your treatment at all. This study is conducted through Marshall and is not directly sponsored by Pretera. Would you be interested in participating or do you have any specific questions?

(Parent response. Request permission to begin taping)

I'm going to ask you a few questions and it will be helpful if you provide as much detail as you can in your answers. If there are questions you wish not to answer, please feel free to decline. You are also free to discontinue the interview at any time. What you say will remain confidential, unless there is information given regarding someone being in danger. In such a case, I would have to take action. With the exception of that rare circumstance, everything is completely confidential. After the interview is completed, I will transcribe what you have said and your name will not appear anywhere connected to the transcription of your interview. Neither you or your child will be identified in any way, although a record of research participants will be kept for a period of time. Do you have any questions before we continue? (Parent response). Is it alright if I begin the interview? (Parent response).

Thank you. Alright, let's begin...

1. a. To get started, I was hoping you could tell me what behaviors prompted you to be interested in coming here?
 - b. How do you usually respond to these behaviors? What do you do when that happens?
 - c. Do you always do that? How consistent are you?
 - d. Does that seem to work? Why do you think it works/doesn't work?
 - e. How many times/how long do you try that before giving up?

2. a. There are a lot of resources out there regarding behavior problems. Have you investigated other resources before coming here?

If yes: Which ones?
_____ Internet:
What websites?
Can you estimate how many?
How long have you spent looking through these?

- ___ books:
What books?
- ___ other media:
What media?
- ___ school staff:
Who?
- ___ family/friends:
Who?
- ___ medical /mental health professionals:
Who?
What type of treatment?
- ___ other:
If no: go through above for denial

- c. What made you select these resources or interventions?
 - d. Have you thought about using other resources?
If yes: What types?
 - e. Are there some that you've thought about using, but haven't gotten around to?
3. Since starting treatment here at Pretera, do you do anything differently?
If yes: What did you try?
Where did you get that idea?
How much time/effort does it take?
How is that working?
4. Have you noticed changes in your child's behavior?
If yes: What are they?
Why do you think those changes have occurred?
How much do you think it has to do with what you're doing?
How much do you think it has to do with your child?
How much do you think it has to do with other factors?

I really appreciate your time and participation in this study. Before we finish, I wanted to ask whether there are any other resources or information that we could provide that might be helpful to you.

Appendix B

Themes Derived From Interview Questions

Theme	Categories	Interview Questions
Description of problem through diagnostic labels vs. behavioral descriptions	Use of diagnostic term Use of behavioral description	What behaviors prompted you to be interested in coming to Pretera?
Awareness of parental behavior on child's behavior.	Expressed awareness Did not express awareness	How do you usually respond to the behaviors? What do you do when that happens? Do you always do that? How consistent are you? Why do you think that does/doesn't work? How long do you try that before giving up?
Perception of need for consistency.	Describe need for consistency Do not describe need for consistency	Do you always do that? How consistent are you? Why do you think that does/doesn't work? How long do you try that before giving up?
Perception of self as consistent.	Perceives self to be consistent Perceives self to be working on consistency Perceives self as inconsistent	Do you always do that? How consistent are you? Why do you think that does/doesn't work? How long do you try that before giving up?
Perception of use of resources.	Limited use of resources Extensive use of resources	Have you investigated other resources before coming here? Internet? What websites? How many? Can you estimate how long you spent looking through them? Books? Other media? School staff? Family or friends? Medical/mental health professionals? What type of treatment? Have you thought about using other resources? Are there other resources you've thought about using, but haven't gotten around to yet?
Amount of parental effort or investment in addressing behavioral problems.	High effort/investment Low effort/investment	Based on a reading of the entire interview transcript.
Attribution of change or stability in behavior since starting treatment.	Child Parent Other factors Combination of parent/child Combination of parent/medication Combination of multiple factors Don't know how to attribute	Have you noticed changes in your child's behavior? What kind of changes? Why do you think that is? How much do you think it has to do with what you're doing? How much do you think it has to do with our child? How much do you think it has to do with other factors?

Appendix C

Hypotheses and Related Themes

Hypothesis	Related Themes
1. Parents who score high on sense of competence and self-efficacy will describe greater effort and persistence in their efforts to address their child's behavior problems. Parents who score low on these measures may believe their actions have little impact on their child's behavior and will describe less persistence in their efforts to address the behaviors.	1. Description of problem behavior through diagnostic labels vs. behavioral descriptions. 2. Awareness of impact of parental behavior on child's behavior. 3. Perception of need for consistency. 4. Perception of self as consistent.
2. Parents who score high on sense of competence and self-efficacy will describe spending more time and effort obtaining resources than those who score low on these measures.	5. Perception of use of resources.
3. Parents with high parental sense of competence and self-efficacy may describe more active involvement in the interventions and treatment and those who score low on these measures may describe being less actively involved.	6. Amount of parental effort or investment in addressing behavioral problems.
4. Parents with high parental sense of competence and self-efficacy may talk about the change or stability or the behaviors in terms of their own efforts and those with low efficacy may talk about the change or stability as resulting from something external to themselves.	7. Attribution of change or stability in behavior since starting treatment.

Appendix D

Categorization Instructions

Instructions for independent coders: Listed below are seven themes that have been identified. Below each theme are categories that have been identified within that theme. Please read the themes and the category descriptions carefully.

You have a complete set of transcripts. Sections of each transcript are highlighted and labeled with a number corresponding to one of the themes listed below. For example, the first section of each transcript is highlighted in blue and labeled with a 1. You would read the responses highlighted in blue and determine which category they fit in for the first theme.

Please read and categorize the highlighted section for each theme. Each transcript may only be placed in one category for each theme. After categorizing the highlighted section of the transcript, please list the participant number on the top of the transcript on the appropriate line below the category definitions.

1. Describing problem through diagnostic labels vs. behavioral description

Use of diagnostic term: Parents talk about the problem by referring to specific disorders. Although they may also describe behaviors, the focus of their explanation is on the diagnostic terms. These terms are often listed before any behavioral description and seem to be assumed to explain the problem to the interviewer.

Use of behavioral description: Parents describe the problem by talking about specific behaviors that are difficult to handle. Although a diagnostic term may be used in the description, the focus of their explanation is on the behaviors that prompted treatment.

2. Awareness of impact of parental behavior on child's behavior

Expressed awareness: Parents describe their effort and the impact it has on their child's behavior. They may describe adjusting their responses based on their child's reaction to their effort. For example, they may mention trying different strategies until they find what works for the behavior. They identify a connection between their response to behavior and their child's behaviors.

Did not express awareness: Parents describe their effort, but do not talk about the effect their efforts have on their child's behavior. Their description of the effort may focus on themselves, rather than on the impact on the child. Alternatively, their description may focus on their child's behaviors. However, they do not really identify a connection between their response to behavior and their child's behaviors.

3. Perception of need for consistency

Describes need for consistency: Parents mention that they recognize consistency as important or their belief that a lack of consistency might make the problem behaviors worse. They may describe their own behavior as inconsistent. For example, they may acknowledge that they give in too easily. However, it is clear from their description that they recognize the importance of consistency.

Do not describe need for consistency: Parents do not talk about the importance of consistency. In their description of their response to their child's behaviors, it is clear that they do not recognize the need for consistency. Although they may suggest that their efforts are consistent, they do not express that they perceive a need for consistency.

4. Perception of self as consistent

Perceive self to be consistent: Parents describe themselves as being consistent in their response to their child's behaviors, even if the response they describe is not necessarily consistent. They do not qualify their response by talking about working or it or trying hard to be consistent. They do not talk about the way different situations or behaviors may impact their consistency.

Perception of self as working on consistency: Parents may acknowledge that being consistent is hard or that they sometimes struggle to be consistent. They may qualify their response by talking about working on it or trying to be consistent. They may talk about the way different situation or behaviors impact their consistency. Parents may mention working on it on their own or at the suggestion of the therapist or psychiatrist.

Perceives self to be inconsistent: Parents describe themselves as being inconsistent in their response to their child's behaviors. They may acknowledge that their response varies or that they do not follow through and it not something that they are currently addressing.

5. Perception of use of resources: (Given the population used, all parents will describe receiving some sort of mental health treatment.)

Limited use of resources: Parent describes limited effort in utilizing resources to address their child's behavior problems. They may have looked at a few websites, for example, but will not describe extensive effort in reading through materials. They may describe being unaware of what resources exist or how to appropriately access them. They may have looked at resources briefly, but will not be specific about information gathered or about the specific resources used. Parents may be bringing their child for mental health services, but seem limited in their involvement with that. For example, they do not seem to contribute much to treatment or to use the professional as a resource for information or suggestions.

Extensive use of resources: Parents describe utilizing different types of resources. They have invested significant time into the resources. They may describe use of resources as an ongoing process. They may provide several specific examples of information gathered or specific resources used. They may take an active role in seeking out information or working with the people involved in their child's mental health services. They may, for example, describe frequently discussing the progress of therapy or the effectiveness of medication with their service providers.

6. Amount of parental effort or investment

High effort/investment in working to address behavior problems: The parent has taken an active role in working to address the behavior problems. They may describe giving careful thought to the selection of treatment modality or the resources used. They may describe use of a variety of resources or extensive use of select resources. (For example, they may have spoken extensively with the doctor or therapist about treatment options or they may have done extensive research on the diagnosis and ways to handle the associated behavior.) They may describe giving careful thought toward identifying the problem, why it is occurring, and how it can be best addressed.

They may describe being involved with treatment, whether though actively discussing the treatment and monitoring progress with the professional or working with the professional to gain ideas about how to better address the behaviors. The parents seem to feel a responsibility for actively working to address the behavior and bring about change. For example, they may describe making changes in their response to problematic behaviors as a result of suggestions they received during treatment or information they obtained from the resources. Even if the parents believe that other factors (e.g. medication, situation) play a role in the behavior and the changes or stability in the behavior, their interviews suggest that they also see themselves as playing an important role in bringing about a change in the behavior or monitoring their child's response to changes in the other factors (e.g. medication, situation). They may describe working to change the situation in order to help the child's behavior.

Low effort/investment in working to address behavior problems: The parent has not taken a very active role in working to address behavior problems. They may have utilized one or two resources, but seem to have put minimal effort into it, as suggested by vague answers about how they search for information or what resources they considered. They do not describe doing specific research on diagnosis or treatment options. They may be excessively dismissive of the resources listed during the interview.

The parent does not seem to see the need for actively putting forth effort or being invested in the treatment. They do not seem to take responsibility for addressing behaviors or contributing to treatment. The parent may describe passively relying upon the recommendations of the doctor or therapist for treatment options. They may express beliefs that the factors responsible for the behavior and the changes or stability in the behavior are beyond their personal control (e.g. medication's effects, child's temperament or effort, specific situation). They seem to feel that these other factors are more accountable for the change or stability in behaviors that they are.

7. Attribution of change or stability in behaviors since starting treatment: child-centered, parent-centered, other factors, interaction

Child: Parents attribute the change or stability in behaviors to their child's efforts. They identify their child as being the biggest factor in the change or stability of the behavior problems.

Parent: Parents attribute the change or stability in behaviors to their own efforts. They identify themselves as being the biggest factor in the change or stability.

Other factors (e.g. medication, therapy, or situation): Parents attribute the change or stability in behaviors to something other than their child or their own efforts (e.g. medication, situation). They identify this other factor as being the biggest factor in the change or stability.

Combination:

Combination of parent and child: The parent attributes the change or stability to an interaction between their efforts and those of their child. They identify themselves and their child as being the biggest factors in the change or stability.

Combination of parent and medication: The parent attributes the change or stability to an interaction between their efforts and the medication. They identify themselves and the medication as being the biggest factor in the change or stability.

Combination of multiple factors: The parent attributes the change or stability to an interaction between multiple factors.

Don't know how to attribute behavior change or stability: The parent insists they do not know to what they should attribute behavior change or stability.
