New Direction for Treating Parent-Adolescent Conflict: Comparison of Problem Solving Skills Training and Social Cognitive Development Training

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Abstract

Parent-teen conflict has been associated with both acting-out behaviours and psychiatric disorders in adolescence, which indicates serious conflicts have negative sequelae that goes beyond the specific area of disagreement. The efficacy of traditional cognitive-behavioural interventions focusing on communication and problem-solving training has been demonstrated, but limitations have been recognised. One possible reason might be a lack of understanding the origin or underlying cause of conflicts in terms of adolescent social-cognitive development.

The initial study utilised a package of self-report measures to investigate actual conflict levels in New Zealand families, and factors suggested as relating to conflict. Measures were completed by 112 parent-teen dyads. Results indicated high levels of conflict were occurring over everyday issues such as doing chores, tidy bedroom, swearing, going out, and homework. Also, higher conflict levels were associated with authoritarian parenting behaviours, lower perceptions of the parent-adolescent relationship, and poorer psychological well-being, but not with divergent conceptions of who makes decisions regarding adolescent behaviour.

Main findings from the survey study were that parents and teens categorised issues differently according to four social-cognitive domains: moral, conventional, prudential (safety) and personal. Parents generally treated issues as belonging to safety and moral domains, while teens categorised issues more often as belonging to the personal domain. Discrepant categorisation of issues to domain categories was related to higher frequency and anger-intensity levels of discussions, supporting the hypothesis that parent-adolescent conflict can be meaningfully understood within a social-cognitive framework.

To investigate whether these constructs could be used in cognitive-behavioural treatment, an exploratory treatment study was designed that compared providing a strategy to assist teens and parents articulate and justify their reasoning in the context of social-cognitive domains with the standard cognitive-behavioural problem solving intervention.

Thirty-two self-referred parent-adolescent dyads reporting high conflict levels and negative family environments were randomly assigned to either the Domain and Development group or the Problem Solving group. Treatment duration was approximately 6 weeks. Dyads were seen individually.

Results showed a similar general trend of improvement for parents and teens in both treatment groups, with a large percentage of individuals reporting meaningful changes after each treatment. Differences that did emerge tended to favour parents in the Problem Solving group and teens in the Domain and Development group, but variable response to treatment appeared more attributable to individual family circumstances than to each intervention. Statistical comparisons did not reveal differences according to teen age or gender, parent gender, religious affiliation, family composition, or dyad. Treatment evaluations, however, generally indicated that middle adolescents were more responsive to the Domain approach and rated it as more acceptable than did early adolescents.

Overall, this project has demonstrated that greater mutual understanding of fundamental differences between parents and teens that lead to conflict, rather than focusing on problem-focused strategies that address conflictual topics only, can reduce their conflict levels. Findings are discussed within the context of theoretical principals guiding treatment outcome research, and recommendations regarding combining the two approaches in clinical practice are made.

Acknowledgments

When you see someone putting on his Big Boots,
you can be pretty sure
that an Adventure is going to happen.
Winnie-the-Pooh

BUT

Rivers know this: There is no hurry.
We shall get there some day.
Winnie-the-Pooh

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Conflict is like the common cold. We all know what it is – and typically find it very unpleasant. But identifying the causes, understanding the effects, discovering a cure seems to be difficult.

Anonymous

Popular stereotypes portray teenagers as troubled and troublesome; they forecast persistent disagreements between moody, misunderstood, unreasonable, and rebellious teenagers, and inflexible but well-meaning parents, which has led to adolescence and conflict being considered virtually synonymous. Early theoretical perspectives established the belief that stormy, stressful, and hostile parent-adolescent relationships were inevitable and represented normal development (Blos, 1962). This traditional view has not been supported in empirical studies (Steinberg, 1990), and recent research reveals that many teens (and parents) traverse this period without significant psychological difficulties.

Adolescence does, however, mark a time of change for individuals and family relationships. It is the developmental period in which the physical and social status of a child changes to that of an adult, and the parent-adolescent relationship undergoes transformations from patterns of unilateral authority towards more cooperative relations. During this transformation parents and teens will differ in what they believe, what they know, what they think should be done and how, as well as what they do. These differences make conflict prone to occur. Although family conflict has been linked to constructive functioning in the interplay of individual development and connectedness in relationships (Cooper, 1988), it remains an important area of inquiry because of consistent associations

between conflicted family interactions and high-risk behaviours and poor psychological well-being in adolescents.

Parent-adolescent conflict is not recognised as a psychiatrically defined syndrome, but a parent-child relational problem can be classified on Axis I when interaction between the parent and child is the primary focus of clinical attention, and on Axis IV if secondary to the principal focus of clinical attention (DSM-IV; American Psychiatric Association, 1994). Specific conflictual behaviours appear explicitly only in the diagnostic criteria of oppositional defiant disorder, but relational problems, excessive conflict, communication problems, and deficits in problem solving are commonly associated with attention-deficit/hyperactivity disorder (Barkley, Anastopoulos, Guevremont, & Fletcher, 1992a; Barkley, Guevremont, Anastopoulos, & Fletcher, 1992b), conduct disorder (Dadds, Sanders, Morrison, & Rebgetz, 1992; Hanson, Henggeler, Haefele, & Rodick, 1984, Sanders, Dadds, Johnston, & Cash, 1992), and depression (Sanders et al., 1992; Sheeber, Hops, Alpert, Davis, & Andrews, 1997; Smith & Forehand, 1986). A high degree of conflict between parents and adolescents is reported to be predictive of a variety of adolescent problems including running away from home, teen pregnancy, dropping out of school, drug abuse, attempted suicide (Montemayor, 1983; Petersen, 1988), delinquency (Mann, Borduin, Henggeler, & Blaske, 1990; Patterson, 1982), and alcohol use (Brody & Forehand, 1993).

In New Zealand, prevalence of internalising and externalising psychiatric disorders in a birth cohort of over 1000 Christchurch-born children shows strong linkages between social and family-related factors and greater susceptibility to later disorder, and a relationship between adolescent suicidal behaviours and exposure to childhood and family-related adversity (Horwood & Fergusson,

1998). Similarly, findings from ongoing studies of a birth cohort of over 1000 children born in Dunedin in 1972-1973, showed that adverse parenting practices were related to emotional and psychological distress, behaviour disorders and delinquency in adolescents (Silva & Stanton, 1996). Further, Ritchie and Ritchie (1993) have studied the general patterns of child rearing practices in New Zealand over the last 30 years, and maintain that anger, physical punishment of children and adolescents, and violence in homes is linked to violence in our society.

The frequent comorbidity of adolescent difficulties and parent-adolescent conflict suggests primary and secondary problems are interconnected. Since most studies are correlational, it is difficult to determine the direction of influence, the point of onset, or the course of each type of problem independent of the other. Whatever the direction of causality, serious parent-adolescent conflict must be viewed as symptomatic of adolescent problems at both an individual and societal level. It is therefore becoming increasingly important to expand our knowledge of treatment approaches to help therapists deal more effectively with conflicted family relationships.

No attempt has been made in the present research to identify whether family conflict preceded or followed adolescent problems. The focus was on parent-adolescent conflict as a problem in its own right, exploring strategies that explicitly aim to improve communication and reduce family conflict in New Zealand families. Due to the paucity of local research that directly addresses parent-adolescent conflict, the literature covered in this introduction is drawn primarily from international material. In investigating conflict between parents and adolescents, researchers have focused on documenting frequency of conflict, describing developmental features of conflicted relationships such as puberty, and

family factors that are associated with conflict levels. Subsequent sections include information on these variations. Prominent in the literature is an empirically based model for conceptualising, assessing and treating parent-adolescent conflict that utilises social-learning, cognitive-behavioural and family systems theories (Foster & Robin, 1988; Robin & Foster, 1989). The present research programme looked at the effectiveness and limitations of this approach, and reviews other treatment approaches and relevant research. Consistent with the proposition that actual clinical practice should be guided by theory (Evans, 1999) attention has been given to social-cognitive developmental perspectives that have promising implications for clinical practice. I conclude by outlining an integration of cognitive-behavioural approaches and theoretical principals derived from social-cognitive developmental literature that may lead to improved ways of addressing parent-adolescent conflict.

Characteristics of Parent-Adolescent Conflict

Definition. Generally, conflict is precipitated when the goals, expectations, or desires of two parties are incongruent, resulting in mutual opposition, expressed either verbally or nonverbally (Shantz, 1987). This is in accord with the Oxford Dictionary (1995) definition: *a state of opposition; the clashing of opposed principles; the opposition of incompatible wishes or needs in a person.* Conflict is therefore distinguished from aggression that is unprovoked or aimed at harming another person. Although aggressive behaviour often occurs in the context of social conflict, the present research is limited to dyadic conflict, as defined, and does not encompass aggression.

According to Foster and Robin (1989), clinically significant conflict has one or more of the following features: it is frequent and intense; communication

fails to produce resolutions, resulting in repetitive disagreements over the same issues; arguments involve high levels of unpleasant, angry interactions; and pervasive negative feelings are experienced about interactions and other family members. Conversely, disagreements that are not problematic tend to be time limited, produce agreement, and are not accompanied by dissatisfaction with family relations. Empirical data support this characterisation of conflict. Compared to non-clinic families, those seeking assistance for relationship problems report discussing more issues with greater levels of anger and hostility, and less satisfaction with family interactions and relationships (Prinz, Foster, Kent, & O'Leary, 1979; Prinz, Rosenblum, & O'Leary, 1978). Discussions of distressed families have been rated as less friendly, containing poorer problem-solving strategies and being further from resolution when compared to non-distressed dyads (Prinz & Kent, 1978).

Prevalence. Little epidemiological information exists concerning prevalence rates of clinically significant conflict in families, either with teens characterised by varying diagnostic labels or in the population as a whole. Some studies regarding rates of parent-adolescent conflict have been carried out in the United States, but not among diverse cultural groups. The research showed that many families report good communication, low levels of conflict (Prinz et al., 1979), and calm discussions about potentially conflictual issues (Tesser, Forehand, Brody, & Long, 1989), but estimated that 15 to 20 percent of families experience conflict significant enough to warrant professional intervention (Montemayor, 1983).

Rates of conflict do, however, differ depending upon how conflict is defined and how it is assessed. For example, an average of 3.3 conflict episodes

were observed during family dinners (Vuchinich, 1987), an average of two conflicts every three days were reported by adolescents during structured telephone interviews, with approximately half of these involving a parent (Montemayor & Hanson, 1985), and interviewed parents and teens reported conflict occurred once or twice weekly over an average of three and four issues respectively (Smetana, 1989).

Topics of conflict. Over what matters do parents and teens come into conflict? Research evidence shows that for both distressed and non-clinic families in Western societies the same mundane day-to-day issues emerge repeatedly, such as household chores, the teen's bedroom, homework, bedtime, sibling relations, appearance and personal hygiene, social life and friends, choice and timing of activities, and curfew (Barber, 1994; Hill & Holmbeck, 1987; Montemayor, 1983; Smetana, 1989; Smetana, 1991; Smetana, Yau, Restrepo, & Braeges, 1991c; Tesser et al., 1989). Since the majority of studies have concentrated on Anglo-European families there is little information available as to how culture-specific parent-adolescent conflict is. A study that did examine cultural variations showed that white, black, and Hispanic families reported they all disagreed over the same everyday matters issues, but white American parents reported more conflict than either minority group (Barber, 1994). Similarly, Chinese adolescents in Hong Kong reported conflicts were over everyday issues (Yau & Smetana, 1996). This does not necessarily mean that parents and teens agree on more substantive issues such as drugs, sex or religion, but rather may reflect less frequent discussions or a reluctance to discuss them.

Conflict resolution in non-clinic families. Although there has been considerable interest in parent-adolescent conflict, there is little research on how

conflicts are resolved. A review of family interaction research (Maccoby & Martin, 1983) suggests that collaboration and compromise are associated with healthier family functioning and fewer conflicts. Developmentally, knowledge of appropriate skills and strategies for negotiation and compromise increase from middle childhood to late adolescence, and these skills are used by teens when responding to hypothetical conflicts and in peer relations, but not typically produced in actual disagreements with parents (Leyva & Furth, 1986; Selman, Beardslee, Shultz, Drupa, & Podorefsky, 1986; Youniss & Smollar, 1985). Available studies have shown that adolescent submission to parent authoritarianism, withdrawal, and disengagement without conflict resolution are consistently more likely to occur than negotiation and compromise (Montemayor & Hanson, 1985; Smetana, Yau, & Hanson, 1991b; Youniss & Smollar, 1985; Vuchinich, 1987). Smetana et al. (1991b) found that conflict resolution varied with adolescent age, gender, and topic of conflict. Adolescent concession declined from pre- to mid-adolescence and more conflicts were left unresolved in families with boys. Also, families compromised more over regulating adolescent behaviour (e.g., bedtime, curfew) than over personal style (e.g., appearance, health, hygiene) and homework. Conflicts over chores and interpersonal relations (e.g., issues of fairness, friendships) were less negotiable and more difficult to resolve than personal style.

Knowledge concerning topics of conflict, and that negotiation or compromise seldom occurs during disagreements, does not however provide information on what contributes to the development or maintenance of conflict. Several of these aspects are incorporated in the conceptual model of parent-adolescent conflict developed by Foster and Robin (1988) and Robin and Foster

(1989), which is outlined below. As the model is embedded within the context of adolescent development, information on the relationship between biological changes and developmental tasks and family conflict is provided first.

Adolescent Development

Developmental tasks faced by adolescents during this transition that seem to perplex researchers, parents and adolescents themselves include adjusting to the biological changes of puberty and new cognitive capabilities, developing a system of values and a sense of identity, establishing effective social relationships with same and opposite-sex peers, and preparing for a career. There is consensus among researchers that conflict is likely to result as family members react and adjust to these developmental changes, particularly when adolescents desire to engage in new peer-related activities and obtain independent decision-making progresses at a faster rate than their parents feel they are capable of handling. Alternatively, when parents do not become involved in this process and allow adolescents as much autonomy as they wish, teens may become involved in antisocial behaviours that result in increased family conflict (Steinberg, 1996).

All individuals, however, grow biologically, cognitively, and socially and this does not propel all families into clinical levels of distress. It seems no developmental task is unequivocally associated with the incidence and intensity of conflicts. Yet, it is fair to conclude that adolescence is a time for practising independence in order to establish the mature identity necessary to assume adult roles and responsibilities, and there is often considerable tension in many families. Interestingly, while there is a proliferation of literature on adolescent developmental tasks, it seems little has been done to provide families with this

information, which could serve to assist with adjustment from unilateral authority towards more horizontal relationships that are cooperative and reciprocal.

Cognitive-Behavioural Family Systems Model

The model of parent-adolescent conflict proposed by Robin and Foster (1984), Foster and Robin (1988), and Robin and Foster (1989) integrates concepts from cognitive-behavioural and family systems theory within a developmental context. These researchers propose that the biological, social, and cognitive changes that take place during adolescence increase the likelihood of conflict occurring. According to this model, several interacting factors determine whether such conflicts are resolved or whether they escalate to clinically significant conflict occurring.

The first two factors that contribute to the nature, acrimony, and pervasiveness of conflicts involve communication patterns and deficient problem-solving abilities. Specifically, excessive negative and deficient positive communication, poor problem definition, and limited ability to generate or evaluate solutions or to negotiate and plan agreements contribute to excessive conflict in most families. The third factor involves family members' belief systems and attributions concerning parenting practices, family interaction, and behaviour of family members. Cognitive reactions to events that are exaggerated or distorted predispose parents and teens to overreactions, rigid thinking and unwillingness to compromise, misattributions, and excessive anger, which interfere with good communication and adaptive problem solving. The fourth factor concerns family structure characterised by problematic hierarchical patterns of influence and authority within the family, that is, who makes the decisions and how. Two constructs developed by structural family therapists considered relevant

to the model are alignment (coalitions, triangulation) and cohesion (enmeshment to disengagement) (Aponte & VanDeusen, 1981). The components of this model are integrated by considering the interlocking contingencies or the function of recurring sequences of interactions for each family member, such as positive and negative reinforcement, punishment, avoidance, and reciprocity.

Elements of the model are further elaborated in the pages that follow, along with research that supports the components of this model and identifies the conditions under which treatment of parent-adolescent relational problems utilising this framework is most likely to be successful. Additional research regarding communication and problem-solving skills, cognitive appraisals and cognitive development, and family structure and characteristics are integrated where relevant.

Communication Processes and Conflict

Communication and problem-solving skills. Self-report and observational studies support Foster's hypothesis that poor communication and problem-solving skills correlate with parent-adolescent conflict. When compared to families satisfied with their relationships, distressed dyads report and display higher levels of anger-intensity disputed topics, more negative communication (criticisms, commands, hostility), less positive communication (humour, approval, praise, support, and acceptance of responsibility), and less problem specification, solution generation and evaluations (Krinsley & Bry, 1992; Mann et al., 1990; Prinz et al., 1979; Robin & Weiss, 1980; Vincent-Roehling & Robin, 1986). The reciprocal nature of interactions has been investigated less frequently with parents and adolescents than in families of younger children and married couples. However, analysis of observed parent-adolescent discussions has found no differences

between distressed and non-distressed dyads for reciprocity of positive behaviour, but significantly more reciprocity of negative behaviour among distressed dyads (Foster & Robin, 1989; Krinsley & Bry, 1992).

Interestingly, data suggest that negative emotions, particularly anger and contempt, disrupts adaptive communication and problem-solving effectiveness (Capaldi, Forgatch, & Crosby, 1994; Forgatch, 1989; McColloch, Gilbert, & Johnson, 1990). Conversely, constructive problem solving is facilitated by a family atmosphere of warmth and supportiveness, and expressions of positive affect or laughter during discussion of difficult issues (Capaldi et al., 1994; Robin, Koepke, & Moye, 1990; Rueter & Conger, 1995a; Rueter & Conger, 1995b).

Social problem solving. D'Zurilla and his associates have developed a model of social problem solving that refers to the process of attempting to discover effective coping responses to specific problematic situations encountered in everyday life for which no effective response is immediately apparent (D'Zurilla & Goldfried, 1971; D'Zurilla & Nezu, 1982; D'Zurilla & Maydeu-Olivares, 1995; Nezu & Nezu, 1989). According to this view, two processes largely determine problem-solving outcomes: (a) problem orientation and (b) problem solving proper, that is, the rational purposeful application of problem-solving skills. Problem orientation involves relatively stable cognitive schemas that reflect a person's general awareness and perceptions of everyday problems as well as their own problem-solving ability and expectancies. Distinctions are made between three concepts: (a) a *problem* is a situation that demands a response for adaptive functioning, (b) a *solution* is a coping response pattern, and (c) *solution implementation* is the process of carrying out the solution in the actual problematic situation (D'Zurilla, 1990).

Numerous studies have indicated that problem solving can have a significant influence on psychological well-being and adjustment, including psychological stress (D'Zurilla & Sheedy, 1991), academic competence (D'Zurilla & Sheedy, 1992), depression and anxiety (Haaga, Fine, Terril, Stewart, & Beck, 1995; Kant, D'Zurilla, & Maydeu-Olivares, 1997). Experimental manipulation has shown that worry decreases problem-solving confidence (Davey, Jubb, & Cameron, 1996; Dugas, Letarte, Rheaume, Freeston, & Ladouceur, 1995). This research supports the view that negative problem orientation may impede use of problem-solving skills because individuals are unlikely to use problem-solving skills if they do not have confidence that something can be done to improve a situation.

Cognition and Conflict

Cognitive distortions. Investigations have supported Robin and Foster's (1989) hypothesis that exaggerated or irrational beliefs induce negative affect and impede adaptive communication behaviour during problem-solving discussions (Robin & Foster, 1989). Fathers' beliefs regarding perfectionism (Vincent-Roehling & Robin, 1986), mothers' and fathers' beliefs regarding ruination, obedience and malicious intent, and adolescents' beliefs regarding ruinous outcomes, and desiring fairness and autonomy have discriminated clinic-referred from non-clinic families (Barkley et al., 1992a; Robin et al., 1990; Vincent-Roehling & Robin, 1986). The studies by Robin and his colleagues do not identify specific situations in which these beliefs are likely to arise, or the extent to which such cognitive processes contribute to actual parent-adolescent conflict. However, Grace, Kelley, and McCain's (1993) findings revealed that reports of parent-adolescent conflict at home were significantly correlated with malicious intent

beliefs in hypothetical conflict situations. This is consistent with findings that distressed spouses are more likely than non-distressed spouses to blame their partner for relationship difficulties and to see the negative actions of their partner as intentional and selfishly motivated (Bradbury, Beach, Fincham, & Nelson, 1996). Also, a recent study involving 40 mother-adolescent dyads showed that negative beliefs of one another was predictive of their respective negative communication during a problem-solving task (Reed & Dubow, 1997).

Social cognition. As individuals reach adolescence, extensive changes in thinking occur, and in this regard, social cognition is especially important. Social cognition refers to how individuals think about themselves, their relationships with others, their participation in groups and in the larger society (Atwater, 1996). Changes in social cognition will therefore affect parent-adolescent relationships throughout adolescence and the transition to adulthood, and consequently should be considered an important determinant when addressing parent-adolescent conflict.

Smetana (1988a, 1988b) utilised social-cognitive development to advance a theoretical paradigm to conceptualise differential perceptions of parents and adolescents regarding conflictual situations. She asserts that alterations in parent-adolescent relationships and conflicts can be meaningfully understood within the social-cognitive framework that takes into consideration the ways in which parents and teens interpret their social worlds, and understand and define family rules, events, and regulations. She proposes that parent-adolescent conflict is related to development of social reasoning in adolescents, and has examined parent-adolescent conflict within a domain model of social cognition.

Early research using the domain model focused on moral and social development in larger social systems (e.g., school) (Turiel, 1983). The family is also recognised as a social system by Smetana and colleagues, entailing hierarchical structures, patterns of authority, rules and conventions. Before describing research that has examined teens' and parents' thinking within this conceptual framework, I will outline the domain model of social-cognitive development and its relevance to parent-adolescent relationships.

Domains of social-cognitive development. A great deal of empirical research exploring the development of social knowledge in children and adolescent indicates that social conventions, morality, and psychological issues constitute conceptually distinct domains of social judgement (Smetana, 1983, 1993b, Turiel, 1983; Turiel & Smetana, 1984). To summarise briefly, judgements about issues differ according to the different domains of social reasoning across ages and settings. In this model, social conventions are behavioural uniformities that serve to coordinate social interactions within social systems. Conventions are arbitrary and are relative to social contexts, with acts being judged as wrong contingent on alterable rules of commands of authority and social consensus. Moral acts are judged as unalterable and wrong independent of social organisation or regulations. Moral prescriptions (e.g., regarding stealing and killing) are determined by factors inherent to social relationships and are based on concepts regarding the rights and welfare of people, and justice in the sense of comparative treatment and fair distribution. The psychological domain pertains to understanding of self, identity, and attributions regarding thoughts and behaviour. Personal issues, which are one aspect of the psychological domain, are evaluated independent of moral concern or societal regulation because they pertain only to

individual preference, privacy and control over one's body. In addition, rules that regulate acts which involve safety, harm to the self, comfort and health have been referred to as the prudential domain, and are differentiated by justifications being based on harmful consequences to oneself rather than the regulation of social interactions (Tiask & Turiel, 1984). Moral transgressions are considered to be more serious than either conventional, personal, or prudential rule violations (Nucci, 1981; Tiask & Turiel, 1984).

The perspective discussed thus far suggests that domains are clearly distinguishable. However, many social situations and behavioural decisions are seen to be multifaceted and contain components of more than one domain, either in conflict or in synchrony with one another (Smetana, 1983; Turiel, 1983), which reflects the complexity of the social world. For instance, Smetana's (1981) research from the domain perspective on women's reasoning and decision making about abortion indicated some viewed abortion as a moral issue, for others it was an issue of a personal nature, while others coordinated the two domains by viewing early pregnancy as a personal issue and later pregnancy as a moral issue. The main finding of this study was that domain related reasoning corresponded with behavioural decisions regarding continuation of pregnancy.

Social-cognitive domains and parent-adolescent conflict. Parents want their children to do, or not to do, certain things, and to hold approved values. Typically, parents see themselves as having authority over their children, with the right to advise, command, or coerce their children to behave and think in ways they believe they should according to the values they hold. Developmental changes in adolescents' understanding of expectations and responsibilities within the family social system have implications for understanding parent-adolescent

relationships. Conflicts are prone to emerge as adolescent age increases and boundaries of legitimate parental authority are renegotiated, and this renegotiation occurs more in conventional and personal domains than in the moral domain (Smetana, 1988).

Turiel (1983) found that prior to ages 12 or 13, adherence to convention was based on concrete rules and authoritative expectations. With the early adolescent transition there was an emergence of awareness that rules are arbitrary and based on the expectations of others. Later, conventions were not defined by the imposition of rules by those with higher authority upon subordinates, but to coordinate and guide social interactions. As such, conventions were viewed as shared and agreed-upon modes of behaviour.

Therefore, as adolescents pass through the period of cognitive development in which they view social conventions as arbitrary, they will typically come to question the necessity for many conventions, as well as parental authority as a basis for following convention. Even when both the parent and teen define an issue of contention in conventional terms (i.e., there are rules that govern one's behaviour), the teen may not adopt the parent's convention (e.g., "You may wear those clothes to the beach, but they are inappropriate when visiting relatives").

Further, as young people develop, they are increasingly likely to view issues defined by their parents as matters of social convention (e.g., "in this family we make our beds every morning") as issues of personal choice ("it is my bed, so I will decide how often to make it"). If parents maintain their conventional stance, conflict is likely to follow.

Parent-adolescent conflict can therefore be characterised in terms of conflicts between domains in social judgements. As adolescents approach adulthood, they expect greater participation and increased autonomy for decisions that affect them. Thus, competing goals of parents and teens in family situations may result in different interpretations of events (i.e., maintaining social order versus developing personal jurisdiction). This mismatch may lead to conflict. It could be expected that conflict where adolescents challenge the legitimacy of parental authority to enforce rules to be more serious than disagreement about the details of their application. For example, an argument about the particular time that a teen comes home at night would be less serious than an argument about whether the parent has the authority to make such a rule at all.

Empirical investigations on discrepancies in parents and adolescents conceptions. In a series of studies, Smetana and colleagues have examined the way parents' and teens' interpret both hypothetical and actual conflictual situations within the social-cognitive development framework. The research has consistently indicated that parents and teens generally agree on the issues that cause conflict but they interpret them in conceptually different ways.

Smetana (1988a, 1989) interviewed 102 children (ages 10 to 18 years) and their parents to assess conceptions of parental authority and reasoning in moral, conventional, personal and multifaceted domains. Based on hypothetical items, parents and adolescents across all ages judged parents as having legitimate authority to make rules regarding moral transgressions that occur in the family context (such as stealing from parents or hitting siblings) and conventional behaviour in the home (such as doing chores or calling parents by their first names). Judgements differed regarding multifaceted issues (such as cleaning one's

room, hanging out with a friend that parents did not approve of) and personal issues (such as sleeping late at weekends, talking on the phone), with parents being significantly more likely to view them as under parental jurisdiction than were adolescents.

Family members were then asked to judge wrongness or permissibility of acts and sort them into one of three categories: always wrong independent of authority, wrong contingent on authority, and not an issue of right or wrong – up to the individual. These three categories were seen to represent moral, conventional, and personal domains respectively. Across both studies, using hypothetical items and actual family conflict, overall, moral items were justified using moral reasoning and sorted as wrong independent of authority, which did not vary according to adolescent age. There were marked differences between parents' and adolescents' conceptions in multifaceted and personal issues. Parents typically focused on the conventional components and were more likely to consider they should retain authority than did the adolescents. Prudential reasoning occurred less frequently. The adolescents were more likely to consider multifaceted and personal issues as under their personal jurisdiction and outside the bounds of legitimate parental authority. Adolescents at all ages were more likely to see personal issues as legitimately within their own personal authority than were parents.

As adolescent age increased, however, parents became less likely to reason about multifaceted and personal issues as conventional and contingent on parental authority and more likely to reason and categorise issues as pertaining to adolescent personal jurisdiction. Consistent with hypothetical conflict situations, when actual family disputes were described, adolescents understood but rejected

their parents' conventional perspectives and reasoned in terms of personal choice. When families were observed discussing actual conflict issues they had selected, differences in reasoning while working towards resolution were consistent with both hypothetical and described disputes (Smetana, Braeges, & Yau, 1991a).

A further study by Smetana and Asquith (1994) examined the consequences of discrepancies between parents' and adolescents' conceptions of authority and parent-adolescent conflict. Again, judgements of legitimate parental authority and sorting of issues into domain categories contingent on authority was consistent with previous studies. It was also found that multifaceted issues were discussed more frequently than other types of issues, followed by conventional issues. Moral issues were discussed infrequently, but discussions about moral and conventional issues were angrier than for other issues, followed by multifaceted issues. These findings support the contention that conflicts between parents and adolescents occur over different interpretations of issues.

The families in the studies described were primarily lower to middle-class white Americans, which limits generalisation of results to diverse ethnic groups. However, a comparable study conducted by Yau and Smetana (1996) in Hong Kong showed that Chinese adolescents also reasoned about conflicts in terms of exercising personal jurisdiction. Parents' reasoning was primarily prudential or pragmatic, that is, references were to safety, health, or practical needs and consequences, which differs from research on European-American adolescents where parent's reasoning is predominantly conventional.

Interestingly, parents and teens not only agree about the issues that caused actual conflict in their relationship, but also typically articulate the other's judgement about topics of dispute reasonably well (Smetana, 1989; Yau &

Smetana, 1996). This suggests parents understand but reject adolescents' claims to personal jurisdiction and similarly, adolescents understand but reject parents' conventional interpretations.

Smetana proposed that the social-cognitive domain distinctions have relevance to understanding parent-adolescent conflict as, overall, the results indicate that adolescents and parents ascribe different meanings to hypothetical and actual family conflicts. Results also suggest adolescents' attempts to assert autonomy over issues compete with parents' conventional goals of regulating the household, maintaining authority and conventional standards. The extent to which these reports generalise to actual disagreements in the home environment has not been determined, but it seems reasonable to assume that discrepancies in parents' and adolescents' conceptualisation of issues and justification for their positions would increase the likelihood of conflict.

In a related vein, some studies have examined parents' and teens' perceptions about who makes decisions on issues of potential conflict. It has been reported that the degree of discrepancy between parent and teen perceptions about who actually makes decisions in the family predicts self-reports of conflict (Holmbeck & O'Donnell, 1991). Another study including 35 adolescents and their parents showed that adolescents thought they should decide more issues alone while parents thought more issues should be decided jointly, but the relationship between discrepant views and conflict levels was not examined (Wierson, Nousiainen, Forehand, & McCombs Thomas, 1992). In this regard, a promising instrument has been developed by Bosma et al. (1996) to provide information about adolescent and parental perspectives about what is appropriate for adolescents to do or decide for themselves. Their investigation among five

hundred Italian adolescents (age 13 to 15 years) showed that parental feeling about issues rather than adolescents' reports of independent decision making was related to conflict. As concurrent information was not obtained from parents the relationship between divergent conceptions of parental authority and conflict was not determined.

Family Structure and Characteristics

Vast research has been conducted on transformations in parent-child relations during adolescence. Consequently, an extensive number of family variables have been implicated in influencing parent-adolescent conflict in addition to problematic family structure described in the cognitive-behavioural family systems model. Following is an overview of factors identified that are relevant to this research programme: family structure, family composition, gender, parental conflict, parental psychological health, parenting style, and the parent-adolescent relationship.

Family structure. Although the family structure or organisation is an important component of the cognitive-behavioural family systems model (Robin & Foster, 1989), few studies have tested hypotheses regarding systemic family problems. Observations of family discussions, however, have shown that agreement between parents correlates positively with ratings of problem-solving effectiveness, and parental blaming coalitions against the child correlates negatively with problem-solving ratings (Vuchinich, Vuchinich, & Wood, 1993; Vuchinich, Wood, & Vuchinich, 1994). No relationship has been found between cross-generational coalitions and quality of problem solving during family discussions, and cross-generational coalitions do not distinguish clinic from non-clinic families (Robin et al., 1990; Vuchinich et al., 1994).

High family cohesion predicts better adjustment among individuals who are experiencing stressful circumstances (Moos, 1994), but extreme positions on the cohesion continuum are related to poorer communication (Barnes & Olson, 1985; Kashani, Allan, Dahlmeier, Rezvani, & Reid, 1995; Prange et al., 1992). In general, adolescents are better adjusted when the family is seen as cohesive, expressive and organised, and independence is encouraged and less well adjusted when they see their family as high in conflict and very controlling (Moos & Moos, 1986). Interestingly, parents tend to perceive the family environment as significantly more cohesive than do adolescents (Ohannessian, Lerner, Lerner, & von Eye, 1995).

Family composition. Studies comparing levels of conflict and family functioning among intact, single parent and blended families have produced mixed results. Greater conflict and poorer adolescent adjustment have been reported between divorced mothers and their adolescent sons and daughters compared to intact families (Hetherington, 1989; Hetherington & Clingempeel, 1992). