A COUNSELLING INTERNSHIP AT THE PSYCHOLOGY DEPARTMENT OF THE JANEWAY CHILD HEALTH CENTRE WITH A STUDY OF THE GROUP THERAPY NEEDS OF PARENTS OF CHILDREN WITH IMPULSIVE AND/OR AGGRESSIVE BEHAVIORAL PROBLEMS

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BY

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A report submitted to the School of Graduate Studies
In partial fulfilment of the requirements for the degree of
Master of Education

Faculty of Education
Memorial University of Newfoundland
December, 1995

St. John's Newfoundland

ISBN 0-612-13954-9

This report is dedicated to my father, Calvin Green,

who always had faith in me.

ABSTRACT

This is a report of an Educational Psychology internship at the Janeway Child Health Centre. The internship was conducted from July 31, to October 27, 1995.

The first section presents a detailed report of the goals and the activities undertaken by the intern to meet these goals. The second section reports on a developmental project studying the group needs of parents of children with impulsive and/or aggressive behaviour problems. This project included a review of the literature, the development of a questionnaire, the interviewing of 8 parents of children with impulsive and aggressive behaviour problems, a discussion of responses to the interview and recommendations for therapists planning to develop parent groups for parents of children with impulsive and/or aggressive behaviour.

TABLE OF CONTENTS

DEDICATION i

ABSTRACT ii

ACKNOWLEDGEMENTS v

LIST OF TABLES vi

INTERNSHIP REPORT

1. Rationale for Internship 1

11. Setting 3

A. Developmental Psychology Service 4

B. Clinical Evaluation and Treatment Services 6

C. Behavioral Therapy Service 7

D. Social Emotional Service 8

111. Duration 9

lV. Supervision 10

V. Goals 13

Vl. Activities Undertaken to Meet the Goals 18

A. Teaching Rounds 19

B. Case Conferences 23

C. Clinics 24

D. Educational and Informational Experiences 28

E. Professional Reading and Discussion 31

F. Assessment and Treatment Preparation 31

G. Observing Individual Therapy Approaches 32

H. Family Therapy 33

I. Administration and Scoring of Tests 38

J. Group Counselling Skills 38

K. Developmental Research-Based Project 39

L. Administration 40

M. Supervision 41

N. Record Keeping 42

O. Conclusion 42

P. A Developmental Project Studying the Group Therapy Needs of Parents of Children with Impulsive and/or Aggressive Behavioral Problems 44

1. Rationale and Purpose 44

2. Literature Review 45

3. Questionnaire 52

4. Sample 52

5. Methodology 54

6. Analysis 54

7. Results 55

8. Discussion 60

9. Recommendations 65

Vll. References 68

APPENDICES 72

A: MUN, Faculty of Education Ethics Committee Approval . 72

B: Janeway, Human Investigations Committee Approval 73

C: Janeway, Psychology Department, Weekly Report 74

D: List of Readings Completed During Internship 75

E: Family Assessment Device 80

F: Questionnaire 81

G: Consent For Referral 86

ACKNOWLEDGEMENTS

I would like to thank Dr. Linda Moxley-Haegert, my field supervisor, for providing me with an internship site second to none in Newfoundland as a learning opportunity for a Master of Educational Psychology intern planning to work as a school guidance counsellor. In particular, I would like to acknowledge her highly skilled, direct, focused manner of supervision.

Dr. Lee Klas started as my professor, became my supervisor, mentor and friend. It was under the direction of Dr. Klas that I coordinated "A Hand Up", a support service program for Memorial University students with learning disabilities. Throughout that year and the years up to the present Dr. Klas always demonstrated confidence in my abilities and judgements. For his professionalism, understanding, wisdom, and kindness I will always be grateful.

Special thanks to my family for their encouragement and unconditional support, especially my husband Craig, our daughters Victoria and Sarah, and my mother Eileen Green.

List of Tables

Table	Title	Page
1	Type and Frequency of Activities Undertaken at the Janeway by the Intern to Further Develop Knowledge and Skills	19
2	Type and Frequency of Activities Undertaken by the Intern to Develop Knowledge, Gain Experience and Build Skills in Family Therapy	34
3	Intentions of Attendance at a Parent Group for Parents of Children with Impulsive and/or Aggressive Behaviour Problems	55
4	Types, Frequency and Location of Children's Problem Behaviours as Rated by Parents of Children with Impulsive and/or Aggressive Behaviour Problems	55
5	What Happens When Problem Behaviours Occur in School as Rated by Parents of Children with Impulsive and/or Aggressive Behaviour Problems	56
6	Discipline at Home as Rated by Parents of Children with Impulsive and/or Aggressive Behaviour Problems	56
7	Types of Behaviour Techniques of Which Parents are Aware and Which Parents Have Tried with Their Children who Have Impulsive and/or Aggressive Behaviour Problems	57
8	Success with Behaviour Techniques Tried and the Willingness to Try New Techniques as Rated by Parents of Children with Impulsive and/or Aggressive Behaviour Problems	57
9	Behaviours for Which Parents of Impulsive and/or Aggressive Children Feel They Need Behavioral Techniques	58
10	What Parents of Children with Impulsive and/or Aggressive Behaviour Problems Would Like a Parent Group to Offer Them	58
11	How Parents of Children with Impulsive and/or Aggressive Problems Feel They Would Benefit by Participating in a Parent Group	59
12	Parents' Willingness to Participate in a Parent Group for Parents of Children with Impulsive and/or Aggressive Behaviour Problems	59

INTERNSHIP REPORT

Rationale For Internship

To graduate, students in the Master's Degree Program in Educational Psychology at Memorial University are provided with a choice of degree completion requirements; they may do either a thesis, project or an internship. Originally, this student opted for the thesis route. However, upon reflection on the gains already achieved from working on a partially completed thesis (for which literature had been reviewed and one year of work was completed as Program Coordinator for "A Hand Up", a support services program for Memorial University students with learning disabilities) the student felt that sufficient awareness and knowledge of and experience with learning disabilities had already been obtained. The writer determined that engaging in an internship would provide a more valuable and pertinent learning experience and would significantly add to her current counselling awareness and skills. The internship would provide an enhancement and/or development of skills in individual and group counselling, family therapy, assessment, and consultation and liaison, all of which are directly related and transferable to her current position as a School Guidance Counsellor/Educational Therapist. The Janeway Child Health Centre (hereafter, referred to as the Janeway) was chosen as the internship site.

The intern is presently employed in the dual role of School Guidance Counsellor/Educational Therapist in two urban schools, working with children with varied difficulties which often result in referrals made to the Janeway. Referrals to the Janeway are now sent to a centralized intake co-ordinator for various services, and may be made for assessment or enrolment in ongoing programs. These programs may involve personnel from the following departments or services: Psychology, Psychiatry, Audiology, the Thomas Anderson Centre, and the Learning Behaviour Clinic. (These have been the ones most commonly utilized by the school systems.)

The intern had enjoyed her work as a School Guidance Counsellor/Educational Therapist and taken great pride in it. She had set high standards to maintain and felt that the internship would increase her knowledge and awareness of services provided by the Janeway, the community and elsewhere, as well as strengthen and broaden her counselling skills. The internship would build on existing skills and develop new ones, thus enabling the intern to provide better services upon return to her dual role job.

A counselling internship is required to be a thirteen week, full-time placement at an approved setting. Supervision is provided by two persons, a field supervisor at the internship site and a university supervisor. Education and guidance services are fields of great change. Increasing demands for working with a variety of problem situations,

scenarios, and attitudes mean that professionals must continuously enhance existing skills and develop new skills vital to providing the best possible services.

Setting

The following criteria, stated in the Department of Educational Psychology Paper on the Internship Programme (1975), were considered in the selection of the internship setting.

1. The quality of professional supervision.
2. The quality of learning opportunities and experiences.
3. The relevancy to and usefulness of such experiences in the actual setting in which the intern ultimately expects to work.
4. The availability of time from full-time involvement of the intern for a minimum of thirteen consecutive weeks.
5. Availability of a qualified field supervisor on-site.
6. Ready access to the university supervisor. (p. 2)

The Department of Educational Psychology Paper on the Internship Programme (1975) states "The intern should work with a variety of clients appropriate to her eventual employment under conditions that protect the interest of the counselee as well as contribute to the competence of the

intern" (p. 2). The student has already achieved employment and will be returning to a setting which is highly related to and often dependent on the services offered by the Janeway. Ethical regulations protect the interest of the counselee. It is also important to recognize that the Janeway provided placement, supervision and clientele for the intern. These clientele supposedly benefited from the interaction with and services provided by the intern. The Janeway also benefited by having the intern as a full-time staff person. In addition, the intern researched and developed recommendations on the nature and type of needs of parents with children with impulsive and/or aggressive behavioral problems; it is intended that such data will be used by the Janeway to develop group therapy programs for these parents.

The Program Description Guide (December, 1994) of The Janeway Psychology Department describes the following services:

Developmental Psychology Service

> Developmental psychology is the branch of science which is concerned with the origin and change in physical, mental and social functioning that occurs through the life span.
>
> On occasion, a young child does not progress along the expected pathway of development or he/she does not progress at the expected rate of development. These observed changes in either the rate or pattern of

development progression may be due to either genetic and/or congenital factors. The aim of the Developmental Service in Psychology at the Janeway is to assess the present developmental status of young infants or children who are suspected of exhibiting a slower rate of development or a pattern of development that is different than might be expected. Upon diagnosis of a significant delay, appropriate stimulation activities can be formulated with the aim to reduce or delay or change the existing pattern of behaviour and counselling with the family may be implemented at this time. Counselling may be in the form of parent groups, family therapy, behaviour modification programs, or consultation with the preschools or a variety of other ways. Most referrals for this program in psychology will come through the Child Development Program.

As well, at this moment in time this service will apply to those preschool children who would fall under neuropsychology, which is the branch of psychology concerned with the study of brain-behaviour or relationship. Clinical psychologists in this area generally assess adaptive abilities. The primary purpose of neuropsychology would be to provide a comprehensive description of a child's ability and to relate this information to brain function, when this information is used to help plan programs for the home.

Referrals for preschool neuropsychology are appropriate in the following circumstances:

a. Where there is known or suspected neuropathology (epilepsy, head injury, CNS infections, congenital neuroanatomical malfunctions).

b. Where there has been a recent marked alteration in performance personality, or other aspects of adaptive functioning suggesting possible CNS involvement.

c. Congenital syndromes associated with psychological or behaviour outcomes (ie, PKU, William's Syndrome, Turner's Syndrome).

Clinical Evaluation and Treatment Services

This service is responsible for general evaluation and program planning for children 5-16 years of age. This evaluation may be in terms of intelligence, school achievement, language skills, visual-spatial motor skills, personality factors, adaptive behaviours and organizational capacities. Based on the results of the assessment, specific recommendations are made to school and home.

Children aged 5-16 may be experiencing some significant problem in adaption academically, socially or both.

It is only appropriate to refer a child for a psychoeducational assessment in cases where:

a. The child has had an assessment and a second opinion is felt necessary (a retest interval of at least 6 months is requested).

b. When assessment is necessary as pre-operative and post-operative evaluation or pre and post-therapy.

Behaviour Therapy Service

Behaviour therapy involves primarily the application of learning principles to everyday problems. It is assumed that most of the actions people perform are learned and that learning principles can be effective in changing what people do. Research has shown that behaviour therapy has proven applications in child and adolescent disorders. Using behaviour therapy methods, the psychologist sets specific treatment goals which are intended to expand the parents' and/or child's skills and abilities.

Treatment can include individual work with the children, and almost always parent counselling.

Typical areas of service from behaviour therapy are:

* Chronic behavioral or medical conditions
* Non-compliance to medical procedures
* Eating disturbances
* Exceptional children
* Pain management
* Toilet training
* Encopresis

* Enuresis
* Social skills training
* Sleep disturbances management
* Stress management
* Behaviour problems in hospital or at home
* Consultation to hospital staff and community agencies

In order to refer to Behaviour Therapy there must be a reasonable basis to assume that the presenting problems have a behavioral component or, alternatively, there is a need, as part of the multi-discipline investigation, to examine possible behavioral contributions to complex symptomatology.

In terms of outpatients, the feasibility of using local resources should be examined in all cases.

Social Emotional Service

This service would include psychodiagnostic assessment, consultation, therapy and counselling for children and adolescents presenting with social, personality and emotional problems and for the families of these children. Such problems would include reactions to parental separation and divorce, bereavement, depression, social skills difficulties, family dysfunction, anxiety coping with chronic disease, post traumatic stress and gender identity issues.

The form of therapy may be individual psychotherapy or family therapy. Some child groups currently are

Social Skills Groups, Large Psychotherapy Group IC, Relaxation Group IC. In other cases the problem with success in therapy is much more simple in that the family and/or client does not have the knowledge to cope with a certain condition. Under those conditions these families should be referred to educational counselling.

Three forms of parent groups are currently being organized in psychology, which include:

1. Group for single parents of hard to control children.
2. Training group for parents of children diagnosed with Attention Deficit Hyperactivity Disorder.
3. Child Management Skill Training Program. (p. 1-4)

Duration

The internship commenced on Monday July 31, 1995 and continued for thirteen consecutive weeks, ending on October 28, 1995. For five days a week the student worked at the internship setting. One day a week was originally designated to work on research and complete reports for the Janeway, but due to the activities scheduled and learning opportunities available, the intern deemed it more valuable to be on site for the full five days each week.

Supervision

All proposed activities for the internship were submitted to Memorial University's Faculty of Education Ethics Committee and the Janeway Child Health Centre Human Investigation Committee and were granted approval. Copies of the letters of approval of both Memorial University's Faculty of Education Ethics Committee and the Janeway Child Health Centre Human Investigations Committee are provided in Appendices A and B respectively. Dr. Lee Klas was the academic supervisor from the Faculty of Education (Division of Educational Psychology) at Memorial University. Periodically Dr. Klas and the intern met and consulted to monitor the intern's progress. Dr. Linda Moxley-Haegert, Director of Psychology at the Janeway, was the field supervisor. Three joint meetings at the beginning, mid point and the end of the internship were held with the intern, Dr. Klas and Dr. Moxley-Haegert present.

Dr. Linda Moxley-Haegert was the field supervisor and the person with whom the intern worked most closely. Dr. Moxley-Haegert and the intern met for one scheduled hour weekly to review the intern's progress and address concerns. In addition, the intern met with Dr. Moxley-Haegert, when necessary, at unscheduled times. The intern also had the opportunity to work with three other full-time psychologists and five part-time psychologists. The psychology staff's clinical responsibilities, as stated in The Program Description Guide (December, 1994), are as follows:

L. Moxley-Haegert - Director

Family Program, Preschool and Adolescent Program

Diabetic Team
Oncology Crisis Intervention
Neurology Team
Family Therapy referrals
Preschool Referrals
Outpatient referrals
Social Skills and Parenting Group

S. Manocha

Preschool and School Age Programs
Cystic Fibrosis Clinic
Asthmatic Clinic
Psychiatry Referrals from Dr. Bowering
Referrals for children with Attention Deficit Disorders
Outpatient Referrals
ADD Parent Groups
Social Skills and Parenting Group

S. Downey

Learning Behaviour and Adolescent Programs

Learning/Behaviour Clinic
Down's and Dysmorphic Clinic
Psychiatry referrals from Dr. White
Referrals for Sleep Disorders, Anxiety,
Pain and Anger Management
Outpatient Referrals
Burn Treatment Management
Chronic Pain Treatment (to be developed)
Prevention Education

J. Lee

Co-ordinator of Preschool, Family and Adolescent Programs
Communication/Development Clinic
Out Patient Referrals
Behaviour Therapy Services
Social Emotional Services
Psychiatry Referrals from Dr. St. John
Adolescent Survivors of Sexual Abuse
ADD Parent Group/Social Skills

A. Wareham

Psychiatry Program

Day Treatment and Psychiatry In-patient Referrals

H. Dalziel

Intake Co-ordinator, Family Program

Community Mental Health Referrals
Co-ordinator of programs from the Thomas Anderson Centre

L. McDonald

Neuropsychology Referrals
Community Mental Health Referrals

D. Coady

Brief Interventionist, Co-ordinator Child Abuse Program
Child Protection - 1/2 time
Social Emotional Therapy - 1/2 time

N. Ornbolt

Psychiatry Community School Age Referrals
Community Mental Health School Age Referrals

C. Clancy

Pre-school Program
Community Mental Health Referrals

C. Arlett

Community Mental Health Referrals
Co-ordinator of School Age Programs

As can be seen, the psychologists provide a very comprehensive set of services and work closely together on a number of their responsibilities. This has been an excellent integrative model for the intern to learn under.

Goals

The Department of Educational Psychology Paper on the Internship Programme (1975) states the goals required of the internship in meeting departmental regulations and standards. These goals are as follows:

1. For the development of competencies for each trainee based on her needs, previous experiences, and future vocational plans.
2. For practical experiences that will bring into focus the theoretical training received during the formal part of the program.
3. For practical experiences that will enable the trainee and the department to evaluate the trainee's ability to effectively work in his chosen field.
4. Opportunities for the trainee to evaluate her personal behaviour modalities and work toward making any necessary changes.
5. For feedback from the internship setting to the department regarding strengths and weaknesses of its students so that program improvements can be implemented.
6. For the development of research and problem-solving skills appropriate to the needs of the student and the setting, considering the nature of her placement and her vocational plans. (p. 2)

The Departmental goals meet the needs of various interns

in varied settings. These goals give an overview and a framework upon which to build. In addition, the intern had goals, both general and specific, which related particularly to her setting and the practical experiences to which she hoped to be exposed and in which she hoped to be involved.

The intern's two general goals were:

1. Through observation, interaction, facilitation, co-leading, leading, supervision and discussion to improve her current counselling skills and behavioral management techniques and, as well, to gain new knowledge, counselling skills and behavioral management techniques.
2. Upon completion of the internship, the intern will provide the Janeway with research based information and recommendations on program development pertaining to the needs of parents of children with impulsive and/or aggressive behaviour problems. These data and recommendations will then be used by the Janeway staff in the development of a program of parent group therapy for parents of children with impulsive and/or aggressive behaviour problems.

The intern had ten specific goals which were based on the goals of the department, with the underlying themes of her own two general goals. These specific goals were as follows:

1. To develop an awareness and understanding of the philosophy and theoretical basis from which the Janeway

operates.

2. To become familiar with the role of the psychologist in the Janeway, more specifically the function of the psychologists in the Thomas Andersen Centre, Learning Behaviour Clinic, Psychology and Psychiatry departments.
3. To gain knowledge of various psychotherapies from a number of psychologists in this medical setting.
4. To become aware of the full therapeutic process, from intake, to therapy, to termination.
5. To become familiar with the services and operations of the Thomas Andersen Centre, Learning Behaviour Clinic and the Psychology and Psychiatry departments and to find out how they are inter-related, the function of each and how they work together. To become fully aware of how the new referral system works.
6. To develop knowledge of and skills in family therapy techniques. This knowledge and skill will be developed through reading, discussion with field and academic supervisors, observation, co-therapy, providing therapy and directed supervision during and after therapy sessions.
7. To enhance group counselling skills. A variety of groups at a variety of age levels are run at the Janeway. Group counselling skills will be enhanced through reading, discussion with other personnel and psychologists who are conducting groups, observation, co-leading, and the

research project component.

8. To enhance individual psychotherapy and counselling skills. This will be achieved by reading, discussion with various psychologists regarding a variety of approaches, and observation and supervision during the actual process of therapy.

9. To conduct a research component. To research and study the group therapy needs of parents with children exhibiting impulsive and/or aggressive behavioral problems. This goal will be addressed through the following processes:

    a. Becoming familiar with parent and child group programs offered at the Janeway.

    b. Thoroughly reviewing the literature on the nature and types of needs shown/reported by parents of children with impulsive and aggressive behaviour and impulsive and on techniques of aggressive behaviour management; reviewing the literature on group therapy approaches and programs for these parents.

    c. Obtaining a list of potential parent participants to interview from the Janeway by approaching Janeway therapists to explain the nature of the interview and asking each therapist to contact his/her own clients who fit the intern's criteria.

d. Devising a parent questionnaire to follow when interviewing parents.

e. Interviewing several parents with children exhibiting impulsive and/or aggressive behaviour problems to discover what they feel they would like to be provided in a parent group.

f. Analyzing information and data gained from the parent interviews and questionnaires.

g. Based on a review of the current parent group counselling programs conducted at the Janeway, the literature review and the data gathered from interviews and questionnaires, identify the needs of parents with children with impulsive and/or aggressive behaviour problems.

h. Leave the Janeway Child Health Centre with a report documenting the parent needs for parents of children with aggressive and impulsive behaviour problems, along with recommendations for developing a group therapy program.

10. To avail of the opportunities to attend information sessions, workshops, clinics, conferences or tele-conferences on any topic relevant to the intern's professional growth.

Activities Undertaken To Meet The Goals

The intern is very pleased to report that she did meet all of her stated goals and even some additional goals which were not formally expressed. These goals were met through the variety of activities which are shown in Table 1.

The intern was required to record all activities and the amount of time spent at each activity, the same as is required of all psychologists at the Janeway. The log was submitted weekly to the Psychology Department secretary, who calculated the various statistics. These statistical analyses provide the Director with valuable information on the functioning of psychologists individually and as a Department. A copy of the weekly log is provided in Appendix C.

Table 1 lists the activities and frequency of activities, measured in hours, that the intern actually carried out at the Janeway. These hours were mainly accumulated during the thirteen week placement, but some additional hours were added at the end of the thirteen consecutive weeks and on weekends throughout the internship. Some components of the activity "assessment and treatment preparation" were possible to accomplish off-site, but all other activities were done directly on site.

A further description of each of the activities in Table 1 follows.

Table 1

Type and Frequency of Activities Undertaken at the Janeway by the Intern to Further Develop Knowledge and Skills

Activity	Frequency (Hours)
Teaching Rounds	26.25
Case Conferences	5.75
Clinics	32.50
Educational and Informational Experiences	63.50
Professional Reading and Discussion	N/A
Assessment and Treatment Preparation	133.50
Observing Various Individual Therapy Approaches	3.25
Family Therapy	52.50
Administration and Scoring Tests	5.00
Group Counselling Skills	8.75
Research	34.00
Administration	34.00
Supervision	15.00
Records	65.00

Teaching Rounds

The intern attended both teaching rounds and case conferences at the hospital in the Department of Child & Adolescent Psychiatry. Teaching rounds and case conferences present inpatients of the psychiatric ward of the hospital. The Policy and Procedure Manual (1994) of the Janeway Psychiatry Department states the following policy regarding

admission for these patients:

> Admission to the inpatient unit may be undertaken following outpatient assessment for further assessment or treatment if the following criteria are met:
>
> 1. The young person has not reached sixteen. Occasionally older patients may be admitted at the discretion of the attending physician.
> 2. If a bed is available. The ward has a maximum capacity of 13, but the functional capacity may be less.
> 3. The child/adolescent is believed to suffer from a psychiatric disorder which requires further assessment or acute treatment.
>
> In extraordinary cases inpatient admission may proceed outpatient assessment - usually for geographical reasons. (p. 2)

Patients with the following diagnoses reside on Ward 1C-Psychiatry: Attention Deficit Disorder; Attention Deficit Disorder with Developmental Delay; Attention Deficit Disorder with Conduct Disorder; Major Depression; Bipolar Disorder (Manic); Bipolar Depression (Mixed State); Separation Anxiety; Conduct Disorder; Adjustment Disorder with Depression; Adjustment with Disorder of Conduct; Post Traumatic Stress Disorder; Schizophrenia; Anorexia Nervosa; Bulimia; Autism; Pervasive Developmental Disorder; Developmental Delay (Mild); Developmental Delay (Moderate); Developmental Delay (Severe);

Alcohol Abuse; Drug Abuse; Tourettes Syndrome; Learning Disability (Dyslexia); Learning Disability (Dyscalculia); Learning Disability (Other); Speech & Language Disorder; and Obsessive Compulsive Disorder (Orientation Handbook, 1993). A patient may receive one or more of these diagnoses.

Teaching rounds were conducted weekly on Thursday mornings starting at 8:30 and usually continuing until 12:00 p.m. All professionals working with the patient attended, including psychiatrists, residents in psychiatry, psychologists, social workers, nurses, teachers (from the Janeway School), and dieticians. Residents presented a case history of each inpatient on the psychiatry ward. This was a very thorough presentation, which included the following for each patient: mode of referral; informants; the presenting problem; current physical and emotional state; medical history; personal history; premorbid personality; family history; descriptive formulation; and diagnosis (Orientation Handbook 1993, p.1-3).

At the first teaching rounds after a new admittance, a new patient was presented in a very thorough manner. Each following week the patient was presented on more of an update basis. Each professional working with the child presented any pertinent information held on the patient and, where appropriate, provided input into developing a plan of therapy for the patient. All professionals provided input on each case, even if they were not working directly with the patient

or the patient was not on their caseload. The intern was occasionally asked about how a school could help or what she could do to help a patient in a particular scenario. Each week there was an update and monitoring of ongoing services for each patient and a decision was made for continuation plans.

The Teaching Rounds presented a golden learning opportunity for the intern; they additionally provided permission to see and talk with children with various psychiatric and other problems, instead of just reading about them. It enabled the intern to understand the child from admission through to discharge and all the therapy and services included in that process. It highlighted the symptoms the children were experiencing and demonstrated the differences in symptoms in comparison to another with the same diagnosis.

In many cases, graduate candidates in Educational Psychology do not have the opportunity to work directly with children with such psychiatric disorders. They are limited to reading. Reading is good, and provides much knowledge on psychiatric disorders, but actually coming face-to-face with the children and observing their behaviour is a much more inclusive learning experience. Guidance counsellors working in the school system have children with such disorders in their schools. The experience of Teaching Rounds was invaluable to the intern.

Case Conferences

Case conferences were held three times per month on Wednesday mornings, usually from 9:30 to 11:00. The intern attended three case conferences. All professionals providing services to the patient attend the case conference. Parents, foster parents, other appropriate relatives, social workers from outside the hospital (with child protection services, financial assistance, etc.), school board personnel and/or school personnel may also attend. Any person that will be providing services for the patient is usually in attendance.

The resident in psychiatry presents. The outline followed by the resident in presenting at case conferences, as stated in the Orientation Handbook (1993), is as follows:

1. Names of those present and their position
2. Brief history in 2-3 lines
3. Investigations in hospital
4. Psychological testing
5. Course in hospital: to include: behaviour on the ward, at school, on outings, etc.;parental interactions, etc.
6. Treatment: meds., progress, interventions, etc.
7. Plans: discharge, follow-up, meds.
8. Copy: to referring physician and/or school authorities and/or Department of Social Services, whenever necessary.

Case conferences are the follow up plan of services for a patient who is being discharged. By attending case conferences the intern confirmed and renewed her belief in

networking on the part of all persons working with or providing services for a child and being aware of the entire picture of that child's life. Such networking ensures that people know who is responsible for what services and helps to avoid duplication of or gaps in services.

Clinics

The Child Development Programme is a department of the Janeway. This department is composed of various professionals and linked with other departments within the hospital and services within the province. The Child Development Programme (March, 1989) of the Janeway Child Development Programme Department states:

> The Child Development Programme is an interdisciplinary service staffed by developmental physicians, nurse coordinator, social workers, psychologist, and clerical staff. Close interdepartmental links are maintained with other hospital departments, such as Speech-Language Pathology, Neurology, Audiology, Genetics, etc.

Interagency links are maintained with Public Health Nursing across the province, Direct Home Services Program, Provincial Perinatal Programme and Children's Rehabilitation Program, to name but a few. (p. 1)

This department provides services to the hospital and community through five clinics: Communication/Development Clinic, Cleft Palate and Craniofacial Clinic, Down's and Dysmorphic Syndromes Clinic, Learning/Behaviour Clinic and

Family Clinic. The Child Development Programme (March, 1989) of the Janeway Child Development Program Department states:

> This programme provides service to the hospital and the community in various ways. Inpatient hospital consultation are done on developmental issues spanning the range of childhood. Programme staff also serve as consultants on child development issues throughout the hospital. Other direct service is provided through the five clinics of the programme. All referrals come through our intake procedure and are slotted to the various clinics as appropriate. (p. 1)

The intern attended the Learning/Behaviour Clinic regularly on Wednesday afternoons from 1:00 to 4:30. She attended the Communication/Development Clinic for one patient case. The Learning/Behaviour Clinic is from where the intern, as a school guidance counsellor, had received most of her correspondence and had the most contact with at the Janeway. Many children are referred to the Learning/Behaviour Clinic by their parents, school guidance counsellors or educational psychologists. The intern wanted to gain a thorough working knowledge of the Learning/Behaviour Clinic for future referrals and consultations with the Learning/Behaviour Clinic. A perk for the intern, besides learning how the clinic operates, is having met and worked with the team members; this should facilitate even better communication with the clinic in the future.

The intern started as an observer and progressed to do follow up visits on her own at the Learning/Behaviour Clinic. She attended sessions with different members of the team, including pediatricians, social worker, special services teacher and the psychologist. A variety of cases and concerns were seen, including learning disabilities and attention deficit disorders of various types. Children's environments were compared and their abilities were assessed in each of these environments. Three environments which usually were monitored were home, school and peer groups. The information provided about a child in each of these environments, coupled with assessment results, is vital in the diagnosing process. Following is the purpose of the Learning/Behaviour Clinic, as stated in the Policy and Procedure Manual (1994), Department of Child Development Programme:

> The Learning/Behaviour Clinic will act to provide school-age children with appropriate assessment and/or management for difficulties related to academic and behavioral functioning. Such difficulties may be evident in the classroom environment or may persist at home. Focus of the Learning/Behaviour will be on understanding and management of learning and behaviour difficulties. (p. 1)

Although most of the school correspondence is with the Learning/Behaviour Clinic, many children with developmental delays are also referred to the Janeway by parents. The Child

Development Program (March, 1989) of the Janeway Department of Child Development states:

> The Communication/Development Clinic is the oldest and largest clinic, having begun in 1968. It serves children zero to six years of age with developmental delay, speech-language concerns,hearing impairment, and various other developmental disabilities. (p. 1)

In the last three years there seems to be more children in schools exhibiting pervasive developmental delay symptomatology. The intern wanted to gain more knowledge in the process of diagnosis, signs, symptomatology and the support services necessary for these children. The intern did get the opportunity to observe and attend one case. The identified child exhibited a developmental concern and the family was seen as a small group by the pediatrician, social worker, pediatrician resident and the psychology intern. The family was also seen by a psychologist and speech-language pathologist. The group meeting continued for one hour and a half. After the family meeting, there was a meeting of all professionals involved with the child, including reports by other professionals who could not attend. A thorough discussion led to a decision regarding diagnosis, a follow-up plan of services necessary, and how these services could be provided. The original small group of professionals, including the intern, met again with the family to present their findings and discuss any concerns or questions that the

family communicated. The developmental concern in this case was a queried pervasive developmental delay, and a diagnosis was withheld pending progress in further development of the child; there was no necessity for a diagnosis at that time.

Educational and Informational Experiences

The intern had formal meetings with all of the psychologists on staff to discuss their roles and the specific components of their positions. This, coupled with observation and working on teams with the psychologists, provided the intern with specifics on the roles of these psychologists from different perspectives.

Discussion with psychiatrists, residents in psychiatry, pediatricians, social workers, teachers, physiotherapist, nurses, audiologists, technicians operating various equipment and doing various procedures, and secretarial staff all provided the intern with valuable information on therapy, institutional procedures and the philosophy of the Janeway.

Although teaching rounds and case conferences were already addressed, it is important to note that they also were highly educational and informative. Practically all of the activities of the internship were for educational purposes, but this section is provided to highlight the special educational opportunities which were not routine, such as attendance at rounds, and do not appropriately fit under other topics.

Hospital orientation provided a wider perspective on the

total operation of the Janeway. Many school children have to stay at the Janeway for various psychiatric and medical reasons. It is effective if the school guidance counsellor can speak to children about the Janeway prior to admittance and after discharge, upon their return to school. This provides a real connection for the child, when the guidance counsellor can knowingly speak of specific aspects of the hospital which the child may have encountered or may be encountering. It provides a stronger basis upon which to build rapport and a trusting relationship.

The intern met with the Director, the psychologist and the teacher of the Children's Rehabilitation Centre. Again, many school children avail of the services provided at the Children's Rehabilitation Centre. The school guidance counsellor has correspondence with the staff there, who provide services to children in the schools. It was good to actually see and talk with these people and gain a better understanding of the services they are providing to school children.

Any school guidance counsellor's internship at the Janeway would not be complete without a tour and thorough understanding of how the Janeway school operates. The intern met with the school principal, visited the school sites and met with the teachers of psychiatry patients. These teachers may or may not see the patient in a school setting. This school setting is not the same as for a student in a regular

school classroom, but it did provide an opportunity to see many of the abilities of the students. Students are often provided bedside teaching. These teachers are a valuable contact for guidance counsellors who wish to gain information regarding a child admitted to the Janeway.

