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African American adolescent males are being diagnosed with externalizing behavior disorders more than any other group. However, there is a dearth of studies that addresses psychosocial treatment for African American adolescent males with these behavioral issues. This study assessed the perceived applicability of the Defiant Teen's Manual designed by Barkley, Robin, and Foster (1989), as a treatment for African American male adolescents and their families. Fifty-four African American and European American families with male adolescents ages 11 to 14 were included in the study. Subjects were asked to respond to a questionnaire that assessed their perception of the appropriateness of the treatment for their adolescent and family. Additional factors such as socioeconomic status (SES) and family makeup were also assessed to identify their impact on families. Multivariate and univariate analyses of variance, regression analysis, and mean comparisons were used to analyze data. Overall findings indicated that groups did not differ based on race, and/or family makeup regarding the perceived appropriateness of the Defiant Teen's manual to their families. However, African-American families rated three behavioral management steps as less appropriate for their families, and single parents rated one behavior management step as less appropriate for their families.

ASSESSING THE PERCEIVED APPLICABILITY OF BARKLEY'S DEFIANT TEENS MANUAL TO AFRICAN AMERICAN AND EUROPEAN AMERICAN FAMILIES

by

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Committee Chair

To Andrea, Kianna, Kameron, Kaleb, Kohen, Rovena, Al, Kainon, Sean, JB, Will, Damion, Rosemery and Sherry; I dedicate this dissertation to you as testament of your persistence, tremendous support and encouragement throughout this process.

APPROVAL PAGE

This dissertation has been approved by the following committee of the Faculty of the Graduate School at The University of North Carolina at Greensboro.

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CHAPTER I

INTRODUCTION

Disruptive behavior disorders of childhood represent the largest group of clinic referrals. Disruptive behavior disorders include: (a) hyperactivity-impulsivity-attention problems (AD/HD) (b) conduct problems (CD); and (c) oppositional defiant disorder (ODD).(Abikoff & Klein, 1992; Hatton & Kendall, 2002; Hinshaw, 1987), Prevalence estimates among school aged children range from 3% to 5% (Barkley, 1990; Austin, et.al., 2007), 4% to 12% (Earls & Foy, 2005) for AD/HD, and 4% to 10% for CD (Kazdin, 1987; Hamilton & Armando, 2008). Estimates for the rate of ODD in the general population are equally high (Abikoff & Klein, 1992; Hamilton & Armando, 2008). In addition, comorbidity is common amongst these three disorders. Specifically, comorbidity is higher amongst the hyperactive impulsive and the combined types of AD/HD, with ODD and CD.

Attention Deficit Hyperactivity Disorder (AD/HD)

Attention deficit hyperactivity disorder (AD/HD) is a chronic mental health disorder characterized by abnormally high levels of inattention, impulsivity, and overactivity (American Psychiatric Association, 1994). It is one of the most common disorders of childhood, occurring with a prevalence rate at 3% to 5% of the population, more often in boys than in girls (Pelham, Wheeler, & Chronis, 1998; Whitbeck et al,

2008). The typical age of onset is 3 years of age, with some predisposing factors such as an infant's temperament. The core characteristics of AD/HD (i.e. inattention, impulsivity, and hyperactivity) have adverse affects on a child's academic performance, school productivity, peer and family relationships, and overall psychosocial adjustment (Barkley, 1990; DuPaul & Stoner, 1994; Teeter, 1998).

Oppositional Defiant Disorder (ODD)

Oppositional Defiant Disorder (ODD) is characterized by a pattern of negativistic, hostile, and defiant behavior (APA, 1994). Rates of ODD range from 2% to 16% depending on the population that is being assessed (Austin & Burghdof, 2008). It is usually evident before 8 years of age with gradual onset, with symptoms first appearing at home, but over time may appear in other settings. In a significant proportion of cases, ODD is a developmental antecedent to Conduct Disorder (APA, 1994).

Conduct Disorder (CD)

The essential feature of Conduct Disorder (CD) is a persistent pattern of conduct in which the basic rights of others and major age-appropriate societal norms or rules are violated (APA, 1994). Aggressive behavior such as fighting, bullying, threatening, destruction of properties, cruelty to others and or animals are characteristics of persons diagnosed as CD. There are two subtypes: the childhood subtype, which is defined by at least one criterion characteristic before age 10, and the adolescent subtype which is the same but not prior to age 10. Prevalence rates for males under age 18 range from 6% to 16% (Austin & Burghdof, 2008). The onset may occur as early as age five, and is rare after 16 years of age.

Comorbidity

Between 35 to 60% of clinic-referred children with AD/HD (especially the hyperactive/impulsive and combined subtypes) will meet criteria for a diagnosis of Oppositional Defiant Disorder (ODD) by 7 years of age or later and 30% to 50% will eventually meet the criteria for Conduct Disorder (CD) (Barkley, 1990; Biederman et al., 1992; Mash & Barkley, 1996; Pliszka, 2000). In general, AD/HD has shown a strong correlation with ODD, CD, and Antisocial Personality Disorder (ASP) in adulthood. Anxiety disorders and mood disorders, specifically depression, have also shown some overlap with AD/HD (Edelman, 2006; Kurzich et al., 2002). In fact, in the Multimodal Treatment Study of Children with AD/HD (MTA), only 31.8% of the participants had a diagnosis of AD/HD alone; 29.5% were diagnosed with AD/HD and either ODD or CD, 14% were diagnosed with both AD/HD and an anxiety disorder, and 24.7% were diagnosed with AD/HD, ODD, or CD, and an anxiety disorder (Jensen et al., 2001).

Empirically Validated Treatments and Disruptive Behavior Disorders

There has been a keen interest in identifying concretely those techniques that have effectively treated specific clinical problems. The terms empirically-validated, empirically supported, and evidence based have been used to delineate these interventions, which have included the treatment of children and adolescents (Roth & Fonagy, 1996). The task force on Promotion and Dissemination of Psychological Procedures, published Training In and Dissemination of Empirically Validated Psychological Treatments: Report and Recommendations (Division 12 Task Force, 1995; Nathan & Gorman, 1998), which identified criteria for EVT's and/or ESTs, both well-

established and probably efficacious. This was the first of three reports which identified a number of psychological interventions as empirically validated treatments (later called empirically supported treatments (ESTs)) for adults, children, and adolescents (Chambless & Ollendick, 2001). Eyberg et al., (2008) conducted a literature review of evidenced based treatments from 1996 to 2007 using the criteria established by the task force on promotion and dissemination of psychosocial procedures. There review was conducted in four stages, and included discussion of medication as well as psychosocial treatments.

Medication

Although not a psychological intervention, the most widely used treatment of behavior problems for children and adolescents continues to be psychoactive medication (Caron, 2008). For example, recent findings of the National Institute of Mental Health Multicenter Multimodal Treatment Study for children with AD/HD (MTA), which compared intensive behavioral treatment, psychostimulant treatment, and combined therapy over a 14-month time period for large numbers of children with AD/HD, corroborate superiority of psychostimulants over behavioral intervention (MTA Group, 1999; Rapport et al., 2001). Jensen et al. (2003) found that 85% of children diagnosed with AD/HD are medicated with stimulants. However, there are some limitations associated with stimulant treatment. Medication appears to have little impact on molar aspects of cognitive ability such as reasoning, problem-solving, and learning (Campbell, 1976). While medication diminishes disruptive classroom behavior, it does not enhance interpersonal skills (Abikhoff, 1985; Pelham & Bender, 1982), or facilitate appropriate

responses to provocative social demands (Abikhoff, 1985). In addition, medication provides limited effects on problems such as academic achievement and peer relationships. Additional limitations of stimulant medication include: the fact that 30% of children do not show clear beneficial responses to stimulants, the inability to continuously medicate children due to side effects such as insomnia and appetite suppression, the potential adverse long-term side effects of taking stimulants, the failure of many adolescents to adhere to medication regimens, and the paucity of evidence supporting long-term beneficial effects of pharmacological therapy on domains of impairment (Chronis et al., 2006; Pelham & Lang, 1993; Smith, Waschbauch, Willoghby, & Evans, 2000; Swanson et al., 1995; Weiss & Hechtman, 1993). The primary focus of this dissertation is to examine the applicability of a specific psychosocial treatment for a disruptive behavior disordered population; therefore an in-depth review of the effectiveness of medication for externalizing disorders is beyond the scope of this project.

Psychosocial Treatments

The most dominant psychosocial treatment that has been classified as a well-established treatment for children with AD/HD/ODD is Behavioral Management Training (BMT) (Chambless & Ollendick, 2001; Eyberg et. al., 2008). Social skills training has shown efficacy, but only when combined with intensive, multicomponent, behavioral treatment packages. Other efficacy research has been done on problem solving communication training (PSCT) with families. Although PSCT and Social Skills training are not classified as ESTs for AD/HD/ODD, there is empirical evidence of their effectiveness with children and adolescents with behavioral problems. Furthermore,

Chambless and Ollendick (2001) list problem-solving skills training as an EST for Conduct Disorder.

Problem Solving Communication Training

The PSCT focuses on training parents and adolescents in more appropriate ways of negotiating conflicts (Robin & Foster, 1975; Robin, 1998). In addition, it provides activities to increase family engagement, address medication issues, restore parental control, improve school performance, teach problem solving and communication, and restructure unrealistic or faulty beliefs (Robin & Foster, 1989; Teeter, 1998).

Research findings have produced mixed results for the PSCT. Robin (1975) compared 22 families that participated in PSCT with 22 mother-adolescent dyads who received no treatment, and did not find any positive effects. Participants reported that there were no dramatic changes in disputes or negative communication patterns at home. However, Foster (1978) did show that PSCT therapy was effective, and in this study fathers were included in the training. Stern (1984) also investigated the effects of PSCT on parent-teen dyads, and found that the PSCT was effective in creating positive behavioral changes for teens and reduced negativity in parents. Barkley et al. (1998) conducted a study on problem solving communication training which suggested that the approach was effective at managing conflict amongst adolescents and their parents, but additional psychosocial treatment would need to be considered and included to improve effectiveness.

Barkley et al. (2001) conducted a study in which 97 families with adolescents with AD/HD and ODD received family therapy. The families were assigned to either

eighteen sessions of PSCT alone or behavior management training (BMT) for 9 sessions followed by 9 sessions of PSCT. Both treatments demonstrated significant improvement in ratings of parent-teen conflicts at the midpoint and posttreatment, but did not differ on effectiveness. There was a distinct pattern that significantly more families dropped out of the PSCT alone than out of the BMT/PSCT group. Such a finding supports the clinical admonitions of the treatment developers of the PSCT (Barkley et al., 2001; Robin, 1998) that BMT may need to be initiated first, involving only parental attendance at these initial sessions before engaging in problem solving training with both parents and teens (Barkley et al., 2001).

Behavioral Parent and/or Management Training (BMT)

Barkley (1981) presented the original version of a parent-training program in his text, Hyperactive Children: A Handbook for Diagnosis and Treatment. He has since modified this program, and has released manuals for both defiant children and defiant teens. The defiant teens manual is geared toward parent and family training for teens and adolescents who have ODD, and also deals with the oppositional defiant or noncompliant behavior of AD/HD. Parents of AD/HD adolescents are often concerned about their teens' greater degree of behavior management problems, rebelliousness, conduct problems, and family interaction conflicts compared with normal adolescents (Ackerman, Dykman, & Peters, 1977; Barkley, Anastopoulos, Guevremont, & Fletcher, 1991; Barkley, Guevremont, Anastopoulos, & Fletcher, 1992; Robin, 1990; Weiss & Hectman, 1986). With these teenagers, parents report more issues of conflict and more negative communication patterns, versus a regular control group. The majority of these interaction

problems occur in that subgroup of AD/HD adolescents having coexisting oppositional defiant disorder (ODD) than with those teens with AD/HD alone (Barkley, Anastopoulos, Guevremont, & Fletcher, 1991). In part to account for this, Barkley et al (1999) combined his parent training techniques with Robin and Foster (1989) problem-solving communication training (PSCT) into a single family training manual.

Barkley et al. (1999), *Defiant Teens: A Clinician's Manual for Assessment and Family Intervention.* was designed for teens whose language level, general cognitive developmental level, or mental age is that of 10-year-old or higher and whose chronological age falls between 13 and 18 years of age (Barkley, Edwards, & Robin 1999). It consists of 18 sessions, with 1-9 focusing on the tenets of BMT, and sessions 10-18 focusing on PSCT. The introduction consists of three chapters that provide an overview of prerequisites for using the program, such as therapist, child, and family factors that might improve the likelihood of success when using the manual.

Barkley et al. (1999) present six goals for the program, as follows: 1. To improve parental management skills and competence in dealing with teen behavior problems, particularly noncompliant or defiant behavior. 2. To increase parental knowledge of the causes of defiant behavior in adolescents and the principles and concepts underlying the social learning of such behavior. 3. To improve teen cooperation with parental requests, directives, and rules. 4. To increase family harmony through the improvement of parental use of positive attention and other consequences with their teens, the provision of clear guidance, rules, and instruction to those teens, the application of swift, fair, and just discipline for inappropriate teen behavior, and the reliance on the principle-guided

parenting behavior more generally. 5. To increase both parental and teen use of problem-solving skills and positive communications styles during problem-focused discussions and interactions that involve the teen. 6. To alter the teen's or the parents' unreasonable beliefs, should they be observed to be guiding either the parent or teen behavior during parent-teen problem-focused interactions.

The discussion of AD/HD and ODD consists of a brief overview of both disorders, and includes a review of the general principles of the parent training program, and highlight the major aspects of the program. The goals of Step 2 (principles of behavior management) are to educate parents concerning the causes of teenagers' defiant behavior, encourage parents to identify the causes or contributors to defiant behavior that exist in their family, and urge parents to begin to remedy the causes of defiance that can be rectified within their family.

The goals of Step 3 (developing positive attention) are to educate parents about how the style of their interactions with their teen greatly affects teen's motivation to work for them, train parents in methods of attending to positive teen behavior while ignoring minor misbehavior, and begin establishing a more positive interaction pattern between parent and teen through these positive attending skills. The goals of Step 4 (developing parental attending skills) are to train parents to use effective attending skills that will increase immediate teen compliance with commands, increase parents' use of effective attending skills in the absence of the teens' common misbehaviors, and to increase the effectiveness of parental commands in eliciting teen compliance. This is achieved

through teaching parents how to increase praise and/or effectively praise their teens for their compliant behavior, and to give effective commands.

The goals of Step 5 (establishing a behavioral contract) are to establish a formal system that makes teen privileges contingent upon teen compliance, either by behavioral contract or point system, increase parental attention to and reinforcement of teen compliance and appropriate social conduct, and to decrease arbitrariness in parental administration of child privileges. The goal of Step 6 (using response cost) is to introduce the use of fines or penalties into home-based contingency management as punishment for non-compliance and unacceptable social conduct.

The goal of Step 7 (completing the contract/point system) is to encourage parents to use a contingency-management approach for any behavior problems their teen displays. The goal of Step 8 (grounding) is to train parents in the use of an effective grounding method as punishment for selected teen misbehavior. Finally the goals of Step 9 (school advocacy) are to review with parents the nature of any behavior or academic problems the teen may be demonstrating at school, and to review the accommodations that schools can make for students with developmental disabilities or special needs.

To briefly review, Steps 10-18 use the PSCT and include an introduction to the PSCT, two sessions of practicing problem-solving, practicing communication skills, dealing with unreasonable beliefs and expectations, and catching unreasonable beliefs. These tenets of PSCT are used in the context of an AD/HD/ODD family, and do not vary from what has been reviewed in detail about the PSCT. Barkley et al. do suggest that changes in the sequencing of these steps may be useful, and benefit some families.

Source*: Defiant Teens: A Clinician's Manual for Assessment and Family Intervention.* (Barkley, Edwards, & Robin, 1999).

For children up to twelve years of age, the procedures in the manual have research supporting their efficacy (Anastopoulos, Shelton, Dupaul, & Guevremont, 1993). Typically, up to 64% or more of the families of defiant children undergoing training in such methods report significant improvement in their children's behavior and their own parenting abilities (Barkley, Edwards, & Robin, 1999). Nonetheless, research also suggests that when used alone with other adolescents who have ODD (or AD/HD), the behavioral parent training programs benefits only about 25% of the families, while 35% or so benefit from the separate PSCT component (Barkley, Guevremont, Anastopoulos, & Fletcher, 1992). Barkley et al's. 2001 study also provides empirical support for the effectiveness of BMT as well as the PSCT. What seems disheartening is the decline in effectiveness when applied to an adolescent population. Specifically older clinic-referred adolescents may benefit less than young adolescents from parent training, although some benefits may still accrue to them and their families (Barkley et al., 1992). Older teens referred to clinics for treatment probably have had more years of effectively utilizing coercive behavior, especially that involving typically physical as well as verbal resistance; may have more severe defiant and conduct problems; may have frank psychiatric disturbance; and may come from more disrupted or impaired families (Barkley et al., 1999; Dishion & Patterson, 1992; Patterson, et al., 1992). In addition, adolescents spend less time with their parents or teachers and more time with peers in unsupervised activities (Chronis et al., 2006).

Smith et al. (2000) consider six important developmental changes that adolescents experience that may also have implications for treatment: a greater cognitive capacity that includes the ability to think more abstractly and solve problems more systematic manner, increased self awareness of behavior, a focus on identity formation and increased independence, greater reliance on peers for information and support, a different daily routine at school involving increased educational demands, and physiological changes such as growth and the development of secondary sex characteristics.

Incorporated into these developmental changes are the social experiences and additional considerations that adolescents may encounter, which can also impact treatment (Smith et. al, 2000). Specifically, for African American male adolescents the considerations include understanding the African American adolescent male and his development, importance of parenting and family influence, ethnic identity, environmental and socioeconomic factors, stress, role of race in therapy, and the importance of proper assessment.

African American Adolescent Males

Adolescence is a critical time for African American males. In addition to dealing with cognitive, physical, emotional, and social issues characteristics of adolescence in general, African American males must work through racism and unique educational challenges (Bradley 2001; Hrabawski, Maton, & Grief, 1998; Lee, 1987; Majors & Billson, 1992). Over the last ten years, young African American males have been over represented in every negative social condition of American society (Moore et al., 2003;

Toldson & Toldson, 1999). These include incarceration (Mauer & Huling, 1995; U.S. Department of Justice, 1997), crime victimization (Peterson et al., 1993; U.S. Department of Justice Federal Bureau of Investigation 1996; U.S. Bureau of Statistics, 1997; Toldson & Toldson, 1999), poverty (Jencks & Mayer, 1990), and unemployment (Bound & Freeman, 1992; Toldson & Toldson, 1999).

According to the U.S. Department of Justice (1997), African American males commit about 80 percent of violent crimes against African Americans between the ages of 12 to 19, and 49 percent of all murder victims are black. In addition, many African American adolescent males are struggling with their identity (Howard-Hamilton & Behar-Horenstein, 1995). Social forces such as racial oppression, discrimination, and overrepresentation of unemployment and poverty become increasingly commonplace for African American males (Lee & Bailey, 1997; Landsford et al., 2004). Madhubuti (1990) proclaimed that young African American males were becoming an endangered species because of the number of forces that work together to deter them from healthy development. Based on a US consensus conducted in 1998 they are 46.7% likely to live in female-headed households.

Research indicates that African American children are being diagnosed with Attention Deficit Hyperactivity Disorder (AD/HD) and Oppositional Defiant Disorder (ODD) at higher rates than children of other ethnic groups (Barbarin & Soler, 1998; DuPaul et al., 1994; DuPaul et al., 1998; Epstein, March, Conners, & Jackson, 1998; Hatton & Kendall, 2002). The majority of research and clinical literature on the processes and outcomes of psychotherapy as an intervention in treating mental health difficulties

have involved primarily Euro-American populations with little emphasis on ethnic, cultural, or class distinctions (Kendall, 1996; Hatton & Kendall, 2002). For example, although African American children are diagnosed with AD/HD at higher rates, there is relatively little research that focuses on this population, including assessment and treatment of AD/HD. In a review article by Samuel et al. (1998), they identified only 17 articles about AD/HD in African Americans.

Treating African American Adolescent Males with Disruptive Behavior Disorders

As part of the treatment of African American male adolescents, there is also the need to treat the family unit. However, treating the African American family comes with its own subset of challenges (Kruzich et al., 2002). In comparison to whites and individuals with higher socio-economic status (SES), ethnic minority and low SES individuals report experiencing more instrumental barriers to using services, such as lack of insurance, time, and transportation (Smedley, Stith, & Nelson, 2003). African-American families are less likely to seek or obtain mental health services (e.g. Armbuster & Schwab-Stone, 1994; Bauermeister et al., 2003; Bussing, Zima, Gary, & Garvan, 2003; Chronis, Diaz, Jones, & Raggi, 2003; Diaz, Jones, & Chronis, 2003). Specifically for African American families with an adolescent with AD/HD, research has shown that they prefer to manage AD/HD within the family instead of seeking professional care (dosReis, 2006; Chronis et al., 2006). In a large survey assessing knowledge and opinions regarding AD/HD, 31% of African American parents incorrectly believed that children with AD/HD will outgrow the disorder (Harris Interactive, 2002).

A key component to the reluctance that African American families have regarding seeking mental health treatment is related to racism and perceived discrimination that African Americans report (Kendall & Hatton, 2002). Race continues to determine health status and social allocation of resources and opportunities (Freeman & Payne, 2000). Despite gains in income, especially among African Americans, race continues to be a greater barrier to improved health than class, primarily because of residential segregation and acts of racial discrimination (Bayne-Smith, 1996).

When further examining AD/HD and disruptive behavior disorders as it pertains to treatment and race, the idea that the majority of research related to etiology and treatment has focused primarily on Caucasian children, with African Americans being diagnosed with the disorder more than any other ethnic group speaks in part to racial disparities that exist related to health care. The facts that AD/HD as a diagnosis has been characterized as a primarily white middle class disease, and research has been based almost exclusively on this population, are strong indicators of underlying racist assumptions (Kendall & Hatton, 2002). Whereas behavioral and learning difficulties in white children often are viewed within a medical and research model, these same difficulties in nonwhite children, especially African American children, tend to be viewed as inherent to poverty, violence, and lower educational opportunities for that group (Richman, Wood, & Williams, 2007). In other words, the learning and behavioral problems associated with AD/HD that are often viewed as medical concerns in white children are more likely to be stereotypically viewed as being the result of poor

parenting, lower intellect, use of substances, violence, or poverty in African American children.

Role of Parental and Family Influence

Parenting Styles: Iannelli (2004) defined authoritarian parents as those that always try to maintain and exert their control over their children, are strict and parent without expression of much warmth and affection. Authoritative parents are democratic in their style, help children learn to be responsible for themselves, and to think about the consequences of their behavior, and do so in a warm and affectionate manner.

Steinberg, Dornbusch, and Brown (1992) found that African American youth performed better when parenting style was authoritarian versus authoritative. Many researchers have described the discipline strategies within African American culture as a more direct, physical form of discipline, which differs from the psychologically oriented approach of mainstream families (Baumrind, 1972; Landsford et al., 2004; Lau et al., 2006). This form of parenting, specifically physical discipline, is often perceived as linked to negative outcomes such as externalizing behavioral problems; however, this association is not necessarily the case for African American families (e.g. Deater-Deckard et al., 1996; Gershoff, 2002; Korbin et al., 2000; Mason, Cauce, & Gonzalez, 1997; McLoed et al., 1994; Peters, 1997). Some writers have speculated that parental authoritarianism may be more beneficial than authoritativeness (responsive and demanding) for African American children (Baumrind, 1972; Steinberg et al., 1998). Specifically, research done by Florsheim, Tolan, & Gorman–Smith (1998) showed that

single mothers who were more firm and less willing to appease their sons, had sons who ranked lower on externalizing behavior scales when assessed.

Another consideration is the importance of parental monitoring, and how persistence usually leads to positive outcomes for African Americans. Parental monitoring is often an attempt by parents to minimize the dangers their adolescents face in some neighborhoods and community settings (Baer, 1999). One previous study of parenting practices in African American families showed that adolescents with behavior problems did best when there was consistent parental monitoring (Baer, 1999; Clark, 1983). This is relevant and a point of possible emphasis when conducting therapy with an African American adolescent population.

Family Make-Up

Single parent families, although not unique to African Americans, are prevalent in the African American community, and usually females serve as the primary caretaker. Poverty rates are also consistently high for African American families. Research indicates a significant association between single parenthood, economic hardship, and maternal psychological distress (Conger et al., 1984; Conger et al., 1992; Edler et al., 1985; Florsheim et al., 1998; McLoyd, 1990; McLoyd et al., 1994; Taylor et al., 1997). The increased rates of mother headed households has raised concerns among clinicians and policy makers because there is substantial evidence that children growing up in single-mother families are at greater risk for developing achievement related problems (Demo & Acock, 1996). In addition, children of single mothers who are not economically disadvantaged are also at greater risk of developing behavioral and academic problems

(Amato & Keith, 1991; Florsheim et al., 1998). The absence of a secondary caregiver, or even a noncustodial father increases the risk for behavioral and emotional problems for African American adolescents (Brody & Forehand, 1990; Shaw et al., 2006; Zimmerman et al., 1995).

African American mothers may be at a greater risk of psychological distress if they live and function in low socioeconomic conditions. Several researchers have suggested that single mothers are less likely to maintain the appropriate mix of control and autonomy granting behaviors, which helps explain why adolescents are more likely to engage in disruptive, impulsive, and self destructive behavior (Dornbusch et al., 1985; Shaw et al., 1999; Turner et al., 1991). Therefore possible parenting distress should also be taken into account in a family therapy setting, and may affect compliance and outcome.

Environmental Factors and SES

Stressors of living in an urban environment include high rates of crime and unemployment, substandard housing, inadequate schools, and limited medical and mental health care (Warner & Weist, 1996). Racism and prejudice may compound these stressors. As Bell and Jenkins (1991) maintain, exposure to violence has become commonplace for inner-city African American adolescents. African Americans, particularly males, have a high exposure to interpersonal violence and are dying prematurely (Bell and Hildret et al., 1988; Warner & Weist, 1996). Homicide is a leading cause of death for this population, and in most cases the victims knew or were acquainted with their assailant. This translates into the homicide occurring in an interpersonal

context, including within families, and the likelihood that there are child and adolescent witnesses to such acts is quite high.

Exposure to violence through co-victimization causes emotional, behavioral, and cognitive changes in children and adolescents (Shakoor & Chalmers, 1991). Both internalizing and externalizing emotional and behavioral difficulties have been noted. Shakoor and Chalmers (1991) concluded that co-victimization among African American adolescents probably contribute to their own violent acts. Accepting this pattern of violence as reality, which is based partly on environmental factors such as poverty and lack of resources, it is necessary for the African American adolescent male to develop survival skills. These survival skills or attributes are (a) collective struggle: the failure that results from a system that does not afford equal opportunity to all its members; therefore, individuals abdicate responsibility for their faults; (b) clientship: rewards for task completion that are perceived to be contingent on one's ability to successfully manipulate those in power; and (c) hustling: material success and prestige achieved by exploiting and manipulating others (Howard-Hamilton & Behar-Horenstein, 1995; Ogbu, 1981).

These constraints and development of these survival skills, although necessary, may prevent the development and the use of socially acceptable ways to mediate violence. As a result, these youth are placed at a higher risk of neither developing nor maintaining healthy social interaction skills, which Reed (1994) defines as (a) the ability to organize cognitions and behaviors toward an action that is culturally and socially acceptable, and (b) the ability to assess, modify, and maximize or reach particular goals.

With regard to violence prevention and intervention for externalizing problems associated with disruptive behavior disorders, these skills involve problem-solving, conflict resolution, and anger management (Banks et al., 1998; Bulkeley & Cramer, 1990).

As previously stated, racism and prejudice may compound some of the issues that are present for African American families who are of a lower SES status. There has been a longstanding discussion about race and SES and the role each plays in the assessment, diagnosis, and treatment of AD/HD for African American children and adolescents (Chronis et al., 2006). African American families, specifically African American single parent families tend to have lower SES, coupled with children who experience behavioral, and emotional problems in the form of AD/HD, and additional disruptive behavior disorders. However, over the past 20 years, socioeconomic gains have been made by both the majority and the minority, but health disparities by race continue to exist (Kendall & Hatton, 2002).

Parental Stress

It has been long recognized that major stressful experiences pose potential risks to the adequate functioning of children and families (Jacobson, Roberts, & Taylor, 1997). These stressful experiences are not uncommon to African American families given their difficult economic circumstances. Unfortunately, empirical research examining the processes by which stressful experiences affect African American families and children is sparse (Jacobson, Roberts, & Taylor, 1997). For the most part, the work that has been done includes drawing inferences about African American families from the studies done on European American families who have dealt with stressful life experiences. These

inferences include the idea that stressful negative experiences are associated with negative parenting for African American mothers; family poverty is associated with lower maternal supervision of adolescents' behavior (Sampson & Laub, 1994); and mothers' emotional distress was negatively associated with positive parenting behavior and positively linked to aversive parenting (Conger, McCarty, Yabb, & Kropp, 1984).

McLoyd (1990) examined some of these inferences and found that for single African American mothers who reported stressful life events, such as economic hardship, used harsher forms of discipline, negatively perceived their maternal role and responsibilities, and reported higher levels of emotional and psychological distress. In a study done by Jacobson, Roberts, and Taylor (1997) similar findings were reported related to the effects that mothers' psychological well-being had on their parenting. Increased stress related to work problems and family disruption were negatively associated with mothers' self esteem, which in turn was negatively associated with mothers' acceptance of their role and responsibilities. In contrast, mothers' stress due to things such as family disruption, did not have an adverse impact on their control and regulation of child behavior. The rationale they provide for this unexpected outcome is that parents may feel the need to increase regulation of their child's behavior during times of family instability. Overall, it is apparent that stress associated with different events can have a negative impact on parent-child relationships, and parenting practices.

Not forgotten in the experience of stressful events is the adolescents' behavior, and how that affects the parents. When a child has behavior problems, daily childrearing tasks can affect parental functioning to an even greater extent (Anastopoulos,

Guevremont, Shelton, & Dupaul, 1992). Hyperactive, aggressive, or defiant children are often associated with, for example, ineffective discipline strategies, complaints from teachers, social embarrassment, sibling conflicts, and strained marital relationships (Baker & Suarez, 1997). These types of occurrences can result in greater levels of parenting stress, and have many different ramifications.

Current Effective Treatments for African American Adolescents Males with Disruptive Behavior Disorders

Toldson and Toldson (1999) have conducted research with African American adolescents, but focused on group therapy with a conduct disorder population. Although specific to one population, their group therapy techniques includes some of the necessary considerations and approaches to conducting therapy with an African American adolescent male population. The considerations include understanding the African American adolescent male and his development, importance of parenting and family influence, ethnic identity, environmental and socioeconomic factors, stress, role of race in therapy, and the importance of proper assessment.

In a article by Huey and Polo (2008) in which they reviewed research on evidenced based treatments for ethnic minority youth, they were able to identify 35 studies that were evidenced based, based on their criteria, which incorporated Chambless et al's (1998) process of identifying evidenced based treatments, as well as Nathan and Gorman's (2002, 2007) criteria for identifying the methodological robustness of a study. Of those 35 studies, no treatments were identified as well established in effectiveness (Huey & Polo, 2008).

However, some studies met criteria for probably efficacious as well as possibly efficacious. For 14 of those studies, African Americans comprised at least 50% of the sample. Of those 14, 12 specifically addressed treatments for African Americans with behavioral and emotional difficulties, with 8 studies classified as probably efficacious. Of these studies the gender breakdown was listed for some, but not listed for others. Considering the moderate effectiveness of psychosocial treatment with a general disruptive behavior disordered population, there is less evidence to support any effective treatments when working with an African American male adolescent population. Although this trend exists across the spectrum when dealing with an African American population, there appear to be clear ramifications of the effects of not having effective treatments for the African American adolescent with behavior problems, such as incarceration, involvement with various illegal activities, and the development of other comorbid psychological disorders (Edelman, 2006).

Limitations of Previous Research

The majority of research and clinical literature on the processes and the outcome of psychotherapy as an intervention in treating mental health difficulties involved primarily Euro-American populations with little emphasis on ethnic, cultural, or class distinctions (Kendall, 1996). Existing examinations of differences among racial/cultural groups in general can be viewed as falling into three categories (a) analogue studies consisting of controlled laboratory experiments simulating therapy situations; (b) epidemiological studies recording patient numbers, types of disorders, treatment methods, and treatment length; and (c) a small number of treatment outcome studies based on data

collected from actual therapy with African American male and female clients (Griffith & Jones, 1978; Thorn & Sarata, 1998).

Reviews of treatment outcome literature involving ethnic comparison have yielded several inconsistent results (Sue et al., 1994). Sue et al. (1994) in their review of the treatment outcome literature stated the following: "In no studies have African Americans been found to exceed White Americans in terms of favorable treatment outcomes; some investigations have revealed no ethnic differences; and some studies have supported the notion that outcomes are less beneficial for African Americans". However, the lack of clarity regarding therapy effectiveness with African American clients in general, and the lack of research focusing specifically on African American adolescents in particular, points to the need for further research clarification in this area. To further the idea of the lack of research specific to African Americans, in studies done by Barkley et al. (1992), and Barkley et al. (2001), African Americans comprised less than 3% of the subject population. In addition, little of the research on social skills training focuses on their relevance for non-White populations. For example, in their otherwise extensive review of social skills training programs with adolescents, Hanson et al. (1989) neither acknowledge the race or ethnicity of the participants involved, nor do they consider the generalizability of social skills training across racial/ethnic groups (Banks et al., 1998).

CHAPTER II

STATEMENT OF PURPOSE

The present study was primarily designed to assess family's perceptions of the applicability of the Defiant Teen's Manual as it is conventionally used as a treatment for African American male adolescents and their families. Applicability was assessed based on families' responses to a questionnaire designed by this researcher. As part of that questionnaire, parents were asked to identify which steps from the Defiant Teen's Manual could be more useful to their families, and those that are not as useful or do not match their family. For those interventions that are not useful to their family, they were provided with a response list of possible reasons why these steps may not be useful. Based on differences in parenting styles, levels of stress, environmental factors, and socioeconomic status, there are parts of the protocol which do not seem as applicable to an African American family and adolescent population.

It was expected that African American adolescents would report their parents as having a more authoritarian parenting style and that African American families would report that the manual as is, is not as applicable to their family and situation. Hypotheses regarding specific steps of the manual follow. Step 3 is developing positive attention, including attending to positive teen behavior while ignoring minor misbehavior. Because African American parents generally employ practices that are characteristic of an

authoritarian parenting style, it is expected that the adolescent engage in behaviors that "he is supposed to do". Therefore, praising their adolescent for common behaviors is somewhat incongruent with the more direct parenting style that is characteristic of African American families.

Step 4 relates to effective commands, and recommends parental attention for the absence of common misbehaviors and spontaneous compliance. Again, these teen behaviors would fall under the umbrella of what is expected. In addition, many African-American families simply demand obedience. Sometimes, this is imperative, given the life circumstances imposed on African-American youth by the social, environmental, and institutional forces in American society (Bradley, 1998; Florsheim, Gorman-Smith, & Tolan, 1998). Furthermore, commands may not always be stated positively. Ordering or demanding their children not to do something may be used as a "second warning" disciplinary technique to protect them from often harsh reactions from police and other authorities. Attributing the reluctance to change this view as a difference in parenting styles and practice, it is expected that African-American families would find Step 4 as not appropriate as it does not match their discipline techniques and/or the way in which they parent.

For Step 5, establishing a behavioral contract or a home point system, it is expected that African-American parents would not find such a system compatible with their households. As an example, African-American families often include reliance on extended family members, due in part to single parent family situations. These extended family members may not maintain consistency within such a system. It is well

documented that AA single parent mothers are at greater risk for psychological distress, often have less time to attend to the needs of the children, and function in low socioeconomic conditions (Edelman, 2006; Taylor et al., 1997). Therefore, African-American families are expected to find Step 5 to not be appropriate, and may remark that their stress levels, time constraints, and financial constraints may make it difficult to employ this strategy.

Step 8 which addresses appropriate punishment and appropriate ways to ground the adolescent is culturally incongruent with the manner in which AA families parent. This step states that grounding is the most serious form of punishment that is used in the program and only reserved for the most significant behaviors (Barkley et al., 1998). This step excludes spanking as part of the punishment process, which contradicts studies that suggest that AA families use more physical forms of punishment than European American families (i.e., Deader-Deckard & Dodge, 1997; Giles-Sims, Straus, & Sugarman, 1995; Flynn, 1998; Korbin, Coulton, Lindstrom-Ufuti, & Spilsbury, 2000). African American children more so the European American children are reared in a context of greater reliance on mild physical forms of punishment. African-American parents are less likely to include physical acts in their definitions of child maltreatment than European American parents (Lansford et al., 2004).

Step 9 addresses school advocacy and recommendations for parents regarding school behavior, and accommodations for students with special needs. This is another area where the practical needs of African American families impact the ability to perform some of what is required with this step. Time constraints and understanding the values of

African American families as it relates to how they react to certain school behaviors is not taken into consideration in this step. For example, the adolescent's teachers may not understand what behaviors are a product of his environment, and essential for him to survive, but are classified as unacceptable at school. Behaviors such as retaliating when someone hits you, or not backing down from a fight could be behaviors that his parent supports, but cause him school problems.

Steps 10, 13, and 15 are cornerstones of the problem solving piece of the manual. These steps incorporate concepts about setting aside absolutist beliefs and unreasonable expectations, and increasing effective communication amongst family members. When examining these steps, they do not seem to be incongruent with the characteristics of African-American families. Therefore, it is not expected that these steps will be perceived as different for families based on race nor family make up.

In addition to cultural differences that exist and among African American families and European American families that impact parenting, the impact the family make up has on perceptions and responses to treatment is also important. As statistics show, more so than any other cultural group African American families are constructed of single parents, mostly female caregiver who may or may not receive assistance from the male counterpart and/or extended family members. As a result, there are fewer male authority figures that impact the lives of African American male adolescents, which can have an impact on their behavior, respect for themselves, and manner in which they treat their mother or female caregiver. Depending on the family's make up, it can lead to stress, economic hardships, and development of certain parenting behaviors. These behaviors

can include difficulty with autonomy granting behaviors, unwillingness to relinquish certain punishment behaviors, as not to be perceived as weak and/or to lenient, as well as practical needs associated with parenting without a level of support.

For the steps for behavior management that have already been addressed from a race perspective, family make-up, specifically for single parent families, may produce a reluctance to develop behavior contracts (Step 5) time to advocate at school (Step 9), relinquish some of the control and absolutists beliefs (Steps 3 and 4), and change the manner in which discipline is employed (Step 8) to not be viewed as weak, or potentially not respected. Furthermore, given the relationship between race and family make-up it is expected that more than any other group, African American single parent homes would perceive these steps as not appropriate for their families.

The main purpose of this dissertation was to examine group differences in parental reactions to the Defiant Teens Manual. In addition, parent's level of stress, parenting styles, and intensity of conflict that exists between them and their adolescent was assessed.

CHAPTER III

METHOD

Participants

Participants were 54 African American and European American families from the Charlotte, Greensboro, Monroe, and Concord communities. Specifically, 27 African American Families and 27 European American Families were recruited from outpatient mental health facilities in the Charlotte, Monroe, and Concord communities. Families from the Greensboro community were recruited from a specific agency that treats families with children with behavioral problems. All adolescent participants were from a clinical sample who had received a prior diagnosis of AD/HD and/or ODD. Of the sample 15 of the African American adolescents had a prior diagnosis of AD/HD, 10 had a diagnosis AD/HD and ODD, and 2 had a prior diagnosis of ODD. For European American adolescents, there are 11 who had a diagnosis of AD/HD, and 16 who had dual diagnosis of AD/HD and ODD. Of the participants, there were 32 families with a single parent and 22 two parent families. All adolescent participants were male between the ages of 11 to 14. Further description of the participants is located in the results section.

Measures

The Parenting Questionnaire is a measure designed specifically for the study to assess the applicability of the Defiant Teens Manual as it is usually administered in treatment.. Of

the 18 steps that comprise the treatment, 8 steps were evaluated to assess their perceptions of applicability to African American families compared to European-American families. These 8 steps comprise the major components of the treatment, and do not include steps such as an introduction to disruptive behavior disorders, or steps that recommend more practice of specific techniques. Once the parent/guardian read over the description of the treatment step, they were asked to complete a portion of the Parenting Questionnaire. For each of the eight steps there are three questions, two of which are on a Likert-type scale. Question three is accompanied by a list of responses from which the parents may choose from. For those interventions that are not useful to their family, they have a response list to choose from of reasons why these steps may not be useful. The response list consists of general response items such as lack of time, financial constraints, does not fit my family's values, does not match my discipline techniques, similar to something I tried before that did not work, too personally stressed to follow through, too physically sick to follow through, and none of these apply. If they check that none of these responses apply, they were given the opportunity to state why it does not apply to their family. As well, they were given a section to comment or suggest proposed modifications they would make to the protocol.

In terms of psychometric characteristics of the parenting questionnaire, it showed adequate internal consistency with a Cronbach's Alpha of .69. In addition, split half reliability as measured by the Spearman-Brown Coefficient, as well as the Guttman Split Half Reliability, were found to be .65 and .64, respectively.

The Issues Checklist for Parents and Teenagers created by Robins and Foster (1981) consists of a list of 44 issues created to assess the intensity of conflict that adolescents have with their parents. Estimates of test-retest reliability for the adolescent have ranged from .49 to .87 for the quantity of issues (Robins & Foster), .37 to .49 for then anger-intensity score, and .15 to .24 for the weighted frequency by anger-intensity score. For the parent, reliability ranged from .15 to .24 for mother and father quantity of issues, .81 to .66 for mother and father anger-intensity scores, and .90 and .40 for mother and father weighted frequency by anger-intensity scores (Robins & Foster).

The Perceived Stress Scale (PSS) is a 10-item instrument with responses on a 5-point Likert-type scale that ranges from never to very often. The scale was used to assess levels of stress. The PSS has established good construct validity, and internal consistency has been reported as .78 (Corcoran & Fisher).

The Two-Factor Index of Social Position created by Hollingshead (1957) was used to assess parent's socioeconomic status. To determine their social position, information was requested on parent's occupation and amount of education or formal schooling they have received. Calculation of the Index of Social position involves multiplying the scale value for occupation and education by its respective factor weight (occupation=7, education=4).

The Authoritative Parenting Questionnaire is a self-report measure that is administered to adolescents and assesses parenting styles and specific disciplinary practices (Steinberg et. al, 1992). The measure is comprised of three dimensions: psychological autonomy, acceptance/involvement, and strictness/supervision. The

Authoritative Parenting Questionnaire has been used with many diverse populations, including African American mothers (Steinberg et. al, 1992; Steinberg et. al, 1994). Initial validity was established in several studies of both two-parent and single parent families (Steinberg et. al, 1992). Coefficient alphas in this sample for each of the subscales were modest to strong and ranged from .76 to .83 (Steinberg et. al, 1992). The Authoritative Parenting Questionnaire has established good construct validity, and internal reliability has been reported at .78

The Behavior Assessment Symptoms Checklist (BASC) (Reynolds & Kamphaus, 1992) is a 126 item comprehensive parent rating scale that assesses a broad range of child psychopathology in children aged 2 years 6 months and older. It yields hyperactivity, aggression, and conduct problems subscales for children ages 6 and above. Research on the BASC suggests that it has excellent reliability and validity (Reynolds & Kamphaus, 1992) particularly with AD/HD children (Ostrander, Wienfurt, Yarnold & August, 1998). All measures are included in Appendix A.

Procedure

Subjects were recruited using sign up sheets from UNC-Greensboro Psychology Clinic, the Greensboro, Monroe, Concord, and Charlotte community and community mental health agencies in these respective areas. As previously stated, adolescents were recruited were from a clinical sample, and were currently participating in services or had been referred for services to address some of their current behavioral difficulties. To obtain this clinical sample, IRB approval was obtained from Daymark Recovery Services, Inc. which treats individuals in the Monroe and Concord areas, Carolinas

Medical Center-Behavioral Health Center which treats individuals in the Charlotte Community, and UNCGreensboro's IRB. An overall description of participants is illustrated in Table 1. All participants were administered the study material by the examiner, who is an African American male who holds a master's degree in clinical psychology and licensed by the North Carolina Psychology board as a Licensed Psychological Associate.

The first page of the packet for both adults and adolescents were read to subjects by the experimenter, in addition to having them read information themselves a second time. Subjects were run individually with parents being administered their information separately from the child/adolescent. Guardians were initially administered the BASC to identify the current difficulties that exist and to help determine appropriateness of subjects for the study. Individuals whose BASC externalizing behavior problems composite scores ranked in the at risk range and higher were included in the study. For two parent families, they were asked to complete one BASC form, and in all cases the mothers completed the form with moderate input from the male parent. Parents were given a brief overview of the study, and then asked to review a series of descriptions of the major steps of the Defiant Teens Manual. Following each step the parent/guardian read, they filled out the Parenting Questionnaire. Once parents/guardians completed the Parenting Questionnaire, they were administered the additional battery of questionnaires to complete. This battery included the Perceived Stress Scale, Authoritative Parenting Questionnaire, Two Factor Index of Social Position and the Issues Checklist.

In the case of two parent families, they were asked to complete one form with collaboration between the parents. In the case of the Perceived Stress Scale, the parent who provided the primary care for the adolescent was asked to complete the form. The child/adolescent subjects completed the Issues Checklist and the Authoritative Parenting Questionnaire. Once all questionnaires were completed, parents/guardians and child/adolescent subjects were debriefed on the purposes of the study.

CHAPTER IV

RESULTS

The distribution of each variable was checked for normality and to determine if outliers existed. All distributions fell within the normal limits with no outliers. Overall means and standard for all measures are shown in Table 1. To answer specific research questions regarding differences that may exist based on race and family make up, means comparisons of the parent's stress levels, parenting styles, and socioeconomic status were conducted. The intensity of conflict that existed between the parent(s) and their adolescent and the intensity of behavioral problems the adolescents presented with served as descriptive measures to help determine the appropriateness of our sample. Internal consistency and reliability analysis were conducted on the parenting questionnaire to identify how well it was assessing family's perceptions of the treatment. Finally, to answer the main research question of the perceptions of treatment and it differing based on race and/or family make up, two multivariate analyses of variance (MANOVA) were conducted to analyze the subject's responses to the parenting questionnaire they were administered. The first MANOVA was on the BMT steps, and the second MANOVA was on the PSCT steps. For both MANOVA's SES, PSS, and the dimensions of the Authoritative Parenting Scale were entered as covariates. Then analyses of variance were used to analyze their responses to each individual treatment step separately.

Description of Race and Family Variables

Descriptive statistics for the variables separated by Race and Family Make up are reported in Table 2. Table 2 presents the means and standard deviations for the BASC, PSS, SES scale and the Authoritarian Parenting Style questionnaire by Race and Family Make Up. To identify if significant differences existed between races and family make up on the different measures, the means were analyzed using one-way ANOVA F tests (Table 3). The one way ANOVA for SES predicted by family make up revealed that SES did vary amongst groups, $F(1,52) = 53.24$, $p<.05$, with two parent homes having a significantly higher SES level. As well the one way ANOVA for psychological autonomy predicted by race did vary amongst groups, $F(1,52) = 4.19$, $p<.05$, with African American adolescents ranking their parent/guardian as having a more authoritarian style of parenting.

Table 4 shows the break down of the sample as it relates to BASC to identify the clinical sample. Of importance in particular are the frequencies for the BASC which shows that 38 of the adolescent subjects (70.4% of adolescents) that were included in the study ranked in the clinically significant range for externalizing behaviors and the other 16 adolescents ranked in the at risk range for externalizing behavior disorders. Of those 38 at the clinically significant range 19 (50% of the clinically significant sample) were African American and 8 (50% of the at risk sample) of those classified as at risk were African American. Twenty three of the adolescents that were rated in the clinically significant range came from single parent families, with 9 of those rated at risk coming from two parent families.

The Issues Checklist for Parents and Teenagers displayed several areas of conflict that existed for each subject with 82% of the parents sampled stating that there is intense conflict around their adolescent following directions in different settings. Of those 82%, 37% were African American single parent families, with 22% being European American single parent families. 63% of the adolescent sample also confirmed that the majority of the intense conflict with their parent centers around their ability to follow directions in different settings. These directions include issues with cleanliness, doing chores, putting things away after use, breaking curfew, getting into trouble at school and talking back to parents. These results are shown in Table 5. Based on this information, it is apparent that the subjects that were included in study fit the population for which the treatment protocol was intended.

Perceptions of Treatment:

To determine if perceptions of the treatment steps differed, a 2 (race) and 2 (family make up) multivariate analysis of variance (MANOVA) was conducted for parent training steps alone as well as the PSCT steps. The SES, PSS, and subscales of the Authoritative Parenting scales were used as covariates in all MANOVA analyses that were conducted. As shown in Tables 6a, and 6b, the MANOVA's for the behavior management steps (table 6a) as well as the PSCT steps (table 6b) yielded no statistically significant differences (using a significance level of 0.05) among groups' perceptions of the treatment steps. These findings did not support the hypothesis that African American families would have a negative perception of the parent training Steps 3, 4, 5, 8, and 9 of the treatment protocol and find it not to be as applicable to their family. However, it did

support the hypothesis that regardless of race and/or family make up, the groups did not differ on their perceptions of the problem solving communication steps which were Steps 10, 13 and 15. These results are also shown in Table 6b.

To further examine if differences existed amongst race and family make-up, the dependent measures were examined separately. The findings suggest that parents perceptions of Step 9 (school advocacy) differed by Race, $F(1,52) = 4.23$, $p<.05$ with African American parents ratings of this step lower than European American parents. For Step 5 which addresses the home point system, racial differences in perception approaches significance, $F(1, 52) = 3.83$, $p<.056$ with African American parents rating this step lower than European American parents. For Step 4 which addresses giving effective commands, racial differences in perception approaches significance, $F(1,52) = 3.58$, $p=.065$ with African American parents rating this step lower than European American parents. Regarding family make up, parents from single parent homes, $F(1,52) = 4.23$, $p<.05$ rated Step 5 which addresses home point systems lower than parents in two parent homes. These results are shown in Table 7. However caution should be used when interpreting these ANOVA results, including statistical caution since the MANOVA were not significant. Furthermore, although the responses differed by groups, the mean responses were all in the appropriate range of the scale. Specifically, regardless of race parents' mean responses were in at least the somewhat appropriate range. The mean responses for groups by race and family make up are shown in Table 8.

CHAPTER V

DISCUSSION

The findings suggest that regardless of race and/or family make up, there were no differences detected among the groups' perception of the treatment and its appropriateness to their families based on the MANOVA. These findings support the prediction that groups' perceptions of Steps 10, 13, and 15, the problem-solving steps, would not differ as they appeared to be more congruent with the values of African American families. In a way, however, these results support the null hypothesis. However, these results did not support the hypothesis that the parent training steps of the Defiant Teen's Manual would be perceived as inappropriate by African American families. Similarly, the stepwise regression analysis did not yield any significant results, and it does not appear that there was a hierarchy relative to steps and the impact that they had on the perceived applicability of the treatment.

In the ANOVA, there was a significant racial difference among perceptions of Step 9 which addresses school advocacy with African American parents finding the step to be less appropriate than European American parents. In addition, although not significant at the .05 level a trend appears to exist for level of perception for Step 5 which addresses home point systems for racial groups, with African American parents again rating this step as less appropriate than European American parents. As well for Step 4 which related to giving effective commands and praise for compliance with behavior,

although not significant at the .05 level, the trend appears to exist that for the perceived applicability African American families rated this step as less appropriate than European American parents. For family make up, it appears that single parent homes rated Step 5 (home point system) as less appropriate than two parent homes. It should be noted that with all three of these significant findings, all ratings were still in the appropriate range. Specifically, regardless of the race of the participant the overall mean suggests that they rated the steps as at least somewhat appropriate. However, these findings are still relevant and address some of the questions. Although African American parents did not rate these steps as not appropriate the difference amongst their perceptions of these three steps when compared to European American families was lower and found to be less appropriate. In addition, when examining each questionnaire for African American parents who found Steps 4, 5 and Step 9 to not be appropriate, they often remarked they felt the system was too difficult to implement due to time constraints, they tried the point system before and it did not work, and it did not match their discipline techniques.

When examining the not appropriate responses of single parent homes for step 5 they often remarked that it was difficult to employ the point system due to time, financial constraints, and similar to something that they had tried before. Being a single parent can be both a stressful and difficult task (McLoyd, 1990). That stress can be exacerbated by having a child who continuously has difficulty in all settings and forces that parent to take time away from work and other responsibilities to address that child's behavioral issues. Given that, it becomes difficult as a single parent to be responsible for managing all household responsibilities and have time to employ a home point system that requires

sustain effort. In addition, if a parent has tried a strategy without much success, they might be more inclined to belief that it is not effective, and will not work in the future.

Regarding ancillary predictions, it does appear there is a significant relationship between family make up and SES, with two parent homes having a higher SES level than single parent homes. These findings were not surprising, it is often expected that in a home with two parents their SES would be higher than that of a single individual responsible for the finances of a household. In addition, there appears to be a relationship between race and the psychological autonomy dimension of the Authoritative Parenting Questionnaire, with African American adolescents rating their parent/guardian(s) as more authoritarian. This finding supports the hypothesis that African American parents would be perceived as having a more authoritarian style of parenting. When comparing the parenting styles of the African American parents in the sample, these parents continue to have difficulty with managing their child's behavior as evidenced by the high BASC ratings, and their acknowledgement of behavioral issues that exist on the Issues Checklist. The assumption could be made that their parenting styles and techniques have not been effective in addressing their adolescent's behavioral issues, and different strategies for parenting could be beneficial.

Strength of Study

There are relatively few studies examining the appropriateness of different treatments to the African American population. Huey and Polo (2008) researched treatments for ethnic minority youth trying to identify evidenced based treatments using the Chambless et al. (1998) criteria for well established treatments. Although no well

established treatments were identified, probably efficacious or possibly efficacious treatments were found for ethnic minority youth with anxiety problems, AD/HD, depression, conduct problems, substance abuse problems, trauma related problems and other clinical problems. In addition although they evaluated the treatment based on a certain criteria, the specific cultural differences that exist between different ethnic groups were not identified. It should be noted that the Huey and Polo meta-analysis focused on treatment outcomes as opposed to families' perceptions of treatment as being appropriate for the adolescent and his family.

A criticism leveled against most behavioral science research is its limited focus on children of color such as African American children (McLoyd, 1998). Absence of accurate base rate information can compromise the applicability of norms to African Americans. This problem can contribute to misclassification, inaccurate research findings, improper diagnostic decisions, and subsequently result in poor treatment outcomes for African American children (Johnson, 1993; Reid, 1995). What differentiates this study from others is its primary focus on the African American clinical population. The present study attempted to properly identify African Americans' perceptions of a treatment that has been used to help them better manage the issues with which their adolescents may present.

The current study included a clinical sample of adolescents with marked externalizing behavior problems, which was closely aligned with the type of population the treatment was intended for. In addition, the parents of these adolescents were seeking help to better manage their adolescent's behavior problems. In addition, the measure used

to answer the primary research question showed adequate internal consistency, and split-half reliability which suggests that it adequately measured family perceptions of the treatment steps.

Limitations of the Current Study

The current study solely assessed the perceptions of the subjects that agreed to participate in the evaluation of the treatment protocol without their actual participation in the treatment process. There is a distinct difference between having subjects rate a treatment after participation versus the rating being solely based on their reading of information about the actual treatment. In addition, although families were informed through the consent process that their honest opinions and responses were encouraged, for some these families, specifically African Americans, there may have been some inclination to agree with the treatment in effort to appease the experimenter who was African American.

Although the relationship that existed between the experimenter and subjects was not the traditional therapeutic paradigm, the process involved some interaction similar to a therapy process, and material relative to treatment of psychological dysfunction. In a study done by Murphy, Faulkner, and Behrens (2004), they found that racial similarity impacted comfort and satisfaction in the relationship between therapist and client, as well as the therapist evaluation of treatment. Given this information, as well as reduction in suspicion of examiner given his race, families may have had a misperception that the experimenter endorsed the treatment as is. As a result, to support the examiner, they might have endorsed that the steps as appropriate, even if they felt otherwise.

The study included 54 participants, with at least 11 families comprising each cell of the design, which is adequate considering the rule of thumb, that at least 10 subjects are necessary to detect differences among groups. However, additional subjects could have potentially increased the power of the analyses and the potential to detect a difference amongst groups. To address this concern a post hoc power analysis was conducted and determined that additional subjects would have increased the potential to detect differences amongst groups which suggests that the trends that were observed could result in significant differences if the number of subjects were increased. The power analysis suggested that as opposed to the 13 participants per group that were used in the study a more appropriate number of participants would have been at least 20 per group to increase the potential to detect a difference amongst groups.

Although having a clinical sample can be seen as strength of the study it also creates some limitations. No accurate assessment of type of treatment the family experienced in the past was assessed. Therefore, these families could have experienced similar treatment with successful outcomes and could be providing their honest perceptions of the treatment. Since the majority of the families regardless of race were either seeking treatment and/or receiving treatment, there is in inherent selection bias associated with the sample. These individuals were motivated to seek treatment in order to create change in their adolescent's behavior, which could provide some justification for them feeling less inclined to perceive the information as inappropriate given their circumstance. The argument could be made that the AA families that participated are atypical of what is expected when it comes to the utilization of mental health services.

Researchers have found that national disparities are common in the utilization of mental health services amongst ethnic and racial groups (Wells et al., 2001). Even when equivalent levels of insurance and care, ethnic minorities utilize treatment less than whites (Padgett, Patrick, Burns & Schlesinger, 1994a, Smedley et al., 2003). If this sample is in fact different from traditional AA families, this could help to explain the lack of significant findings, as these families are motivated to seek appropriate treatment for their family.

To date there are no controlled treatment outcome studies comparing any theoretical models or interventions with a specific focus on African American adolescent males (Thorn & Sarata, 1998). The reluctance of African Americans to participate in research studies is one of the factors that has hindered this type of research. To combat this, researchers interested in conducting therapy with a AAA male population should increase their visibility in African American communities, to help establish credibility, and to offer treatment and collect data at locations in the communities where the subjects reside.

Directions for Future Research

African American male adolescents are frequently diagnosed with AD/HD and Disruptive Behavior Disorders. The Huey and Polo (2008) meta-analysis of treatment outcomes for minority youth is very helpful, but it presents results in broad-brush strokes without a fine-grained analysis. Many questions remain unanswered by available research, including whether treatment outcome is influenced by interaction between treatment type with ethnic group, the impact on outcome of matching therapist and client

on ethnicity, and possible useful adaptations of therapy (Arnold et al., 2003). Weisz et al. (1998) noted that the empirical literature lacks studies with direct, within study comparisons using adequate numbers of minorities and nonminorities to allow proper matching of ethnic groups and treatment conditions. As Arnold et al. (2003) noted, for example, no research addressed the specific moderating effects of culture or race on outcome of treatment of AD/HD.

Interventions should be evaluated in relation to the cultural realities and contextual characteristics of the families' and adolescents' daily life. Successful assessment must differentiate between skills required to successfully adapt to specific contents, and those that are aggressive and symptomatic of disruptive behavior disorders and deviant from the norm. The field could benefit from a continued push to promote cultural sensitivity amongst mental health professionals, and an understanding of how the social history of African American adolescent males differs from other groups. Sensitivity to cultural issues and societal pressures should be acknowledged, and can be translated into supportive behaviors that validate feelings of anger and hopelessness, during the course of therapy.

The field could benefit from empirical tests of what impact culturally sensitive strategies would have on treatment outcomes. This process could occur both through the use of large samples, and single subject designs. Conducting a similar study with a larger sample size could potentially result in detectable differences, as the current studies power although adequate, could have been increased the likelihood of the trends that were discovered being statistically significant difference with an increase in sample size.

Conducting the study with at least 10 to 15 more subjects per cell would increase the power and provide a more adequate determinant of the observed differences and trends that were found in the study.

The current study could be enhanced by changing the design to include the standard manual as well as a modified manual, and have parent's rate their perceptions of what treatment they find more appropriate for their family. Another variation of the current study is placing the families in treatment groups, where some are administered the standard defiant teen's manual, and others are administered an adapted manual. The families could be asked their perceptions of the treatment, as well as track and compare outcomes. Another variation is where therapists could conduct varying "traditional" treatments without adhering to certain cultural issues, and then while adhering to these issues and concerns.

One of these cultural issues that has been identified that African American parents employ is known as racial socialization (Coard et al., 2004). Racial socialization refers to the developmental processes by which children acquire the behaviors, perceptions, values, and attitudes of an ethnic group, and come to see themselves as members of the group (Rotherman & Phinney, 1987). It also refers to the promotion of psychological and physical health through child-rearing in a society where dark skin and/or African features may lead to discrimination and racism, which in turn can lead to detrimental outcomes for African Americans (Peters, 1985) such as high rates of behavioral problems, depression, and anxiety. There is a growing body of evidence supporting the notion that the more parents engage in specific racial socialization practices, the more their children

show better socio-emotional, behavioral, and academic outcomes (Caughy et al., 2002). Given this evidence, the teaching of racial socialization as part of an evidenced based parent training program could potentially have several beneficial effects for African American parent and their children. Determining whether well-established therapeutic techniques and practices are effective with African American adolescent males is also important.

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APPENDIX A
TABLES

TABLE 1
Description of Participants
Means and Standard Deviations

Measure	**Mean**	**SD**
AGE	**12**	**1.07**
	33.2	**16.49**
SES		
	23.4	**8.58**
PSS		
	1.70	**.46**
BASC-Externalizing		
	24.60	**4.70**
Strictness		
	26.85	**4.97**
Involvement		
	19.92	**4.10**
Psychological Autonomy		

Family Make Up

N=54	**# of Participants of Race**	**Family Make Up**
AA	**27**	16=1 parent 11=2 parent
EA	27	16=1 parent 11=2 parent

AA-African American
EA= European American
SES=Two factor Index of Social Position
PSS=Perceived Stress Scale
BASC=Behavior Assessment Symptom Checklist-Externalizing Composite
Involvement=Dimension of Authoritative Parenting Scale
Strictness= Dimension of Authoritative Parenting Scale
Psychological Autonomy= Dimension of Authoritative Parenting Scale

TABLE 2
MEANS BY RACE AND FAMILY MAKE UP

	Age		SES		PSS		BASC		Involvement		Psychological Autonomy		Strictness	
Variable	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
RACE														
AA	12.3	1.1	34.2	17.1	25.5	7.0	1.7	.46	27.3	5.6	21.3	4.1	23.5	5.3
EA	12.2	1.0	32.3	16.0	21.4	9.6	1.7	.46	26.3	4.1	18.8	3.7	25.7	3.8
Family Make up														
Single Parent	12.2	1.1	23.6	9.9	25.1	8.9	1.7	.45	27.5	4.5	19.8	4.2	24.1	5.1
Two Parent	12.4	1.0	47.3	13.9	21.0	7.5	1.6	.47	25.8	5.5	20.9	4.0	25.3	4.0

AA-African American
EA= European American
SES=Two factor Index of Social Position
PSS=Perceived Stress Scale
BASC=Behavior Assessment Symptom Checklist-Externalizing Composite
Involvement=Dimension of Authoritative Parenting Scale
Strictness= Dimension of Authoritative Parenting Scale
Psychological Autonomy= Dimension of Authoritative Parenting Scale

TABLE 3
ONE WAY ANOVA'S FOR RACE AND FAMILY MAKE UP COMPARISONS

ANOVA For Psychological Autonomy by Race

Variable	***Source***	***SS***	***DF***	***MS***	***F***	***SIG***
Psychological Autonomy						
	Between Groups	66.66	1	66.66	**4.19**	**.04****
	Within Groups	827.03	52	15.90		
	Total	893.70	53			

ANOVA For SES by Family Make Up

Variable	***Source***	***SS***	***DF***	***MS***	***F***	***SIG***
SES						
	Between Groups	7299.26	1	7299.26	**53.24**	**.00****
	Within Groups	7127.99	52	137.07		
	Total	14427.25	53			

***p<.05**

AA-African American
EA= European American

TABLE 4
BASC-Externalizing Composite

Classifications	Total Frequency	Percent	Total AA	Percent	Family Make Up (1 Parent)
1= At Risk	16	29.6%	8	50%	9
2=Clinically Significant	38	70.4%	19	50%	23

AA-African American
EA= European American

TABLE 5
Issues Checklist
(N=108; 54 Adults, 54 Adolescent Males)

Type of Conflict	Frequency	Percent	AA (1 Parent)	EA (1 Parent)
Compilation of Following Direction Statements For Adults	**44**	**82%**	**37%**	**22%**
Compilation of Following Direction Statements For Adolescents	**34**	**63%**	**22%**	**19%**

AA-African American
EA= European American

TABLE 6A
MANOVA FOR BEHAVIOR MANAGEMENT STEPS

Source	***Hotelling's Trace***	***DF***	***F***	***Sig***
SES	.20	5	1.600	.17
PSS	.05	5	.471	.79
Involvement	.25	5	2.000	.09
Psychological Autonomy	.16	5	1.300	.26
Strictness	.07	5	.570	.72
Race	.23	5	1.800	.12
Family Make up	.24	5	1.900	.10
Race *Family Make up	.06	5	.530	.75
Error		40		
Total		54		

SES=Two factor Index of Social Position
PSS=Perceived Stress Scale
Involvement=Dimension of Authoritative Parenting Scale
Strictness= Dimension of Authoritative Parenting Scale
Psychological Autonomy= Dimension of Authoritative Parenting Scale

TABLE 6B
MANOVA FOR PSCT STEPS

Source	***Hotelling's Trace***	***DF***	***F***	***Sig***
SES	.09	3	1.20	.30
PSS	.06	3	.92	.43
Involvement	.15	3	2.10	.11
Psychological Autonomy	.08	3	1.10	.35
Strictness	.01	3	.20	.89
Race	.03	3	.52	.67
Family Make up	.04	3	.66	.57
Race *Family Make up	.05	3	.78	.50
Error		42		
Total		54		

SES=Two factor Index of Social Position
PSS=Perceived Stress Scale
Involvement=Dimension of Authoritative Parenting Scale
Strictness= Dimension of Authoritative Parenting Scale
Psychological Autonomy= Dimension of Authoritative Parenting Scale

TABLE 7
ONE WAY ANOVA'S FOR RACE AND FAMILY MAKE UP FOR TREATMENT STEPS

ANOVA For Step4 (Effective Commands) By Race

Variable	*Source*	*SS*	*DF*	*MS*	*F*	*SIG*
Step 4						
	Between Groups	3.43	1	3.43	3.57	***.06****
	Within Groups	47.15	52	.960		
	Total	50.58	53			

ANOVA For Step 5 (Home Point System) by Race

Variable	*Source*	*SS*	*DF*	*MS*	*F*	*SIG*
Step 5						
	Between Groups	18.84	1	18.84	3.16	***.056****
	Within Groups	252.48	52	4.91		
	Total	271.32	53			

ANOVA For Step 9 (School Advocacy) by Race

Variable	*Source*	*SS*	*DF*	*MS*	*F*	*SIG*
Step 9						
	Between Groups	9.14	1	9.14	4.23	***.04***
	Within Groups	134.11	52	2.15		
	Total	143.25	53			

ANOVA For Step 5 (Home Point System) by Family Make Up

Variable	*Source*	*SS*	*DF*	*MS*	*F*	*SIG*
Step 5						
	Between Groups	20.84	1	20.84	4.23	***.04****
	Within Groups	250.49	52	4.91		
	Total	271.33	53			

***p<.06 **p<.05**

TABLE 8
MEANS OF STEPS BY RACE AND FAMILY MAKE UP

	Step 3		Step 4		Step 5		Step 8		Step 9		Step 10		Step 13		Step 15	
Variable	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
RACE																
AA	6.6	.62	6.3	1.3	5.2	2.4	5.5	2.4	5.8	1.9	6.4	1.3	6.4	1.4	6.2	1.9
EA	6.4	1.5	6.8	.32	6.3	1.9	6.2	1.8	6.7	1.1	6.4	1.6	6.4	1.6	6.7	1.1
Family Make up																
Single Parent	6.6	.97	6.6	1.1	6.3	1.6	6.4	1.5	6.5	1.3	6.5	1.3	6.4	1.6	6.5	1.4
Two Parent	6.4	1.4	6.6	.72	4.9	2.8	5.0	2.6	6.0	1.9	6.2	1.6	6.5	1.3	6.2	1.7

Step 3 = Step 3 of the Defiant Teen's manual (developing positive attention)
Step 4= Step 4 of the Defiant Teen's manual (giving effective commands)
Step 5= Step 5 of the Defiant Teen's manual (implementing a home point system)
Step 9= Step 9 of the Defiant Teen's manual (school advocacy)
Step 10= Step 10 of the Defiant Teen's manual (absolutist beliefs)
Step 13= Step 13 of the Defiant Teen's manual (unrealistic expectations
Step 15= Step 15 of the Defiant Teen's manual (increasing effective communications)

APPENDIX B
CONSENT FORMS

Subject Number: _____

THE UNIVERSITY OF NORTH CAROLINA AT GREENSBORO

CONSENT TO ACT AS A HUMAN SUBJECT

The purpose of this study is to gain information from families and adolescents, regarding how appropriate a treatment is for you and your adolescent. As part of this project parents/guardians and adolescents will be asked questions regarding parenting practices, level of stress, socioeconomic status, the adolescent's behavior, and appropriateness of different forms of treatment.

It is the parent/guardian and adolescent's understanding that upon the completion of the study their family will receive 20 dollars for their time and efforts. The information that is provided could have an impact on the different components of treatment, and could translate into more effective treatment for families with adolescents who have similar behavioral difficulties. The total estimated time to complete the questionnaires is 60 minutes for adults and 30 minutes for the adolescents.

Some questions ask delicate information and might be unpleasant to parents/guardians and or adolescents. If at any point during the research any participant experiences emotional distress, please seek assistance from the experimenter. As well, participants have the right to refuse to continue to participate or withdraw their consent at any point during the research without penalty or consequences.

In order to protect the family's privacy, names will not appear on the questionnaires used in the study. Instead a subject number will be assigned to both the parent/guardian and adolescent. This form along with the answers to the questionnaires will be kept in a locked file cabinet for 3 to 5 years and only the experimenter will have access to them.

_____ has verbally explained to you this information and answered any questions concerning your participation. You are aware the research and this consent form has been approved by the University of North Carolina at Greensboro Institutional Review Board which guarantees that research involving people follows federal regulations. Any questions you have regarding you and your adolescent's rights as participants in this project can be answered by the Director of Research Services, Beverly Maddox-Britt at 334-5878. As well, any questions regarding the current research project can be addressed by calling Kendell Jasper at 256-0050 or Dr. Rosemery Nelson-Gray at 334-5817.

If you have read the preliminary description of this study, agree to participate, give consent for your adolescent to participate, and you understand that you have the right to refuse to continue to participate or withdraw consent, please complete the information below. If you have any additional questions please feel free to ask the experimenter at this time.

_____
Parent/Guardian Signature

_____ _____
Witness Signature Date
(Experimenter)

Subject Number: _____

THE UNIVERSITY OF NORTH CAROLINA AT GREENSBORO

ASSENT TO ACT AS A HUMAN SUBJECT

The purpose of this study is to gain information from families and their male adolescents, regarding how appropriate a treatment is for parents/guardians and their adolescent. As part of this project adolescents will be asked questions regarding their parent/guardians parenting practices, and their behavior.

It is the parents/guardians and adolescents understanding and that upon the completion of the study their family will receive 20 dollars for their time and efforts. The information that is provided could have an impact on the different components of treatment, and could translate into more effective treatment for families with adolescents who have similar behavioral difficulties. The total estimated time to complete the questionnaires is 60 minutes for adults and 30 minutes for the adolescents.

Some questions ask delicate information and might be unpleasant to adolescents. If at any point during the research any participant experiences emotional distress, please seek assistance from the experimenter. As well, participants have the right to refuse to continue to participate or withdraw their assent at any point during the research without penalty or consequences.

In order to protect the family's privacy, names will not appear on the questionnaires used in the study. Instead a subject number will be assigned to both the parent/guardian and adolescent. This form along with the answers to the questionnaires will be kept in a locked file cabinet for 3 to 5 years and only the experimenter will have access to them.

_____ has verbally explained to you this information and answered any questions concerning your participation. You are aware that this research project and this assent form have been approved by the University of North Carolina at Greensboro Institutional Review Board which guarantees that research involving people follows federal regulations. Any questions you have regarding your rights as a participant in this project can be answered by the Director of Research Services, Beverly Maddox-Britt at 334-5878. As well, any questions regarding the current research project can be addressed by calling Kendell Jasper at 256-0050 or Dr. Rosemery Nelson-Gray at 334-5817.

If you have read the preliminary description of this study, and give assent to participate, and you understand that you have the right to refuse to continue to participate or withdraw assent, please complete the information below. If you have any additional questions please feel free to ask the experimenter at this time.

_____ _____

Participant's Signature Child/Adolescent Signature

_____

Witness Signature
(Experimenter)

_____

Date

Carolinas Healthcare System

Child/Adolescent Assent Form

Title: The Perceived applicability of the Defiant Teen's manual to African American Families.

Introduction: This assent form may contain words that you do not understand. Please ask the study staff to explain any words or information you do not know. You may take home an unsigned copy of this consent form to think about or discuss with family or friends before making your decision.

Why are we asking you to be a part of this research study?
We are asking you and about 60 to 80 other adolescents to be in our research study at the Behavioral Health Center (BHC). This study will help us learn more about treatments for adolescents with behavior problems. The main reason we are doing this study is to see if different types of treatments might work better for some adolescents compared to others.

In order to be a part of this study, you and your parent (legal guardian) will listen to someone explain the information about this study, and you should ask any questions that you have. Then, in order for you to start the study, your parent or your legal guardian must agree, in writing, that you will take part. Also, we are asking you to agree to take part, and you can do this by signing this form at the end. If you decide to take part in this study and then change your mind, you may choose to stop at any time.

Do you need to be in this study to be treated?
Being in this study is your choice and the choice of your parent or guardian. You do not have to be in this study to be treated for your behavior issues. This study is not part of your treatment.

What kinds of things will you do if you take part in this study?
If you agree to be in this study, you will be asked to fill out several questionnaires about your relationship with your parents and the issues that may cause conflict in your family. It typically takes about 30 minutes to complete these questionnaires.

Will you feel uncomfortable during this study?
Sometimes answering questions about family relationships and/or conflict may make you feel uncomfortable.

Possible Benefits
This study may or may not benefit you. The information you and your family provide may benefit others by helping us better understand which treatments are most helpful for adolescents with behavior problems.

Your participation in the study
You can stop being in the study at any time and nobody will be upset with you.

Confidentiality
The information you share with study staff will be kept in a private manner. A special code, using numbers and initials will refer to you and your records.

When will this study end?
This study will end after you and your parent/legal guardian have completed the questionnaires.

Assent:
For you to be part of this study, your parent or legal guardian must sign a Parent/Guardian Information and Consent Form and you are being asked to sign and date the signature page for this Child Assent Form. By signing this page, you are agreeing with the following:

- You have read all of the information in this Patient Information and Consent Form, or have had it read to you, and you have had time to think about it.
- All of your questions have been answered.
- You voluntarily agree to be part of this research study, to follow the study procedures, and to provide necessary information to the staff members as requested.
- You may freely choose to stop being part of this study at any time.

You will receive a signed and dated copy of this Patient Information and Assent Form to keep for yourself.

_____	_____
Name of Child (subject)	Date
_____	_____
Signature of Child (subject)	Date
_____	_____
Signature of Parent (guardian)	Date
_____	_____
Signature of Person Administering Assent	Date
_____	_____
Signature of Investigator	Date

Check which applies (to be completed by person administering assent):

_____ The subject is capable of reading the assent form and has signed above as documentation of assent to take part in this study

_____ The subject is not capable of reading the assent form, however, the information was explained verbally to the subject who has verbally given assent to take part in this study.

_____
Name of Person Administering Assent (Print)

APPENDIX C
STUDY QUESTIONNAIRES

Subject Number: _____

Parenting Questionnaire

Listed below is a number and the response that corresponds to that number. Please use this table when answering the first two questions below. Circle the number that matches the verbal response you would like to use.

1= Totally Inappropriate
2= Mostly Inappropriate
3= Somewhat Inappropriate
4= Undecided
5= Somewhat Appropriate
6= Mostly Appropriate
7= Absolutely Appropriate

1. How appropriate is this treatment component for your family?
   1 2 3 4 5 6 7

2. How appropriate is this treatment component for other African American families?
   1 2 3 4 5 6 7

3. If you answered 1, 2,or 3 to either question above, then from the list below please place a **check mark** next to the responses that apply to why the component is **not appropriate**:

____ Does not fit my family's values and/or beliefs
____ Does not match my discipline techniques
____ Does not match the way I parent
____ Not practical due to financial constraints
____ Not practical due to time constraints
____ Similar to something I tried before that did not work
____ Too personally stressed to follow through
____ Too physically sick to follow through
____ To much general environmental stress to follow through

Other:
_____
_____

Subject Number: _____

Parenting Questionnaire

Listed below is a number and the response that corresponds to that number. Please use this table when answering the first two questions below. Circle the number that matches the verbal response you would like to use.

1= Totally Inappropriate
2= Mostly Inappropriate
3= Somewhat Inappropriate
4= Undecided
5= Somewhat Appropriate
6= Mostly Appropriate
7= Absolutely Appropriate

1. How appropriate is this treatment component for your family?
   1 2 3 4 5 6 7

2. How appropriate is this treatment component for other Caucasian families?
   1 2 3 4 5 6 7

3. If you answered 1, 2,or 3 to either question above, then from the list below please place a **check mark** next to the responses that apply to why the component is **not appropriate**:

____ Does not fit my family's values and/or beliefs
____ Does not match my discipline techniques
____ Does not match the way I parent
____ Not practical due to financial constraints
____ Not practical due to time constraints
____ Similar to something I tried before that did not work
____ Too personally stressed to follow through
____ Too physically sick to follow through
____ To much general environmental stress to follow through

Other:
_____
_____

Subject Number: _____

PSS

The questions in this scale ask you about your feelings and thoughts during the *last month*. In each case, please indicate by writing a number in the space how often you felt or thought a certain way.

0 = Never
1 = Almost Never
2 = Sometimes
3 = Fairly Often
4 = Very Often

____ 1. In the last month, how often have you been upset because of something that happened unexpectedly?

____ 2. In the last month, how often have you felt you were unable to control the important things in your life?

____ 3. In the last month, how often have you felt nervous and "stressed"?

____ 4. In the last month, how often have you felt confident about your ability to handle your personal problems?

____ 5. In the last month, how often have you felt that things were going your way?

____ 6. In the last month, how often have you found that you could not cope with all the things that you had to do?

____ 7. In the last month, how often have you been able to control irritations in your life?

____ 8. In the last month, how often have you felt that you were on top of things?

____ 9. In the last month, how often have you been angered because of things that were outside of your control?

____ 10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

Subject Number:_____

SES Scale

1. What type of work does the head of your household do (mother/father etc.)?
   If Retired/Deceased: What kind of work did he/she do?

2. How far did he/she get in school?

Subject Number: _____

Authoritative Parenting Scale

MY PARENTS

Please answer the next set of questions about the parents (or guardians) you live with. If you spend time in more than one home, answer the questions about the parents (or guardians) who have the most say over your daily life.

If you STRONGLY AGREE with the statement, put a 4 on the line next to it.
If you AGREE SOMEWHAT with the statement, put a 3 on the line next to it.
If you DISAGREE SOMEWHAT with the statement, put a 2 on the line next to it.
If you STRONGLY DISAGREE with the statement, put a 1 on the line next to it.

____ 1. I can count on my parents to help me out, if I have some kind of problem.
____ 2. My parents say that you shouldn't argue with adults.
____ 3. My parents keep pushing me to do my best in whatever I do.
____ 4. My parents say that you should give in on arguments rather than make people angry.
____ 5. My parents keep pushing me to think independently.
____ 6. When I get a poor grade in school, my parents make my life miserable.
____ 7. My parents help me with my schoolwork if there is something I don't understand.
____ 8. My parents tell me that their ideas are correct and that I should not question them.
____ 9. When my parents want me to do something, they explain why.
____ 10. Whenever I argue with my parents, they say things like, "You'll know better when you grow up."
____ 11. When I get a poor grade in school, my parents encourage me to try harder.
____ 12. My parents let me make my own plans for things I want to do.
____ 13. My parents know who my friends are.
____ 14. My parents act cold and unfriendly if I do something they don't like.
____ 15. My parents spend time just talking with me.
____ 16. When I get a poor grade in school, my parents make me feel guilty.
____ 17. My family does things for fun together.
____ 18. My parents won't let me do things with them when I do something they don't like.

MY FREE TIME

1. In a typical week, what is the latest you can stay out on SCHOOL NIGHTS (Monday-Thursday)?
   I am not allowed out _____
   Before 8:00pm _____
   8:00pm to 8:59pm _____
   9:00pm to 9:59pm _____
   10:00pm to 10:59pm _____
   11:00pm or later _____
   As late as I want _____

2. In a typical week, what is the latest you can stay out on FRIDAY OR SATURDAY NIGHT?

I am not allowed out	_____
Before 8:00pm	_____
8:00pm to 8:59pm	_____
9:00pm to 9:59pm	_____
10:00pm to 10:59pm	_____
11:00pm or later	_____
As late as I want	_____

3. How much do your parents TRY to know?

	Don't Try	Try a little	Try a lot
Where you go at night?	____	____	____
What you do with your free time?	____	____	____
Where you are most afternoons after school?	____	____	____

4. How much do your parents REALLY know?

	Don't Try	Try a little	Try a lot
Where you go at night?	____	____	____
What you do with your free time?	____	____	____
Where you are most afternoons after school?	____	____	____

ISSUES CHECKLIST FOR PARENTS AND TEENAGERS (FORM 9)

Name_____ **Date**_____

☐ Adolescent		☐ Adolescent
☐ Mother	*with*	☐ Mother
☐ Father		☐ Father

Below is a list of things that sometimes get talked about at home. We would like you to look carefully at each topic on the left-hand side of the page and decide whether the *two of you together* have talked about that topic at *all* during the last 2 weeks.

If the two of you together have discussed it during the last 2 weeks, circle *Yes* to the right of the topic.

If the two of you together have *not* discussed it during the last 2 weeks, circle *No* to the right of the topic.

Now, we would like you to go back over the list of topics. For those topics for which you circled Yes, please answer the two questions on the right-hand side of the page.

1. How many times during the last 2 weeks did the topic come up?
2. How hot are the discussions?

Go down this column for all pages first. Then go down these columns for all pages.

					How hot are the discussions?				
	Topic			How many times?	Calm		A little angry		Angry
1.	Telephone calls	Yes	No		1	2	3	4	5
2.	Time for going to bed	Yes	No		1	2	3	4	5
3.	Cleaning up bedroom	Yes	No		1	2	3	4	5
4.	Doing homework	Yes	No		1	2	3	4	5
5.	Putting away clothes	Yes	No		1	2	3	4	5
6.	Using the television	Yes	No		1	2	3	4	5
7.	Cleanliness (washing, showers, brushing teeth)	Yes	No		1	2	3	4	5
8.	Which clothes to wear	Yes	No		1	2	3	4	5
9.	How neat clothing looks	Yes	No		1	2	3	4	5
10.	Making too much noise at home	Yes	No		1	2	3	4	5
11.	Table manners	Yes	No		1	2	3	4	5
12.	Fighting with brothers or sisters	Yes	No		1	2	3	4	5
13.	Cursing	Yes	No		1	2	3	4	5
14.	How money is spent	Yes	No		1	2	3	4	5

15.	Picking books or movies	Yes	No		1	2	3	4	5
16.	Allowance	Yes	No		1	2	3	4	5
	Topic			How many times?	Calm		A little angry		Angry
17.	Going places without parents (shopping, movies, etc.)	Yes	No		1	2	3	4	5
18.	Playing stereo or radio too loudly	Yes	No		1	2	3	4	5
19.	Turning off light in house	Yes	No		1	2	3	4	5
20.	Drugs	Yes	No		1	2	3	4	5
21.	Taking care of records, games, toys, and things	Yes	No		1	2	3	4	5
22.	Drinking beer or other liquor	Yes	No		1	2	3	4	5
23.	Buying records, games, toys, and things	Yes	No		1	2	3	4	5
24.	Going on dates	Yes	No		1	2	3	4	5
25.	Who should be friends	Yes	No		1	2	3	4	5
26.	Selecting new clothing	Yes	No		1	2	3	4	5
27.	Sex	Yes	No		1	2	3	4	5
28.	Coming home on time	Yes	No		1	2	3	4	5
29.	Getting to school on time	Yes	No		1	2	3	4	5
30.	Getting low grades in school	Yes	No		1	2	3	4	5
31.	Getting in trouble in school	Yes	No		1	2	3	4	5
32.	Lying	Yes	No		1	2	3	4	5
33.	Helping out around the house	Yes	No		1	2	3	4	5
34.	Talking back to parents	Yes	No		1	2	3	4	5
35.	Getting up in the morning	Yes	No		1	2	3	4	5
36.	Bothering parents when they want to be left alone	Yes	No		1	2	3	4	5
37.	Bothering teenager when he/she wants to be left alone	Yes	No		1	2	3	4	5
38.	Putting feet on furniture	Yes	No		1	2	3	4	5
39.	Messing up the house	Yes	No		1	2	3	4	5
40.	What time to have meals	Yes	No		1	2	3	4	5
41.	How to spend free time	Yes	No		1	2	3	4	5
42.	Smoking	Yes	No		1	2	3	4	5
43.	Earning money away from house	Yes	No		1	2	3	4	5
44.	What teenager eats	Yes	No		1	2	3	4	5

APPENDIX D
TREATMENT STEPS HANDOUTS

PARENT HANDOUT FOR STEP 3: PAYING ATTENTION TO YOUR TEEN'S GOOD BEHAVIOR

Like all people, your teenager (let's say a boy) wants to be appreciated for the work he contributes around the home as well as the good behavior he displays to other family members. But, like many of us, he may come to feel taken for granted, that no really appreciates the positive things he contributes to family life or his unique qualities as a person. Although you may feel that your teenager does little that is deserving of appreciation, when you take a more careful look at all of the things he does over the course of a day, you will probably find that not to be true. The purpose of this handout is to help you develop better skills at attending to your teenager's appropriate behavior in hopes that, by doing so, it will increase. When good behavior increases, there is always a corresponding decrease in bad behavior.

Learning to pay attention to the good behavior of others is not an easy thing to do. Many of us do not know how to supervise, manage, or interact with another person so as to increase their desire to work harder for us or follow our rules. Certainly we know how to talk to others, but simply talking to someone may not be very effective at improving our relationship with him/her. It is important to pay attention to how we talk to them, *when* we do so, and *what* we say. Effective supervisors have learned skills that make them better able to motivate their employees to work well for them. Like such supervisors, you may need to learn better ways of "supervising" your teenager to improve his motivation to obey and work for you. Here is a list of things which you should try to do to improve your attending skills to your teenager. Your therapist will discuss them in detail with you.

1. Spend at least 15 minutes, three or four times per week, doing something one-on-one with your teen (let's say a girl). The activity should be something enjoyable to the teen, preferably her choice (as long as it is within reason), such as taking a drive to the mall, shooting hoops, playing a video game, and the like. During this limited period of time, **ask no questions, give no directions, make no corrections, give no instructions.** Either make positive comments or neutral descriptive comments. Ignore minor misbehavior. Terminate the activity if the teen becomes disrespectful or violates household rules.

   Alternatively, there will be times when your teen is doing some activity that she enjoys, such as playing a game, building a model, or watching television. Provided her behavior is appropriate, take a minute and go to her to provide some positive attention. When you do this, be sure to be relaxed and casual. Reflect what you think she is doing, such as "It looks like you've go an exciting football game on TV there" or "I see you have started that model car you bought last weekend." Thereafter, look for positive things to say about what the teen is doing, how well she is accomplishing it, or how quiet and well-behaved she is. If you ask questions, do so only for information about what the teen is up to or how she likes what she is doing. Don't ask questions that imply disapproval or criticism, such as "Couldn't you be doing something more useful than watching that boob tube again?" Show interest in what your teen is doing.

2. At times when you are busy and your teen is not bothering you but behaving well, interrupt your activity to go to him and state how much you appreciate his not disturbing you while you work. Done frequently, this will increase the teen's willingness not to

3. Whenever your teenager volunteers to help you do something or performs a helpful task around the home without being told, be sure to acknowledge her help and appreciate her effort. It takes only a few seconds to say, “Thanks for helping out with…” or “I really appreciate it when you…” Although such things may not seem worthwhile to say, done frequently over time they do produce a significant improvement in your working relationship with your teenager. Don’t expect your teenager to show any gratitude for your attention initially, but don’t be discouraged. Your teen has heard you and it will have an effect on her behavior.

4. If you ask your teenager to do something, be sure to take a few moments and immediately praise him for beginning to start the task. Giving such positive attention to compliance will eventually increase it.

5. Whenever you are praising or appreciating your teen’s behavior, do not use sarcasm or back-handed compliments (for example, “It’s about time you cleaned your room”). You may think you are being positive, but you are actually decreasing the odds that she will do this job again for you. Instead, make your statements positive yet accurate. Say precisely what you like about her behavior and even why you like it. Don’t exaggerate your praise, as any teen can sense false flattery.

6. The whole secret to being a good supervisor of another person is learning to be attentive to even the small things that others do for us. Be honest, positive, and accurate in your feedback to others. By noticing the little things your teen does for you, may notice a positive change in your relationship with him and an increase in the teen’s desire to work for you. If your teenager rejects your initial positive statements with sarcasm, coolness, or disrespect, don’t get discouraged. He probably thinks you have an ulterior motive or want something from him. In time, this reaction should pass and he will come to appreciate your attention.

Remember!! Practice these skills every day as often as you can to improve your relationship with your teen!

PARENT HANDOUT FOR STEP 4:
HOW TO GIVE EFFECTIVE COMMANDS

In our work with many behavior-problem teenagers, we have noticed that if parents simply change the way they give commands to their teen, they can often achieve significant improvements in the teen's compliance. When you are about to give a command or instruction to your teen, be sure that you do the following:

1. *Make sure you mean it!* That is, never give a command that you do not intend to see either completed or followed up with a consequence if not completed. When you make a request, plan on backing it up with appropriate consequences, with positive or negative, to show that you mean what you have said.

2. *Do not present the command as a question or favor.* State the command simply, directly, and in a businesslike tone of voice. However, if you truly mean to give the teen a choice, be clear (for example, "Would you like to do your homework?" when what is meant is "Do your homework" is not a legitimate choice).

3. *Do not give too many commands at once.* Many teens with ADHD have trouble with multi-step commands. If a task you want your teen to do is complicated, then break it down into smaller steps and give only one step at a time.

4. *Tell the teen what **to do** rather than what **not to do.*** If you state your request in such a way that it provides the teen with information about what his/her next step should be, he/she will be much more likely to comply.

5. *Avoid competing distractions when giving commands.* A very common mistake that parents make is to try to give instructions while a TV, stereo, or video game is on. Parents cannot expect the teen to pay attention to them when something more entertaining is going on in the room. Either turn off these distractions yourself or tell the teen to turn them off before giving the command.

6. *Be cautious of commands that involve the concept of time.* By definition, teens with ADHD experience an impaired perception of time. If parents make requests such as "Have your room cleaned in one hour" or "You have 15 minutes to get ready for school," the teen will probably need some external time marker such as a digital clock, a timer set to go off, and the like.

If you follow these six guidelines, you will find some improvement in your teen's compliance with your requests. When used with the other methods your therapist will teach you, significant improvements can occur in how well your teen listens and behaves.

PARENT HANDOUT FOR STEP 5: THE HOME POINT SYSTEM

When trying to manage the behavior of a defiant teen, it is common to find that praise is not enough to motivate the teen to do chores, follow rules, or to obey commands. As a result, it is necessary to set up a more powerful program to motivate the teen. One such program that has been very successful with younger teens (ages 12 through 14 or 15 year old) is the home point system. Your therapist will explain in detail how to set up such a program, but her are the steps to follow.

1. Get a notebook, and set it up like a checkbook with five columns, one each for the date, the item, deposits, withdrawals, and the running balance (or actually use a checkbook with only the register portion placed in it). When the teen is rewarded with points, write the job under "item" and enter the amount as a "deposit." Add it to the teen's balance. When the teen "buys" a privilege with his points, not the privilege under "item," place this amount in the withdrawal column, and deduct this amount from the "balance."

2. Make up a list of rewards and privileges. These should include not only occasional special privileges (going to the movies, buying a CD, have a party) but also the everyday privileges the teen takes for granted (TV, video games, use of the telephone, etc.). Your therapist will explain what types of privileges you might include on this list. Be sure to have at least 10, half to two thirds of which should be daily privileges.

3. Now make up a second list that will contain the jobs and chores you often ask the teen to perform. These can be typical household chores such as making the bed, washing dishes, putting dirty laundry in the hamper, or empting the trash. Also, put on the list things like getting dressed for school, being in bed by a certain time, getting up for school on time, brushing teeth, or any other self-help task the teen has trouble with. Your therapist can help you decide what types of jobs to put on this list.

4. Next, take each job or chore and decide how much you feel it is worth in points. Use a range of 100 to 1,000 points, and remember, the harder the job, the more points it is worth.

5. Add up approximately how many points you think your teen will earn in a typical day if he/she does most of these jobs. Then, remembering this number, decide how many points your teen should have to pay for each of the privileges you listed. We generally suggest that one half to two thirds of the teen's daily points should be spent on typical daily privileges. This allows the teen to save about one third of his points every day toward the purchase of some of the very special rewards on the list. Don't worry too much about the exact numbers to use here. Just use your judgment as to how much each reward should cost, be fair, and charge more points for the special rewards and less for the daily ones.

6. Be sure to explain the system to the teen before getting started. If the teen expresses resistance, tell him that the will have a chance to earn bonus points when chores are performed in a prompt and pleasant manner. You will not give these bonus points all the time but should give them when your teen has done a job in an especially pleasant and prompt manner.

7. Be sure to tell the teen that points will only be given for jobs that done on the first request. If you have to repeat a command, the teen will not receive any points for doing it.

Note: **Do not take points away this week for noncompliance with requests on the list.** After 1 week of earning points, your therapist will explain how to use penalties--points that are deducted when the teen does not comply on the first request or when the teen violates a common household rule.

OTHER REMINDERS

- Only parents are to write in the point notebook or checkbook register.
- Review the list of privileges and rewards every week or so and add new ones as you deem necessary. Check with your teen for new rewards he/she may want on the list.
- You can reward your teen with bonus points for almost any form of good behavior.
- The teen must have a sufficient number of points in his/her balance in order to purchase a privilege. No credit card mentality!
- Do not give the points before the teen has done what he was told to do, only afterward. Try to do so immediately.

PARENT HANDOUT FOR STEP 8: GROUNDING

Grounding is the most serious form of punishment used in this program and is reserved for the most significant misbehaviors. Use grounding with only one or two misbehaviors during the first week. Choose those behaviors that are not responding very well to behavioral contracts or the use of penalties.

Warn the teen in advance that if a specific misbehavior occurs, the consequence will be grounding, or "house arrest". This means that for a specified period of time, the teen will have no access to anything that the parents define as a privilege.

Grounding must follow the following guidelines:

1. One or both parents must be in the house to enforce the grounding. This may mean that the grounding is postponed until later in the day or later in the week.

2. The period of the "house arrest" last anywhere from 2-3 hours to no more than 2 full days. The length of time will depend on the seriousness of the misbehavior as well as the availability of one or both parents to enforce the grounding.

3. During "house arrest," the teen may perform an onerous work detail such as washing windows, sweeping out the basement, and so forth. He will not be paid or reward for this job.

4. There may be some items in the house that parents decide are not under their control but truly belong to the teen and which they cannot legitimately withhold from him (for example, a walkman and tapes purchased with the teen's money from a part-time job). This scenario will compromise the effectiveness of grounding and may be justification for using a penalty approach instead.

5. Similarly, an older teen (16, 17, or 18 years old) may have a driver's license and car, and may simply walk out of the house, get into the car, and drive away from grounding. Grounding is not appropriate for teens at this developmental level of maturity, and parents should focus instead on penalties, withholding those valued privileges over which they do have control.

STEP 9: SCHOOL ADVOCACY

Session Outline

- Review and refine implementation of the grounding procedure.
- Review and refine other major aspects of the program to date.
- Discuss concerns related to the teen's school performance.
- Inform parents about where ADHD is covered by law (e.g., the Individuals with Disabilities in Education Act and the Americans with Disabilities Act).

Homework

- Consult with school personnel if necessary.
- Continue previously taught methods.

Discuss with parents all efforts to use grounding this past week. Review the diary they kept for any problems with inappropriate or excessive use of grounding, excessively long groundings, or any parental reluctance to use grounding. Also discuss the teen's reaction to grounding, especially coercion or escalation in hostility. Once again, discuss the possibility that parents may have to call outside authorities such as the police or juvenile court if they feel that the teen's or their own safety is in danger.

Review implantation of the entire program to date. Diagram for parents the components of the program, emphasizing the balance of positive and negative strategies, as well as the absence of physical coercion or yelling (in this program, punishments are things we *take away,* not thing we *inflict upon*):

Positive	*Negative*
Nonjudgmental positive time	Ignoring minor misbehavior
Praise	Giving penalties
Incentives/privileges	Grounding

Be sure to commend any success to date. Refine program implementation as needed. If parents are not using any aspect of the program on a regular basis, get them to clarify what is getting in the way and problem-solve so they may continue.

Review of School-Based Concerns

Give parents the hand on classroom accommodations for improving teen school performance. Describe "reasonable accommodations" in a middle school or high school setting, with examples such as the following:

- The guidance counselor acts as the "coach" in school, checking in with teachers weekly to monitor progress, meeting with teen briefly each morning to review the day's schedule and assist with organization and time management
- The ADHD teen does as much homework as possible in school, preferably in a monitored study hall or a resource room study hall.

- The ADHD teen is allowed two set of text books, the teacher's phone number or e-mail address to contact about assignments, a peer tutor or study buddy to assist with recording of assignments, photocopies of the class syllabus or lecture outlines.
- The ADHD teen is allowed access to technological supports, such as tape recorders for class lectures, calculators, laptop computers for note taking in class, word processor for written assignments, or computerized instructional programs.
- Classroom teachers utilize multi-method instructional strategies, such as an overhead projector with lecture outlines or assignments on it: cooperative group learning; art, music, dance, or dram; hands-on projects; computer products; and props of any sort to stimulate and entertain as well as teach.
- Classroom teachers utilize multi-method assessment procedures, such as allowing the student to give oral responses to test questions, to dictate responses that someone else transcribes, to take an un-timed test, or to take a test in a separate classroom with few distractions and with an adult to make sure he/she doesn't rush through it.

Homework

Have parents stipulate a time for homework to be done each day. The teen will then be rewarded with access to a privilege or points if homework is completed, or a penalty will be imposed if homework is not completed. In addressing homework problems, however, it is critical for parents to be confident that the amount of work the teachers are assigning is reasonable for a student with ADHD.

The therapist might develop a comprehensive behavioral contract to enhance completion of homework. The following example of such a contract for Michael Adams, and adolescent with ADHD, has proven clinically useful (Robin, 1998):

A Home work Contract for Michael Adams

I, Michael Adams, together with my parents, teachers, guidance counselor, and principal, agree to carry out to the best of our ability the following homework plan:

I. Keeping Track of Assignments

A. My teachers will write the assignments on the board every day. They will also give a copy of all the assignments for the week to Mrs. Smith, my guidance counselor, each Monday. She will keep a copy and mail a copy home to my parents.

B. I will write down the assignment from the board every day before I leave each class. I will write it on the back of the section divider for the section o my loose-leaf binder for each class. I will read over what I have written down to make sure I understand it. I will ask the teacher to explain any assignment I do not understand.

C. During my last period study hall, I will read over each assignment that I have written down and make sure I understand what I am being asked to do. I will make a list of all of the materials I needs to bring home and gather them from my locker. My study hall teacher agrees to give me a hall pass during last period to got to my locker and find any material I need.

II. Bringing Home Materials

A. I will bring home all of the materials I have gathered as well as the binder in which I have written my assignments down.

B. My mother agrees to ask me nicely one time without nagging to see my list of assignments. I agree to show it to her without a big hassle or an attitude.

C. During my last period study hall, I will read over each assignment that I have written down and make sure I understand what I am being asked to do. I will make a list of all of the materials I needs to bring home and gather them from my locker. My study hall teacher agrees to give me a hall pass during last period to got to my locker and find any material I need.

III. Schedule and Setting for Doing Homework

A. From Sunday through Thursday, I agree to work on homework from 6:00 p.m. to 8:00 p.m. If I finish early, I will show my completed work to a parent, and if he/she agrees that it is completed, I can do whatever I want.

B. I will do my homework at the big desk in the den. I can listen to soft music with headphones, but no loud rock. If I find myself getting distracted, I will take a short break, do something physical (not using the telephone), and start working again.

C. My mother will remind me once without nagging to start on my homework at 6:00 p.m. I will start without an attitude.

IV. Daily Plan for Organizing Homework Completion

A. With help from my mother, I will make an organized plan for each night's homework. This plan will guide me in which subject I will do first, second, etc. It will also divide up homework time between assignments due tomorrow and long-term assignments. My mother agrees to permit me to determine the order of doing homework.

B. My plan will estimate the time needed to complete each assignment, as well as how I will check each assignment for accuracy, completeness, and legibility.

C. The plan will specify how often I will take breaks during homework time, how long the breaks will be, and how large assignments will be divided into smaller units.

D. The plan will specify where I will put the completed assignments and how I will make sure I turn the work in.

V. Medication. I agree to take a dose of Ritalin at 5:00 p.m., Sunday through Thursday, to help me concentrate on homework.

VI. Turning in Assignments

A. As I finish an assignment, I will put it in the section of my binder for that class.

B. I will do my best to remember to hand in each assignment.

VII. Feedback. My teachers agree to tell me how I did within 2 days after I hand in an assignment. They also agree to send my parents feedback on how many of the last week's assignments were turned in on time, when they send the next week's assignment list. The guidance counselor will collect these materials from the teachers and mail them out.

VIII. Rewards. My parents agree to let me make 20 minutes of long-distance phone call to my girlfriend each night that I do my homework. If I do my homework for vive nights in a row, they agree to let me make 45 minutes of long-distance phone calls on the weekend.

Educational Rights

Discuss the educational rights of children diagnosed with ADHD as outline in the handout "1991 Memorandum from the U.S. Department of Education. The public school student with a disability that impairs his academic functioning is entitled to services via anyone or a combination of three possible mechanisms:

1. An individualized educational plan (IEP) written and implemented by the special education department that addresses both a diagnosed specific learning disability as well as ADHD.
2. And IEP written and implemented by the special education department that addresses only ADHD, which is defined under special education law as a "health impairment."
3. A Section 504 Plan written by the school's coordinator for the Americans with Disabilities Act, to be followed by all regular education teachers working with the child.

Highlight the importance of teachers needing to have proper knowledge and understanding of ADHD as well as administrative support; otherwise, they very likely will not be receptive to incorporating any recommended accommodations. Encourage parents to take an active role in their teen's schooling and work closely and in collaboration with teachers and the guidance counselor. They may also want to investigate local parent support groups or parent advisory committees for specific advice regarding their own school system.

A comprehensive analysis of the education problems of adolescents who are defiant and/or have ADHD goes beyond the scope of this manual, which focuses primarily on home-based problems. However, many of the adolescents participating in this family treatment program will also benefit from such interventions. Readers interested in procedures for addressing additional school-related concerns might consult Market and Greenbaum (1996) or Robin (1998).

Parents should consult with school personnel regarding any proposed changes to the teen's education plan. Address academic homework problems as necessary.

Inform the teen that the will be attending the remaining nine therapy sessions with his parents. Both parents and teen complete the Issues Checklist before the next session.

PARENT HANDOUT FOR STEP 9: ACCOMODATIONS FOR IMPROVING TEEN SCHOOL PERFORMANCE

- Daily School assignment notebook
- A “case coordinator”
- Extra set of books maintained at home
- Additional school/home tutoring needed
- Careful scheduling of classes
- Modified homework load
- Oral rather than written documentation of knowledge
- Large calendars
- Special time and place for homework
- Tape recorder
- Daily/Weekly school conduct card (coordinate with point system)
- Untimed tests
- Study hall in the resource room
- Study buddy to contact for missed assignments
- Preferential seating
- Visual teaching tools
- Photocopies of lecture outlines

PARENT HANDOUT FOR STEP 10:
STEPS TO BETTER PROBLEM SOLVING

1. Define the problem – then stick to it

2. Brain storm: Think of as many possible solutions as you can

3. Evaluate your options

4. Select the option most agreeable to all

5. Implement the plan

6. Evaluate the implementation of the plan

    - Go back to Step 2, if necessary.
    - Go back to Step 1, if necessary.
    - Establish consequences, if necessary.

PARENT HANDOUT FOR STEP 10: PROBLEM-SOLVING EXERCISE

Name_____ **Date**_____

The purpose of this worksheet is to give practice with the steps of problem solving. Write out the answers as best you can. Bring the sheet to your therapist at your next session; the therapist will go over it with you.

I. Defining the problem

A good definition of the problem explains what it is that the other person is doing or saying that bothers you and why it bothers you. The definition is short, neutral, and does not blame the other person. Below are several definitions. Read each one, then say whether it is bad, write down a better definition.

A. **Mother:** My problem is that I don't like to see your room dirty; all the clothes are on the bed and the dust is two inches thick. I'm upset when my friends come to visit and see the room looking that way.

1. Is this a good definition of a room-cleaning problem?
   _____ Yes _____ No
2. If you said No, write a better definition: _____
   _____
   _____
   _____

B. **Daughter:** I hate you, Mom. You just a real pain. I'm missing out on all the fun because you make me come home by 9 p.m. on weekends.

1. Is this a good definition of a coming-home-on-time problem?
   _____ Yes _____ No
2. If you said No, write a better definition: _____
   _____
   _____
   _____

C. **Father:** Son, the real problem with you is that you is that you don't respect your elders. Kids just don't know the meaning of respect today. When I was your age I would never talk to my father the way you talk to me.

1. Is this a good definition of a talking-back problem?
   _____ Yes _____ No
2. If you said No, write a better definition: _____
   _____
   _____

D. **Son:** I get any when you bug me 10 times a day about taking out the trash and feeding the dogs. I'm old enough to do these things without being reminded.
   1. Is this a good definition of a chores problem?
      _____ Yes _____ No
   2. If you said No, write a better definition: _____
      _____
      _____
      _____

E. Below, a mother and a daughter define their problem about playing the stereo too loud. Notice how each accuses and blames the other; this is a poor way to define the problem. Read their definitions, then write a better definition for each person.

   Mother: You are ruining your ears with that loud stereo. You just don't have good taste in music. How can you stand all that loud noise? I can't, and what's more, I *won't* stand for it.

   Daughter: Don't talk to me about taste in music. You sit around all day listening to 1940 junk music. No one listens to that stuff anymore. And get off my back about the loud stereo. I'll play it as loud as I like so I can enjoy my music.

   Better definitions:

   Mother: _____
   _____
   _____
   _____

   Daughter: _____
   _____
   _____
   _____

II. Listing solutions

A. List as many ideas as you can.
B. Be creative and free.
C. Anything goes.
D. Don't say whether ideas are good or bad now – this comes later. Make believe you are trying to solve a telephone problem: A mother is upset because her son talks on the phone 2 hours a night and runs up bills. The son says his friends live too far away to visit on the weekdays; he call the instead. Make a list of 10 ideas to solve this problem. Put down anything you can think of. Try to be creative.

List of solutions:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

If you run out of ideas, here are some hints:

- Is a trade-off possible?
- Can they change anything around the house to help?
- Is a change of place or time possible?
- What about other ways to talk to friends?

III. Picking the best idea: decision making

When you decide on the best idea, you should state the good and bad points of each idea on your list. Then rate each idea "+" or "-". Ask yourself about each idea:

A. Will this idea solve my problem?
B. Will this idea solve the other person's problem?
C. Will this idea really work?
D. Can I live with it?

Consider the telephone problem we discussed above. Make believe one idea was "buy a second telephone."

1. An adolescent might evaluate this as follows: "Well, this idea meets my need to talk to my friends, and my mother get off my back for talking on her phone too much. I'll give it a '+'."
2. A parent might evaluate it as follows: "It is true that this would get my son off my phone, but it would not solve the problem of high bills – we would have to pay for two phones. Now, if my son wants to get a job to pay for the new phone, that's different. As is I rate this '-'."

Now write out evaluations of the first two solutions to the telephone problem from your list on the last page. For each idea write out an evaluation from the parent's side and a second evaluation from the adolescent's side.

Idea 1
Parent's evaluation: _____

Adolescent's evaluation: _____

Idea 2
Parent's evaluation: _____

Adolescent's evaluation: _____

PARENT HANDOUT FOR STEP 13: COMMUNICATION HABITS

Poor	Good
Insults	State the issue
Interrupts	Take turns
Criticizes	Note good and bad
Gets defensive	Calmly disagree
Lectures	Short and straight
Looks away	Make eye contact
Slouches	Sit up straight
Sarcasm	Talk in normal tone
Goes silent	Say what you feel
Denial	Accept responsibility
Commands, orders	Ask nicely
Yells	Use normal tone of voice
Swears	Use emphatic but respectful language
Throw a tantrum	Cool it, count to 10, take a hike

GENERAL PRINCIPLES OF GOOD COMMUNICATION

1. Listen when your teen/parent is in the mood to talk, but don't force him/her to open up.
2. Use active listening to encourage your teen/parent to express opinions and feelings.
3. Honestly express how you feel, good or bad, without being hurtful to your listeners.

PARENT HANDOUT FOR STEP 15: UNREASONABLE BELIEFS CHART

PARENTS

Perfectionism/ obedience

Ruination

Malicious intent

Appreciation/ indulgence

ADOLESCENT

Unfairness/ ruination

Autonomy

Love/ appreciation

Unreasonable beliefs	Reasonable beliefs
I. **Perfection / obedience:** Teens with ADHD should behave perfectly and obey their parents all of the time without question.	I. It is unrealistic to expect teens with ADHD to behave perfectly or obey all of the time; we strive for high standards but accept imperfections.
A. School	
1. He should always complete homework on time.	1. I will encourage him to complete homework all the time but will recognize this won't always happen.
2. She should study 2 hours every night, even when she has no homework.	2. If your attention span is short, you are lucky to get basic homework done. Extra study is just unrealistic. These kids need a break after all the effort it takes to do basic homework.
3. He should always come to class prepared.	3. He will sometimes come to class unprepared, but I will help him learn good organizational techniques.
4. She should do papers for the love of learning.	4. Research shows teens with ADHD need salient, external reinforces to motivate their behavior. *C'est la vie.*
B. Driving	
1. He should never get any speeding tickets.	1. All teens with ADHS get at least one speeding ticket. He should be responsible for paying it and take his medicine while driving.
2. She will never have an accident.	2. Research shows most teens with ADHD will get in at least one minor accident. She should take her medicine when she will be driving, and do her best. She should drive an old car.
3. Teens shouldn't adjust the radio turner while driving down the highway.	3. He should avoid tuning the radio while driving as much as possible, but this may occasionally happen.
4. She will always stop completely for stop signs.	4. I should stop completely at stop signs to model good behavior when my teen is in my car. I can only expect my teen to do as well as I do.

Unreasonable beliefs	Reasonable beliefs
C. Conduct	
1. He should be a perfect angel in church.	1. This is unrealistic. As long as there are no major disturbances, I'm satisfied. Perhaps I should find a youth group service of more interest for him anyway.
2. She will impress all the relatives with her love for family gatherings.	2. Give her space. Teens just don't want to be with their families that much. This is normal. She should attend same family functions, but that is all I can reasonably expect.
3. He should never treat us disrespectfully.	3. You can't become your own person without some rebellion. Some back-talk is natural. He shouldn't curse or ridicule severely, and might be expected to apologize occasionally.
4. She should get out of a bad mood when we tell her to change her attitude.	4. People with ADHD are just moody and can't stop it. She should let us know when she is in a bad mood and keep to herself. We should not make a lot of demands on her at such times.
D. Chores	
1. She should put away the dishes the first time I ask.	1. It won't always happen the first time, but after several reminders, I should act, not yak: apply consequences.
2. He should always get the room spotless.	2. He should get it generally neat. Spotless isn't realistic.
3. She should not waste electricity by leaving the lights on.	3. She is just forgetful. We could work out a reminder system, but this is the least of my worries with a teen ADHD.
4. He shouldn't be on the telephone when I've sent him to clean up his room.	4. Teens with ADHD will get off task; I will redirect him back to the task, and if it happens too much, assume it is defiance and ground him from the telephone.

Unreasonable beliefs	Reasonable beliefs
II. **Ruination:** If I give my teen too much freedom, she will mess up, make bad judgments, get into big trouble, and ruin his/her life.	II. She will sometimes mess up with too much freedom, but this is how teenagers learn responsibility—a bit of freedom and a bit of responsibility. If she backslides, no big deal. I just pull back on the freedom for a while, and then give her another chance.
A. Room incompletely cleaned: he will grow up to be a slovenly, unemployed, aimless welfare case. B. Home late: she will have unprotected sex, get pregnant, dump the baby on us, take drugs, and drink alcohol.	A. The state of his room has little to do with how he turns out when he grows up. B. I have no evidence that she would do all these things. She is just self-centered and focused on having fun. So she will be punished as we agreed for coming home late.
C. Fighting with siblings: He will never learn to get along with others, have friends, have close relationships, or get married. He will end up a loser and be severely depressed or commit suicide.	C. There is no scientific evidence that sibling fighting predicts later satisfaction in relationships. Siblings always fight. They will probably be closer when they grow up.
III. **Malicious intent:** My son misbehaves on purpose to annoy me or to get even with me for restricting him.	III. Most of the time adolescents with ADHD just do things without thinking. They aren't planful enough to connive to upset parent on purpose.
A. Talking disrespectfully: She mouths off on purpose to get even with me for _____. B. Doesn't follow directions: He purposefully doesn't finish mowing the grass just to get me angry. C. Restless behavior: She shuffles her feet and plays with her hair to get on my nerves.	A. Impulsive teenagers just mouth off when frustrated. I'll try not to take it to heart. B. Teens with ADHD are allergic to effort. They don't take the time to plan to upset parents by not doing things. C. Teens with ADHD just can't contain themselves. I'll try not to attach meaning to her restlessness and ignore it.

D. Spending money impulsively: He bought $100 of CDs just to waste our money.

IV. **Appreciation / indulgence:** My teen should appreciate all of the great sacrifices I make. Showing indulgence or buying things for teenager is the best way to show love.

A. Money: What does he mean he wants more allowance? He should be grateful for all the money I spend on him now. Some kids are no so lucky.
B. Gifts: If I give her a large gift, she will then appreciate me and do what I say.
C. Unconditional love: She needs to be loved and accepted no matter what she does or how she act.

D. He probably just saw the CDs and had to have them. Poor delay of gratification is part of ADHD. He won't get any extra money for lunch or gas.

IV. Teens with ADHD are so self-centered they don't easily show appreciation until they grow up and have their own children with ADHD. Indulgence reinforces coercion; it doesn't teach responsibility.

A. He will have to earn more allowance. I'd appreciate a thank you even though I understand he doesn't really think about what I do for him.
B. If I give her a large gift, she may expect large gifts all the time and become spoiled and manipulative.
C. Unconditional acceptance is important, but I don't want to reinforce bad behavior.