The intern also attended several presentations. One was at Memorial University, sponsored by the Psychology Department, by Dr. Linda Siegal on the "Myths and Realities of Learning Disabilities". Several presentations were made at the Psychology Department of the Janeway. Paul Ludlow of the Department of Social Services presented an intensive intervention program for adolescents which he is coordinating. Dr. Elizabeth Woods, of the Division of Adolescent/Young Adult Medicine Children's Hospital, Boston, presented on "Interviewing and Confidentiality for Adolescent Patients" at the Psychology Department. She also met for an informal discussion of psychiatry cases at the psychiatry department. The intern was pleased to be able to attend and hear Dr. Woods these two times on two different topics. She had much experience and education to pass on in a clear and easy to understand and follow manner. The intern also attended a meeting of all psychologists in the St. John's health care system. It was very interesting to hear their concerns and the possible changes for psychologists working in St.John's.

The intern accompanied a child, with parental consent, to the Audiology Department for several audiology tests. This is

a department where the school guidance counsellor may need to refer a student for hearing and language related testing. The audiologist, Tim Lushington, explained each test and gave the intern a great deal of information about his work, the types of tests administered, and the information gained on a child from a visit to the Audiology Department for testing.

Professional Reading and Discussion

The intern did a great deal of professional reading prior to the commencement of and during the internship. Much reading was done on family therapy, which was one area on which the intern focused. Much reading was also done on parent training, anger and aggression and programming for parents and their children with impulse and aggressive behaviour problems. Appendix D provides a list of readings completed during the internship.

Throughout the internship the intern had opportunity for informal discussions on a variety of topics and counselling issues with both psychologists and social workers. These informal discussions during lunch or in a more relaxed setting than in administrative meetings provided the intern with the opportunity to ask questions and gain opinions more freely.

Assessment and Treatment Preparation

Assessment and treatment time included a variety of activities, the main activity being preparation for therapy sessions. There was time spent with the team in preparation for family therapy or time alone reading on the particular

focus of a family's problems or issues. Time was then taken to review a case and its issues and to decide on a plan for the next session.

This also included time spent getting familiar with tests which were necessary to administer and getting the appropriate consent forms ready for therapy. There are different consent forms for the different requests made of clients. Some of these forms include: consent for video-taping, consent for audio-taping, consent for observation by an intern, consent for observation through the one-way mirror, consent to consult, consent for referral and consent to release information. It also included any calls which were made regarding clients, for example calls to schools and doctors.

Sometimes after a session, either with the team or as an individual, a note reiterating the focal points presented in the therapy session would be composed and mailed out to the client or family. This note would be composed during the assessment and treatment preparation time.

Observing Individual Therapy Approaches

The intern's graduate courses in educational psychology and her work experience has provided her with much knowledge and experience in individual counselling. However, the intern did arrange to observe psychologists in individual therapy; the intern observed individual counselling by psychologist Scott Downey at the Learning/Behaviour Clinic and two sessions of brief therapy with psychologist Doreen Coady. The sessions

included adolescents presenting with phobias and suicidal tendencies. The intern also observed one-half session of play therapy with psychologist Chris Clancy.

These experiences gave the intern the opportunity to see how different therapists work. Their philosophy, techniques and levels of experience all influenced their styles of counselling. The intern also had an opportunity to observe other psychologists' and social workers' counselling styles in the family programme and single-session therapy. It is always helpful to observe others' counselling styles and techniques. Opportunity for such observation do not often occur in the school setting, where there is usually only one guidance counsellor in each school.

Family Therapy

A variety of activities in which the intern participated provided the opportunity to develop knowledge, gain experience and build skills in family therapy. These activities and their frequency represented in hours are presented in Table 2.

The intern had very limited knowledge and experience in family therapy and felt she needed to start with the basic historical development of family therapy and proceed through to the current philosophies and therapies in use. The book Family Therapy is the text used at Memorial University for the course in family therapy. It is current, systematically organized, well written and provided an excellent introduction to family therapy.

Dr. Moxley-Haegert has taught the family therapy course at Memorial and used the text herself. She was very familiar with the text, which proved useful in discussion and reference to specific concerns the intern presented.

Table 2

Type and Frequency of Activities Undertaken by the Intern to Develop Knowledge, Gain Experience and Build Skills in Family Therapy

Activity	Frequency (Hours)
Reading and Discussion with Dr.Moxley-Haegert of the Text Book Family System Therapy (Becvar & Becvar, 1993)	N/A
Observed Single Session Family Therapy	3.00
Observed Family Therapy - one way mirror	6.50
Co-therapist with Dr. Moxley-Haegert	20.75
Primary Therapist Supervised by Dr. Moxley-Haegert	15.75
Administration and Scoring of Family Assessment Device	N/A
Read Articles on Family Therapy	N/A

The psychologists in the family therapy programme read articles and discussed how to provide single-session therapy. The intern also took part in these exercises and observed as the psychologists offered single-session therapy for the first time to two families. In single-session therapy, the families were informed when they were first contacted that they would be receiving single-session therapy and to have in mind the issues they would like to deal with. They were told that they

could remain on the waiting list for family therapy even if they participated in the single-session therapy. Two therapists met with the family, while the other members of the team viewed the session in another room on a television screen. One of the people viewing the family was appointed the spokesperson. The family met with the two therapists, then went out to the waiting room while the spokesperson went in and talked with the therapist to pass on insights which he/she had picked up and some possible issues to focus on, particularly strengths. The family returned, and the therapists informed the family of the information passed on by the spokesperson.

The family program staff also met as a team to see special families that had been specifically identified for the team approach. The intern observed and was a part of the reflecting team for five family sessions. The family was seen by two therapists and the team viewed the family either through a one-way mirror or on a television screen in another room. The reflecting team used two therapies most frequently, that of Michael White and Just Therapy. The Michael White approach notes the positives and focuses on the clients' ability to externalize the problem in the family as the session progresses. Just Therapy is a reflective approach which looks closely at the webs of meaning in a family such as gender, culture, economy and social aspects. The family would work with the therapists for approximately one hour and

then take a break, going out to the waiting room. There were several different ways in which the team interacted with the family at this point. Sometimes three team members went into the room with the family present and discussed their thoughts on the process and how the family was functioning. The family listened quietly while the team discussed their perspectives for approximately fifteen minutes, and then were provided an opportunity to give feedback or ask questions of the team. Sometimes, the therapists spoke directly to the team and went back after the break and passed on the information that the team had given. Sometimes a written message from the team was mailed to the family the next day.

Although the intern was co-therapist with Dr. Moxley-Haegert, she initially had limited interactions in the session and mainly observed, developing an understanding of the process of family therapy, which is very different from individual therapy. Individual therapy concentrates on one person and what he/she is communicating in therapy. Family therapy focuses on the process of the family and how it is or is not meeting the family's needs, rather than on one person's perspective. This was a very new framework for the intern to understand and gain experience in using.

Reading, discussion and the viewing of family therapy using the team approach also provided the intern with the opportunity to get into the mode and framework of family therapy. After only a few sessions of co-therapy, the intern

was able to engage in therapy with the family. After each session, Dr. Moxley-Haegert discussed how the intern performed and the techniques used in the session.

The intern had two families with whom she conducted therapy sessions as the primary therapist. With the first family, Dr. Moxley-Haegert was in attendance for the first session. Dr. Moxley-Haegert then felt that the intern was competent enough to see families on her own so all other sessions with these families were held by the intern only. Both families were new cases to the Psychology Department. The intern had the opportunity to start with a family, provide therapy and discharge the family. This experience was considered the most valuable of the entire internship. The intern took all of the knowledge and experience gained and had the opportunity to provide family therapy for two families from the start on to discharge. Regular updating and consultation was held with Dr. Moxley-Haegert regarding these families.

The *Family Assessment Device* is an assessment tool that is regularly used in the family programme; a copy is provided in Appendix E. This device is given to parents and any persons over twelve years of age in the family. The *Family Assessment Device* is a questionnaire composed of questions about all aspects of family life including: problem solving; communication; roles; affective responsiveness; affective

involvement; behaviour control and general family functioning. The intern administered and scored seven *Family Assessment Devices*.

Many articles and books on family therapy were read to build a knowledge background, develop a framework, promote understanding, gain a philosophy and develop skills necessary to provide family therapy. The readings completed during this internship are listed in Appendix D.

Administration and Scoring of Tests

The intern administered and scored seven Family Assessment Devices, two *Conners' Rating Scales* and one *Becks' Depression Inventory*. Two *Vineland Adaptive Behaviour Scales* were scored but not administered. The intern found it quite useful using these assessment tools. She was familiar with the Conners' prior to the internship, but the others were new instruments to the intern.

The intern also reviewed many other assessment instruments available at both the Psychology Department and the Thomas Anderson site. There was also discussion with the psychologists concerning the variety of assessment instruments available and their use.

Group Counselling Skills

Many groups are convened in the Psychiatry Department for inpatients. The intern attended and participated weekly in a group composed of all of the children on the psychiatry ward.

The purpose of the group was to provide the patients with the opportunity to discuss any concerns they had about the psychiatric ward and how it operates. The group started each session with a "check in" on how everyone was feeling and "checked out" with a happy thought.

By attending and participating in the group the intern had the opportunity to experience the dynamics of the group process. Another valuable gain of attending the group was that it permitted the intern to become familiar with the patients so that when they were presented at teaching rounds and case conferences the intern could place a face and certain behaviours with a case for better identification and understanding.

The developmental project component of this internship also studied group work, the dynamics of a group and what people expect or would like to gain from a group. Reading on different types and processes of groups was also done by the intern.

Also, the intern sat in on meetings at the Psychology Department with psychologists and social workers who were planning and leading groups.

Developmental Research-Based Project

Time was provided in the internship to complete a developmental research-based project. The research was proposed to the Human Investigations Committee and the Faculty of Education Ethics Committee for approval. Therapists at the

Janeway were presented with information regarding the research. It did take a reasonable amount of time to discuss and explain the research to the therapists and to remind them to contact their clients. Once consent for referral was received, the intern contacted the willing parents and scheduled an interview time. Parents occasionally missed appointments and had to be rescheduled. The interviews lasted from forty-five minutes to one hour.

These activities comprise the 34 hours spent on research reported on Table 1. The analysis and results were all completed after the internship was completed. The parent interviews were not completed until the final week of the internship. Referrals were late coming in and the intern was very busy with other activities, making it difficult to schedule appointments. One interview was done in the parent's home, as it was more convenient for her. The project is further detailed in a later section of this report.

Administration

Each week the intern attended staff meetings in the Psychology Department and site meetings at the Thomas Anderson site, where her office was located. The Janeway as a whole is undergoing tremendous change. Originally, the Psychology Department and the Thomas Anderson Centre existed as separate entities. Now, these two sites are combined, but there is still some confusion, because many of the people that worked in the Thomas Anderson site are social workers. This is the

rationale for the two meetings. Only psychologists attend the staff meetings. Both psychologists and social workers working at the site attend the site meetings.

Each program has a team of members and these teams have meetings. The intern attended one team meeting for each program, primarily to gain an idea of the systems of the administration and how long the waitlists are for each program. The intern also attended a joint discipline mental health meeting, which included all of the professionals working in mental health at the Janeway.

Other administrative tasks included the booking of therapy rooms, setting up of video equipment, recording information in the weekly log and calling families on the wait list to confirm if they do still wished to be seen.

Supervision

The 15 hours of supervision shown in Table 1 reflect supervision time with the on-site supervisor, Dr. Linda Moxley-Haegert. The intern met regularly at 2:00 p.m. for one hour each week with Dr. Moxley-Haegert, and more often when necessary. The intern entered each meeting with a list of concerns which she presented and Dr. Moxley-Haegert provided responses to the concerns and discussed the intern's work and progress. Specific discussion concerning skills, approaches and therapy sessions was usually done prior to or immediately after a therapy session.

Academic supervision was also conducted by Dr. Lee Klas.

He met on three occasions with both the intern and Dr. Moxley-Haegert. These meetings were prior to starting the internship, at the midpoint of the internship and at the end of the internship. Dr. Klas also met with the intern alone and had several telephone conversations with the intern throughout the internship.

Record Keeping

The intern kept her own set of notes on every therapy session in which she took any part. These notes were useful throughout the internship and were all destroyed at the end of the placement. Other record keeping included report writing and documentation. Reports were written for the family therapy sessions and the activities at the Learning/Behaviour Clinic.

Conclusion

The chosen internship site, The Janeway Child Health Centre, provided a great learning and skill development opportunity. Foremost, it provided access to psychology in a medical setting. It provided access to a variety of psychologists and psychotherapy approaches. It gave the intern an inside look into the programs and services provided by the Janeway; certainly, such insights are invaluable to a school guidance counsellor, who regularly makes referrals to that setting.

Dr. Linda Moxley-Haegert is a highly qualified and experienced family therapist, and there are several other registered psychologists in the unit. Unfortunately, the Janeway receives so many referrals that there are waiting lists for children, adolescents, adults and families awaiting services. This was a positive factor for the intern, because it meant that the Janeway psychological services were in demand and are under constant development. The setting provided a good atmosphere for an intern who was trying to enhance skills and gain new knowledge and expertise in counselling and therapy.

A Developmental Project Studying the Group Therapy Needs of Parents of Children with Impulsive and/or Aggressive Behaviour Problems

Rationale and Purpose

A research and/or developmental project is one of the required components of an internship in the Master's Degree in Educational Psychology at Memorial University of Newfoundland. The project should provide both the internship site and the intern with valuable useful information and insights. At the Janeway, therapy services addressing a variety of issues and concerns are offered to individuals and families by psychologists and social workers, all from varied backgrounds of interest and expertise. Therapy services for children and adolescents with impulsive and/or aggressive behaviour difficulties make up a large percentage of the population receiving or requesting services; these services are offered through the pre-school, school-age, adolescent, family, psychiatry and learning behaviour programs.

Along with individual and family therapy, group therapy has been utilized to meet the needs of large groups with identified common needs. These groups are offered regularly on a needs basis. Due to the high incidence of children with impulsive and/or aggressive behaviour difficulties there is a great need for therapy services for both children and parents. These parents have varied needs for approaches, strategies,

support and therapy in parenting children exhibiting these difficulties. "Parents have been appropriate change agents because the number of children with behaviour problems has been so large that only teachers and particularly parents have constituted a presence large enough to meet the needs of all these children" (O'Dell, 1974 as cited in Williams et al., 1991, p. 387).

Services for children with impulsive and/or aggressive behaviour is in high demand in the schools as well as at the Janeway. Guidance counsellors are often approached by parents and teachers of children with impulsive and behavioral difficulties in search of help to assist in parenting, instructing and working with these children. Williams et al., 1991, stated "that parents have been, by virtue of their roles in the family, the appropriate therapists for their children" (p. 404).

Literature Review

A historical review of the literature revealed that literature on parenting in general is profuse, covering a wide spectrum of topics. Parenting literature has grown and now specifically addresses parent training. Parental training and actual parenting techniques useful in solving various child problems have been extensively researched and developed and comprehensive texts have been written by such authors as Adams, 1992; Christophesen, 1977; Dickersonenson & Zimmerman, 1992; Gelfand, Jenson & Drew, 1982; Kelly, 1983; Krumboltz

& Krumboltz, 1972; Ollendick & Cerny, 1981; Phelan, 1995; Ross, 1980; Schaefer, 1982; Schaefer & Millman, 1981; Sulzer-Azaroff & Mayer, 1977; Eastman & Rozen, 1994; Millar, 1994. "Parent training is barely 20 years old, and has become one of the most rapidly expanding areas of psychological intervention and research" (O'Dell, 1985, p.100).

A more narrowly focused but abundant amount of literature exists on parental technique training in groups. A variety of parent training approaches has been applied to most all types of problem behaviours (Berkowitz and Graziano, 1972). The popularity of training parents in behavioral principles and parenting techniques has resulted in the publication of many parent training manuals by behaviorally oriented authors (Bernal and North, 1978). However, the literature on parent training by the group method and specific topics or issues dealt with in parent groups is much more limited.

Parents of children with impulsive and/or aggressive difficulties would benefit from a number or combination of services such as individual, family and group therapy. There are different types of services available from personnel with varying degrees of education and competency. "At one extreme, materials may be used in a self-help format with little or no therapist guidance (Rosen, 1976, p. 140). "At the other extreme, therapists may rely solely on providing direct modelling and rehearsal with the parent" (O'Dell et al., 1977

as cited in O'Dell et al., 1979, p. 103-104). "Many therapists who train parents in behavioral principles and skills rely on various mass produced media materials as the primary or secondary sources of training" (O'Dell et al., 1979, p. 103).

Recent books which address parenting children with impulsive and/or aggressive behavior include: Kurcinka, Mary. Your Spirited Child. New York: Harper Perennial, 1991; Tobin, L. What Do You Do With A Child Like This? Inside the Lives of Troubled Children. Duluth, MN: Pfiefer-Hamilton Publishers, 1991; Samalin, Nancy. Love and Anger, the Parental Dilemma. New York: Viking, 1991; Gathercoal, Forrest. Judicious Parenting. San Francisco: Caddo Gap Press, 1992; Whitham, Cynthia. Win the Whining War and Other Skirmishes: A Family Peace Plan. Los Angeles: Perspective Publishers, 1991; Schmidt, Fran & Friedman, Alice. Creative Conflict Skills for Little Kids. Miami Beach, Fl: Peace Works, 1993; Shure, Myrna. I Can Problem Solve (ICPS): An Interpersonal Cognitive Problem-Solving Program for Children. Champaign, IL: Research Press, 1992.

A shift from the traditional one-to-one client therapy model evolved out of various needs. "Parent behaviour training developed to meet the need of a psychological child treatment approach that is more short-term and focused than traditional psychodynamic approaches" (Graziano and Diament, 1992, p. 4). "Traditional therapy sessions took place in an

essentially artificial situation and were too brief, infrequent, and removed from the child's other life experiences to have a significant impact" (Graziano, 1971, as cited in Gordon and Davidson, 1991, p. 518). "Secondly, the therapist rarely had an opportunity to observe the specific problem behaviours of the child (e.g, tantrums, fighting) or the parent child interactions in the natural environment" (Gordon and Davidson, 1991, p. 518). "Third, the therapist rarely made useful suggestions to the parents as to how they might cope with the demands of a disturbing child" (Gordon and Davidson, 1991, p. 518). "Finally, the evaluation of the effectiveness of treatment was difficult to measure due to the absence of objective measures of behaviour change" (Hawkins et al., 1966, as cited in Gordon and Davidson, 1991, p. 518).

Graziano and Diament (1992) measured therapeutic change in three ways: (1) targeted changes in the child (2) targeted changes in the parents (3) nontargeted changes in parents and others. "Overall, the evidence is strong that parent behaviour training has significant positive effects on the functioning of children and parents" (Granziano and Diament, 1992, p. 26). "There is a significant body of evidence to indicate that behavioral parent training meets the first criterion for validation as a psychotherapeutic approach" (Gordon and Davidson, 1991, p. 544).

A further shift has been toward group parent training. "Training parents in groups seems to offer relief for

overburdened clinicians, particularly those who practice in community mental health centres with large catchment-area populations and relatively small staffs" (Rinn, Vernon, and Wise, 1975, p. 378). This is also true for school guidance counsellors and educational therapists who are required to carry out so many different roles in a school and are pressed for time to meet the needs and demands facing them.

> The efficiency of the group approach allows one therapist to see a large number of clients at one time. This improved use of therapists helps to relieve the critical shortage of professionals needed to treat child behaviour problems (Pevnser, 1982, p. 122).

Group parent training has been found superior to waiting list control (Baker and Heifetz, 1976; Rinn, Vernon and Wise, 1975) and to placebo control (Walter and Gilmore, 1973).

Brightman et al. (1982) stated that group and individual training formats were equally effective. They did state that while individual training affords the opportunity for greater flexibility, group affords more support for trainers and parents. Staff preferred group training, according to Brightman et al. (1982), because the co-trainer model includes a colleague with whom to share responsibilities and problem solve.

The development from a child centred psychotherapy to parent therapy and on to parent group training has occurred largely because of the needs of a changing society. "Evidence

continues to accumulate that many children who display antisocial behaviour, such as aggressiveness, destructiveness and disruptiveness in early childhood continue to do so in later childhood, adolescence and adulthood" (Sutton, 1992, p. 115). The book High Risk Children Without A Conscience is "about babies, parenting, genetics and crime, and how they are vitally connected" (Magid & McKelvey, 1989, p. ix). The authors present statistics and valuable information from both professionals and court documents regarding antisocial personality disorder and violent and impulsive and/or aggressive behaviours in children. This book states that the reason the problem (with children) is so serious is that there is tremendous continuity into adulthood; approximately 50% of children will continue to have antisocial behavior into adulthood (Magid & McKelvey, 1989). The need and demand for parent training is high. Although the number of personnel offering these services is growing, there is still not enough personnel currently in place to meet the demand for the services. This is evidenced by the wait lists at settings such as the Janeway and the referral lists for services at guidance counsellors' and educational therapists' offices in schools. The preface in the book Taming The Dragon In Your Child by Meg Eastman and Sydney Craft Rozen (1994) states:

> Millions of parents of normal children will welcome a book filled with ideas, strategies, and examples of how to handle anger in children of all ages. This book is

> intended for them. It will also be a valuable resource for the more than one million parents who seek professional guidance each year for their children. (p. ix)

The literature tends not to address the specific concerns/needs of parents as related to what they actually expected and wanted from a parent group. One factor possibly influencing this lack of information on parent needs and expectations is the difficulty parents have stating the actual problem behaviours that their children exhibit without bias or giving allowances. These actual behaviours are usually the baseline for parents' needs and expectations. According to Millar (1994) parents feel the need to be loyal to their children.

> It is a real problem for parents to report their children's symptoms. It seems to be disloyal to do so. Many parents have to preface each complaint with some extenuating remark such as 'All kids are like that' or 'He can be very well behaved when he wants to.' (p. 8)

The need for strategies and actual parenting skills appeared to be assumed and was identified as appropriate components of any group set up to help parents solve specified problem behaviours. Many therapists use mass produced media materials and rely on manuals almost verbatim for parent groups. Although many of the materials available are quite good and fitting for group parenting training in general, it is

important to be aware of the needs and desires of parents with children having specific behavioral problems, such as children with impulsive and/or aggressive behavioral disorders.

> Those seeking to provide parents with training in behavioral principles have an abundance of other researchers' work to turn to: for example, Patterson (1974), Herbert (1981) and O'Dell (1985). Clear, empirically derived guidelines concerning structure, form of instruction and methods of training are still lacking, however, although a few pointers are beginning to emerge to guide practice (Sutton, 1992, p. 116).

Questionnaire

The intern devised a general questionnaire to determine the needs and desires of parents with children with impulsive and/or aggressive behaviour problems in relation to group therapy (Appendix F). The questionnaire was comprised of both factual/information gathering questions and opinion and feeling/gathering questions. The questionnaire was divided into four categories: attendance, discipline, needs, and participation.

Sample

A letter and proposal of intention was submitted to the Janeway Human Investigations Committee and permission was granted to interview eight parents of children with impulsive and/or aggressive behaviour problems (Appendix B). The list of eight parents was provided by the individual therapists

working at the Janeway. The therapists, consisting of both psychologists and social workers, would contact their own clients and request written consent to pass on their names and telephone numbers to the intern, enabling her to contact them to set up an interview time (Appendix G). The intern spoke to the therapists, both individually and as a group, to explain the nature of her research and the criteria she wished the parents to meet.

A criterion set for selecting the parents was that the children, the parents, or both have received therapy in the past two years. The intern considered using the client waitlist, but determined this to be inappropriate because some clients initially present with several concerns and problems; it is therefore difficult to determine the primary problem until the clients are actually seen. The intern wanted genuine cases of parents with children with impulsive and/or aggressive behaviour difficulties; by genuine cases, it was meant that the impulsive and/or aggressive behaviour problem was the primary reason the parent was seeking or receiving services. This is often very difficult to determine, as impulsive and/or aggressive behaviours often coincide with other individual or family problems and concerns. The therapists themselves made the final judgement as to which clients were appropriate for the intern to interview, using the criteria previously stated and their knowledge of the cases.

Methodology

The questionnaire was read to the parents in individual interview sessions of forty-five minutes to one hour by the intern; responses were recorded by the intern on the questionnaire form. Written responses were repeated to the parents for confirmation of accuracy. Eight parents, seven female and one male, were interviewed and questionnaires remained anonymous. Thus, the interview results predominantly reflect feedback from mothers.

Analysis

This main purpose of this aspect of the developmental project was to determine the needs and desires, in relation to group therapy, of parents of children with impulsive and/or aggressive behaviour problems. It also provided information on attendance, discipline and the willingness of participation.

Information was gathered by completion of the questionnaire, during the interviews, and the findings of the questionnaires were tabulated. The findings are presented in descriptive terms. Consent for the use of the information acquired from the questionnaires was obtained from the families, therapists and the Janeway Human Investigations Committee. All parties were informed of the confidentiality and anonymity of the information gathered.

Results

Tables 3-12 report the descriptive data compiled from the interviews.

Table 3

Intentions of Attendance at a Parent Group for Parents of Children with Impulsive and/or Aggressive Behaviour Problems

Question	Response Yes	No	Depends
Would Both Parents Attend	3	5	N/A
Do Parents Live Together	5	3	N/A
Should Both Parents Attend	6	0	2

Table 4

Types, Frequency and Location of Children's Problem Behaviours as Rated by Parents of Children With Impulsive and/or Aggressive Behaviour Problems

Question	Response	n
Types of Behaviour Exhibited	Physical	8
	Verbal	8
	Interrelations	5
Frequency of Behaviour	Daily	2
	Weekly	1
	Monthly	1
	Varies	4
Location of Behaviour	Home	8
	School	7
	Other	6
Usual Location of Behaviour	Home	4
	School	4

Table 5

What Happens When Problem Behaviours Occur in School as Rated by Parents of Children With Impulsive and/or Aggressive Behaviour Problems.

Question	n
Problem Behaviour Occurs in School	7
School has a Plan	7
Child has a Teacher Aid	2
Child is Sent Home	2
School calls Home or RNC	1
Time Out is Used	2
Token System in Place	1
Child Goes to Educational Therapist	1

Table 6

Discipline at Home as Rated by Parents of Children With Impulsive and/or Aggressive Behaviour Problems

Question	Response	n
Who Handles Discipline at Home	Mother	5
	Father	0
	Both	3
Is There a Method	Yes	6
	No	2
Are You Content with the Method	Yes	6
	No	1
	Not Long Enough	1

Table 7

Types of Behaviour Techniques of Which the Parents are Aware and Have Tried with Their Children Who Have Impulsive and/or Aggressive Behaviour Problems

Types of Behaviour Techniques	Aware of	Tried
Token Systems	1	1
Taking Privileges	5	5
Walking Away/Ignore	1	1
Talk It Out	1	1
Time Out	5	5
Rewards	4	4
Praise	1	1
Outside Activities (eg.,Cadets)	1	1

Table 8

Success with Behaviour Techniques Tried and the Willingness to Try New Techniques as Rated by Parents with Children with Impulsive and/or Aggressive Behaviour Problems

Question	Response	n
How Successful Were Behaviour Techniques Tried	Not	4
	Good	3
	Worked Sometimes	1
Willing to Try New Techniques	Yes	7
	No	1

Table 9

Behaviours for Which Parents of Impulsive and/or Aggressive Children Feel They Need Behavioral Techniques

Question	Response	n
Need Techniques For	Physical to Others	8
	Destroying Property	4
	Verbal Concerns	8
	Slams Doors	1
	Not Listening	1
	Stomps Off	1
	Control of Emotions	1
	Thinking Before Acting	1
	Completing Schoolwork	1

Table 10

What Parents of Children with Impulsive and/or Aggressive Behaviour Problems Would Like a Parent Group to Offer Them

What Parents Want Offered in a Parent Group	n
Emotional Release Outlet	1
Coping Mechanisms	1
Techniques	4
Strategies to Control Own Anger	1
Parenting Skills	1
Participate to Show Child Interest	1
Ways to Increase Child's Self Esteem	1
Support	1
Compare Own Child to Others	1

Table 11

How Parents of Children with Impulsive and/or Aggressive Behaviour Problems Feel They Would Benefit by Participating in a Parent Group

Benefits Parents Feel Would Be Gained	n
Learn From Others	3
Gain Perspective	1
Feel You Are Not Alone	4
Help To Not Feel Guilty	3
Get Support	1
Learn Techniques	1
Talk More to Own Family	1

Table 12

Parents' Willingness to Participate in a Parent Group for Parents of Children with Impulsive and/or Aggressive Behaviour

Question	Response	n
Willing to Share Information	Yes	7
	No	0
	Unsure	1
Willing to Receive Input	Yes	8
	No	0
	Unsure	0
Willing to Give Feedback	Yes	6
	No	0
	Unsure	2
Willing to Try Techniques	Yes	7
	No	1
	Unsure	0

Discussion

Although only 3 interviewees stated that both parents would attend a parent group, questions regarding general attendance were responded to positively. Of the 8 interviewed, 6 interviewees stated they felt it would be best for both parents to attend a parent group. Due to their own extenuating circumstances, 2 stated it would not be possible for both parents to attend a parent group. Their circumstances were (1) that visitation by the parent was not permitted, as ruled by the court, and (2) that the parent was severely physically and mentally handicapped and resided in a hospital with no visitation privileges with his children. These two interviewees stated that it would not be desirable for both parents to attend in circumstances where there was only one primary custodian for the children or when one parent was unconcerned and not involved with disciplining the child. Even the two interviewees with extenuating circumstances felt that in most cases it would be best for both parents to attend. The interviewees all felt that if parenting is shared, whether parents live together or not, it would be valuable for both to attend, because consistency in parenting styles and discipline is more likely to result. Balancing child care, work and other commitments were stated as difficulties in getting both parents in attendance to a parent group.

Interviewees were asked to relate the specific problem

behaviours that their children exhibited and the frequency and location of occurrence. All interviewees were experiencing both verbal and physical problems, but at varying levels of frequency. In all cases the problem behaviours were occurring at home, and in 7 of the 8 interviewees stated that the behaviours were also occurring at school. When behaviours occurred in school, all schools had some type of plan in place for dealing with the behaviour. These plans varied in severity from time out to calling the Royal Newfoundland Constabulary. These responses were somewhat expected, since children spend most of their time either at home or at school and thus, these would be the logical places for problem behaviours to occur. It was also anticipated that the schools would have a plan, as these children's behaviour problems had been reoccurring.

Mothers handled the disciplining of the children in 5 of the 8 interviews; in 3 interviews it was stated that both parents handled the discipline. Many questions arise from this information. Do mothers handle the discipline because the mother spends the most time with the children? If the father had more involvement would the problem exist or be as severe?

Of the 8 interviewees, 6 had an ongoing discipline method, and were pleased with their method. One interviewee was satisfied with having no method in place. The other interviewee had only recently begun a new method, which she

was felt had not been in place long enough to pass judgement on the results. Interviewees were aware of several behaviour techniques, 8 in total. Interestingly the numbers of techniques of which respondents were aware and the number of techniques tried were the same, Indicating that when parents were aware of a technique they tried it. This information suggests that these parents are willing to try new techniques and also that they are always looking for new techniques, due to the significance of the problems and their general lack of satisfaction with techniques already in use. Many of the interviewees had been reading about the problem and some had already received extensive therapy. The mixed responses to the success of the new techniques suggests that the problems that these parents are facing are ongoing and that there usually has not been a specific technique which has worked satisfactorily for these parents.

Responses to the success of behaviour techniques being tried were mixed, with 4 responding that the behaviour techniques did not work, 3 that they worked at a good level and 1 that they worked only sometimes. All responded favourably to behaviour techniques, with 7 willing to try new techniques and 1 not. The respondent who was not willing to try new techniques stated that the behaviour technique she currently was using was working well and a new technique was not necessary at the time.

The main behaviours that interviewees stated they needed

techniques or help with were aggressive physical interaction with others, harming others, damage to property and verbal concerns. The verbal concerns varied from a child being "lippy" to a parent, to a child being verbally abusive and using profane language to parents and others. These are serious and valid concerns facing parents of children with impulsive and aggressive behaviour problems. These behaviours are not just limited to the household, because if they continue these children may experience trouble with the law and possibly end up with criminal records. As earlier stated in the literature (Sutton, 1992), the children exhibiting these behaviours often continue to do so in adulthood; these parents were very concerned, naturally not wanting that to happen.

Of the 8 interviewees, 4 stated they wanted new techniques. They wanted different forms of support, varying from support directly for themselves to, indirect support for their children. Several interviewees wanted a combination of techniques and support.

The three common responses for the benefits of a parent group were the feeling of not being alone, not feeling guilty and being able to learn from others. All 8 were willing to receive input, 7 were willing to share information, 6 were willing to give feedback, and 7 were willing to try new techniques. Interviewees were concerned about giving feedback, and felt that it needed to be done delicately and

not authoritatively. All were very concerned about the feelings of others. Many stated they had attended such groups before.

In conclusion, behavioral parent training is a significant concern for all parents and especially for the parents of children with impulsive and/or aggressive behavioral problems. These parents are seeking therapy and various other services in hope of finding help and support in parenting their children. "Ultimately, behavioral parent training needs to be made an elective part of the school curriculum. The educational system, being society's last formal link with every future parent, provides the correct soil for the growth of parenthood." (Gordon & Davidson, 1991, p. 550)

Parent group therapy is one way that parents of children with impulsive and/or aggressive behaviour can receive help and support. Having interviewed these parents, and noted the severity of the problem behaviours their children are exhibiting, the intern feels that parent group therapy should be provided along with individual family therapy and not on its own. "To best help parents acquire the needed skills, it appears that direct interaction and shaping of behaviour-is the preferred, yet most costly, method". (O'Dell, 1985, p. 97)

Recommendations

Based upon the results from this developmental project,the intern proposes several recommendations for therapists to consider in developing a parent therapy group of parents with impulsive and/or aggressive behaviour problems:

1. A needs survey or interview with parents planning to attend a parent group is necessary. All parents have different needs. A starting point is discovering the actual nature and severity of the problem behaviours their children are exhibiting. The seriousness of the behaviours and their likelihood to continue into adulthood present a large concern for parents. Therapists should not assume the needs this parent group would have, but rather develop a group based upon the specific needs expressed by the potential participants.
2. The primary needs reported by parents are for new techniques and support; support includes direct support for themselves and indirect support for their children.
3. The Omnipotent Child (Millar 1994) gives clear, practical parenting programs for sixteen behaviours or issues which may cause difficulty for parents of children with impulsive and/or aggressive children. These programs are clearly written and would provide valuable information and techniques for a parent group.
4. There are many levels of impulsiveness and aggression,

from mild to severe. It is recommended that a parent group consist of parents of children with similar levels of impulsiveness and aggression. In this way parents would not compare their child's behaviour to that of the children of the other group members.

5. Keep the group small, in case both parents want to attend. Know prior to the start of the group exactly how many plan to attend. Parents of children with impulsive and/or aggressive behaviour problems have a lot to share, and a large group would not permit as much time for the sharing of information and feelings.
6. Try to have an equal representation of male and female members. Mothers and fathers may have different perspectives; also this reinforces the concept of both parents being responsible for and consistent in the parenting and disciplining of their children.
7. Find the most convenient time for the group to meet so as to encourage and permit both parents to participate. It is also suggested that, where possible, run a child group at the same time or offer child care services. It is important to consider both school time for children and work time for parents.
8. Include time in the parent group to explain to the parents the techniques the children are learning in a children's group or from their therapist. Parents need to know exactly what techniques their children are being

taught in order to set them up for maximum success.

9. Include time in the parent group for emotional support and sharing. Most parents felt that they needed to know they were not alone. Of course, some parents may not feel the need for this support and may want only techniques. If the parent group time was divided, allotting time to each of these components, the parents could choose themselves which components they would like to attend.

10. Different types of groups could be offered for separate purposes; (1) therapy (2) education about behaviour (3) strategies. As shown in the data, a needs survey would indicate the needs and therefore determine the type of group most appropriate for meeting the parents' needs.

11. Therapy may not be necessary for all parents. Educational groups focused on teaching, with a core curriculum of materials and text, may prove most valuable for some parents.

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APPENDIX A

MUN, Faculty of Education Ethics Committee Approval

Memorial
University of Newfoundland

Faculty of Education

June 12, 1995.

To: Ms. Catherine Tremblett, c/o Dr. Lee Klas
From: Dr. Walter C. Okshevsky, Chair, Ethics Review Committee
Subject: Internship proposal

The Committee has completed its review of your internship proposal entitled "Proposal for a counselling internship at the Psychology Department of the Janeway Child Health Center with development of a parenting program for use with parents of children with impulse and anger control difficulties." On behalf of the Committee, I am pleased to be able to advise you that your proposal has received conditional approval subject to the following conditions.

Regarding your Client Consent Form:

1. Please include a concluding statement in the fist-person as provided in the Sample Letter of Consent at the back of our Faculty Guidelines. Your present concluding statement at the bottom of this Form is not required and should not be used.
2. Assure your subjects that they are free to withdraw from the study at any time without prejudice of any kind.
3. Should interviews be taped, please indicate the disposition of the tapes upon completion of your study. Normally, these are erased or destroyed. If not, indicate explicitly their disposition.
4. Do indicate whether subjects will be provided with the opportunity to see the transcripted version of the tapes for purposes of accuracy before your actual use of these within your study.

Regarding your Letter to the Janeway Human Investigation Committee:

5. Include a concluding statement in the first-person reviewing the assurances being provided.

St. John's, Newfoundland, Canada A1B 3X8 • Fax: (709) 737 2345 • Telex: 016 4101

6. Please submit for Committee approval the final version of the questionnaires and the interview protocols once these have been developed.

If I may be of any further assistance to you, please do not hesitate to contact me at your earliest convenience.

Sincerely,

Walter C. Okshevsky

Committee members: Drs. Singh, Seifert, Sharpe, Norris, Okshevsky

cc: Dr. Stephen Norris, Acting Associate Dean, Research and Development

APPENDIX B

Janeway, Human Investigations Committee Approval

Janeway
Child Health Centre

Janeway Place
St. John's Newfoundland
Canada A1A 1R8

Telephone 709 778-4222
Facsimile 709 778-4333

June 13, 1995

Catherine Tremblett & Dr. Linda Moxley-Haegert
Janeway Child Health Centre

RE: Development of a Program of Group Counselling for Parents of Children with Impulsive-Aggressive Behaviour Difficulties - C. Tremblett and Dr. L. Moxley-Haegert.

Dear Ms. Tremblett & Dr. Moxley-Haegert:

I am writing to advise you that your proposal was reviewed by the Janeway's Human Investigation Committee and that it is:

☐ approved.

☑ approved with the following questions, observations or limits (see attached).

☐ deferred pending receipt of additional information (see attached).

☐ deferred pending your personal view of this proposal at the next Human Investigation Committee meeting.

☐ not approved.

Should you have additional information or requests, please submit them to the committee (via Mrs. Joanne Tiller, my office).

Yours sincerely,

Wayne L. Andrews, MD., FRCP.(C)
Chairman,
Human Investigation Committee.

:sjt

cc: Dr. A. R. Cooper

APPENDIX C

Janeway, Psychology Department, Weekly Report

REVISED: MAY 4, 1995.

PSYCHOLOGY DEPARTMENT

Statistics - To be kept on a daily basis, returned to Director no later than Tuesday of the following week.

WEEKLY REPORT FOR: _____ 1995

CLIENT STATISTICS			**TIME**
Total No. of Client Contacts	= _____		_____
Individual	= _____		
Group	= _____		
Indirect	= _____		
Referral - In	= _____		_____
- Out	= _____		_____
Follow-Up - In	= _____		_____
- Out	= _____		_____
Number of Cancelled Patients	= _____		_____

THERAPY STATISTICS		
Psychological Testing	= _____	_____
Number of Individual Therapy Sessions	= _____	_____
Number of Family Therapy Sessions	= _____	_____
Number of Counselling Sessions with Parents	= _____	_____
Group Therapy	= _____	_____
Co-Therapy ( )	= _____	_____
Phone Contacts with Clients or or Parents (Indirect)	= _____	_____
Other Professionals (Indirect)	= _____	_____

MULTIDISCIPLINARY INVOLVEMENT

Time spent in Case Conference, Ward Rounds, or Clinics = _____ _____

Specify: 1.
2.

Number of Cases Presented (at Case Conference) = _____ _____

PROFESSIONAL CONSULTATIONS

Specify: 1.

2.

3.

4.

NAME AND CHART # OF NEW CLIENTS SEEN	OUT-PT	IN-PT	WARD	REF. PERSON
1.	_____	_____	____	_____
2.	_____	_____	____	_____
3.	_____	_____	____	_____
4.	_____	_____	____	_____
5.	_____	_____	____	_____
6.	_____	_____	____	_____
7.	_____	_____	____	_____
8.	_____	_____	____	_____
9.	_____	_____	____	_____
10	_____	_____	____	_____

NAME AND CHART # OF REVIEWED CLIENTS SEEN

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

OTHER ACTIVITIES:

Time spent in report writing and record keeping _____

Time spent in assessment and treatment preparation _____

Time spent in home or school visits (do not include travel time) _____

Time spent in visits to other centres _____

Travel time _____

Time spent for educational purposes, peer supervision, quality assurance activities, lectures etc). _____

Time spent in teaching and supervision _____

Time spent in Administration _____

Research _____

Other, please explain _____

_____

_____

LEAVE STATISTICS

Annual Leave

Sick Leave

Weekly Schedule i.e. 9 - 5, 8:30 - 4:30

OVERTIME

Monday

Tuesday

Wednesday

Thursday

Friday

NAME AND SIGNATURE

APPENDIX D

List of Readings Completed During Internship

List of Reading Completed During Internship

Adams, C. D. (1992). Managing Sibling Aggression: Overcorrection as an Alternative to Time-Out. Behavior Therapy 23, 707-717

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APPENDIX E

Family Assessment Device

BROWN UNIVERSITY Providence, Rhode Island • 02912
Division of Biology and Medicine

BROWN/BUTLER FAMILY RESEARCH PROGRAM

INSTRUCTIONS FOR COMPLETING THE FAMILY ASSESSMENT DEVICE

1. Each member of your family, over the age of 12, should complete a FAD.
2. Please respond to the items in terms of how you feel your family has been functioning in the past two months.
3. Complete the FAD privately; away from other family members.
4. Do not discuss your responses with your family members.
5. We are interested in your personal view of your family.

INSTRUCTIONS FOR COMPLETING THE FAMILY INFORMATION FORM

1. We also require general information about your family. To help us with this, we ask that either the Husband/Father or Wife/Mother complete the Family Information Form.

When you have completed the Family Assessment Device (FAD) and the Family Information Form, please return to _____.

Version 3

Nathan B. Epstein, M.D.
Lawrence M. Baldwin, Ph.D.
Duane S. Bishop, M.D.

The Brown University/Butler Hospital Family Research Program
Butler Hospital
345 Blackstone Boulevard
Providence, Rhode Island 02906

Date of Administration: _____

Family Role: _____

Identification Number or Family Name: _____

FAMILY ASSESSMENT DEVICE
Brown/Butler Family Research Program

INSTRUCTIONS:

This booklet contains a number of statements about families. Please read each statement carefully, and decide how well it describes your own family. You should answer according to how you see your family.

For each statement there are four (4) possible responses:

Strongly Agree (SA)	Check SA if you feel that the statement describes your family very accurately.
Agree (A)	Check A if you feel that the statement describes your family for the most part.
Disagree (D)	Check D if you feel that the statement does not describe your family for the most part.
Strongly Disagree (SD)	Check SD if you feel that the statement does not describe your family at all.

These four responses will appear below each statement like this:

41. We are not satisfied with anything short of perfection.

_____ SA _____ A _____ D _____ SD _____

The answer spaces for statement 41 would look like this. For each statement in the booklet, there is an answer space below. Do not pay attention to the blanks at the far right-hand side of each answer space. They are for office use only.

Try not to spend too much time thinking about each statement, but respond as quickly and as honestly as you can. If you have trouble with one, answer with your first reaction. Please be sure to answer every statement and mark all your answers in the space provided below each statement.

FAMILY ASSESSMENT DEVICE
Brown/Butler Family Research Program

ID _____ _____ _____

1. Planning family activities is difficult because we misunderstand each other.

   _____ SA _____ A _____ D _____ SD _____

2. We resolve most everyday problems around the house.

   _____ SA _____ A _____ D _____ SD _____

3. When someone is upset the others know why.

   _____ SA _____ A _____ D _____ SD _____

4. When you ask someone to do something, you have to check that they did it.

   _____ SA _____ A _____ D _____ SD _____

5. If someone is in trouble, the others become too involved.

   _____ SA _____ A _____ D _____ SD _____

6. In times of crisis we can turn to each other for support.

   _____ SA _____ A _____ D _____ SD _____

7. We don't know what to do when an emergency comes up.

   _____ SA _____ A _____ D _____ SD _____

8. We sometimes run out of things that we need.

   _____ SA _____ A _____ D _____ SD _____

9. We are reluctant to show our affection for each other.

   _____ SA _____ A _____ D _____ SD _____

10. We make sure members meet their family responsibilities.

    _____ SA _____ A _____ D _____ SD _____

11. We cannot talk to each other about the sadness we feel.

    _____ SA _____ A _____ D _____ SD _____

12. We usually act on our decisions regarding problems.

    _____ SA _____ A _____ D _____ SD _____

13. You only get the interest of others when something is important to them.

_____ SA _____ A _____ D _____ SD _____

14. You can't tell how a person is feeling from what they are saying.

_____ SA _____ A _____ D _____ SD _____

15. Family tasks don't get spread around enough.

_____ SA _____ A _____ D _____ SD _____

16. Individuals are accepted for what they are.

_____ SA _____ A _____ D _____ SD _____

17. You can easily get away with breaking the rules.

_____ SA _____ A _____ D _____ SD _____

18. People come right out and say things instead of hinting at them.

_____ SA _____ A _____ D _____ SD _____

19 Some of us just don't respond emotionally.

_____ SA _____ A _____ D _____ SD _____

20 We know what to do in an emergency.

_____ SA _____ A _____ D _____ SD _____

21. We avoid discussing our fears and concerns.

_____ SA _____ A _____ D _____ SD _____

22. It is difficult to talk to each other about tender feelings.

_____ SA _____ A _____ D _____ SD _____

23. We have trouble meeting our bills.

_____ SA _____ A _____ D _____ SD _____

24. After our family tries to solve a problem, we usually discuss whether it worked or not.

_____ SA _____ A _____ D _____ SD _____

25. We are too self-centered.

_____ SA _____ A _____ D _____ SD _____

26. We can express feelings to each other.

_____ SA _____ A _____ D _____ SD _____

27. We have no clear expectations about toilet habits.

_____ SA _____ A _____ D _____ SD _____

28. We do not show our love for each other.

_____ SA _____ A _____ D _____ SD _____

29. We talk to people directly rather than through go-betweens.

_____ SA _____ A _____ D _____ SD _____

30. Each of us has particular duties and responsibilities.

_____ SA _____ A _____ D _____ SD _____

31. There are lots of bad feelings in the family.

_____ SA _____ A _____ D _____ SD _____

32. We have rules about hitting people.

_____ SA _____ A _____ D _____ SD _____

33. We get involved with each other only when something interests us.

_____ SA _____ A _____ D _____ SD _____

34. There's little time to explore personal interests.

_____ SA _____ A _____ D _____ SD _____

35. We often don't say what we mean.

_____ SA _____ A _____ D _____ SD _____

36. We feel accepted for what we are.

_____ SA _____ A _____ D _____ SD _____

37. We show interest in each other when we can get something out of it personally.

_____ SA _____ A _____ D _____ SD _____

38. We resolve most emotional upsets that come up.

_____ SA _____ A _____ D _____ SD _____

39. Tenderness takes second place to other things in our family.

_____ SA _____ A _____ D _____ SD _____

40. We discuss who is to do household jobs.

_____ SA _____ A _____ D _____ SD _____

41. Making decisions is a problem for our family.

_____ SA _____ A _____ D _____ SD _____

42. Our family shows interest in each other only when they can get something out of it.

_____ SA _____ A _____ D _____ SD _____

43. We are frank with each other.

_____ SA _____ A _____ D _____ SD _____

44. We don't hold to any rules or standards.

_____ SA _____ A _____ D _____ SD _____

45. If people are asked to do something, they need reminding.

_____ SA _____ A _____ D _____ SD _____

46. We are able to make decisions about how to solve problems.

_____ SA _____ A _____ D _____ SD _____

47. If the rules are broken, we don't know what to expect.

_____ SA _____ A _____ D _____ SD _____

48. Anything goes in our family.

_____ SA _____ A _____ D _____ SD _____

49. We express tenderness.

_____ SA _____ A _____ D _____ SD _____

50. We confront problems involving feelings.

_____ SA _____ A _____ D _____ SD _____

51. We don't get along well together.

_____ SA _____ A _____ D _____ SD _____

52. We don't talk to each other when we are angry.

_____ SA _____ A _____ D _____ SD _____

53. We are generally dissatisfied with the family duties assigned to us.

_____ SA _____ A _____ D _____ SD _____

54. Even though we mean well, we intrude too much into each others lives.

_____ SA _____ A _____ D _____ SD _____

55. There are rules about dangerous situations.

_____ SA _____ A _____ D _____ SD _____

56. We confide in each other.

_____ SA _____ A _____ D _____ SD _____

57. We cry openly.

_____ SA _____ A _____ D _____ SD _____

58. We don't have reasonable transport.

_____ SA _____ A _____ D _____ SD _____

59. When we don't like what someone has done, we tell them.

_____ SA _____ A _____ D _____ SD _____

60. We try to think of different ways to solve problems.

FAMILY ASSESSMENT DEVICE

FAMILY INFORMATION FORM

Only one family member should complete this form.

Family Name: _____ Date: _____
day/month/year

For each person ***living in your household,*** please list the following information, indicating the nature of each person's role in the house (e.g., husband, wife, son, daughter, sister, friend, grandmother, etc.).

	Family Role	First Name	Religion	Age	Sex	Education Total # of Years In School	Medical/ Psychiatric Problems
1.							
2.							
3.							
4.							
5.							
6.							

For each family member or significant other ***not living in the home,*** list the following:

	Full Name	Relationship	Religion	Age	Sex	Education Total # of Years In School	Medical/ Psychiatric Problems
1.							
2.							
3.							
4.							

Present marital status of heads of household: (check all that apply)

	Male	Female
Married only once	( )	( )
Remarried	( )	( )
Single	( )	( )
Never married	( )	( )
Divorced	( )	( )
Separated	( )	( )
Widowed	( )	( )

Number of years in present marital status _____

Number of previous marriages - (male) _____

- (female) _____

Total *family* income (all sources) during past year:

$ 0 - 9,999	( )	$ 50,000 - 59,999	( )
$10,000 - 19,999	( )	$ 60,000 - 69,999	( )
$20,000 - 29,999	( )	$ 70,000 - 99,999	( )
$30,000 - 39,999	( )	$100,000 +	( )
$40,000 - 49,999	( )		

Do you identify with any specific ethnic group? If yes, check below the ***primary*** ethnic group.

Western European (British, French, German, etc.)	( )
Eastern European (Russian, Polish, etc.)	( )
Mediterranean (Italian, Middle Eastern, North African, Greek, Cyprian, etc.)	( )
North American (U.S. American, Canadian)	( )
South American (Central and South American)	( )
African (South African)	( )
Asian or Pacific Islander	( )
Australian/New Zealander	( )

What is your race?

American Indian or Alaskan native	( )
Oriental	( )
Black	( )
Hispanic	( )
White	( )

The remaining questions are to be answered for the heads of the household.

As briefly as possible, please describe:

a) What kind of work you are (or were) engaged in:
(e.g., electronics engineer, nursing, stock-clerk, farming, etc.)

Male: _____

Female: _____

b) Your major or most important activities/duties at work:
(e.g., keeping the accounts, selling cars, operating printing press, caring for patients, etc.)

Male: _____

Female: _____

c) The kind of industry or organization this work is (or was) in:
(e.g., Radio-TV, manufacturing firm, retail shoe store, general hospital, etc.)

Male: _____

Female: _____

APPENDIX F

Questionnaire

Questionnaire/Interview Protocol

Attendance

1. Would both parents attend group counselling?

   Yes _____ No _____

2. Do both parents live together?

   Yes _____ No _____

3. Do you feel it would be valuable for both parents (whether living together or not) to attend?

   If yes, why? If no, why not?

   _____

   _____

Discipline

4. What are the impulsive and/or aggressive behaviors that your child exhibits? _____

   _____

   _____

   _____

   _____

5. How frequent do these behaviors occur?

   Daily _____ Weekly _____ Monthly _____

   _____

6. Where do these behaviors occur? _____

   _____

   Where is the most usual occurrence? _____

If these behaviors occur at school what does the school do?

_____

_____

Does your child receive the services of either a School Guidance Counsellor or an Educational Therapist?

Yes _____ No _____

7. Who currently handles discipline issues at home? _____

_____

8. Is there a specific discipline method at home?

Yes _____ No _____

If yes what is this method? _____

_____

_____

In your opinion is your home discipline method effective?

Yes _____ No _____

Are you comfortable and/or content with this method? Explain.

_____

_____

_____

9. What behavioral management techniques are you aware of?

_____

_____

_____

Which of these techniques have you tried? _____

_____

_____

How successful do you feel they were? _____

_____

10. Would you be willing to try suggested behavioral management techniques? Yes _____ No _____

Needs

11. For which specific types of impulsive and/or aggressive behaviors would you like management strategies and techniques? **Prioritize**

(1)_____

(2)_____

(3)_____

12. What would you like a group counselling program to offer you?

_____

_____

_____

13. How do you feel you will benefit by participating in group counselling? _____

_____

_____

_____

Participation

14. How would you feel about sharing information or your own personal experiences with the group? _____

How would you feel about receiving input from others on how you handled a situation? _____

How would you feel about giving feedback to others on how they handled a situation? _____

15. Would you be willing to try suggested behavioral management techniques and share your experience with the group?

Yes _____ No _____

APPENDIX G

Consent For Referral

CONSENT FOR REFERRAL

It has been explained to me that a research project is being carried out through the Psychology Department of the Janeway Child health Centre by Catherine Tremblett, a graduate student of Memorial University of Newfoundland. I understand that the purpose of this research is to develop a program of group counselling for parents of school age children with aggressive and impulsive behavioral difficulties. My participation in this study will involve a single, approximate one hour interview. I understand that if I choose not to participate in this study, it will not change the treatment I receive from the hospital.

I give permission for my therapist to give my name and telephone number to the researcher so that she may contact me about the study. I understand that all information gathered in this study is private/confidential. I know that participation is voluntary and that I may withdraw at any time.

_____ _____

(Print your name) (Signature)

_____ _____

(Signature of Therapist) (Date)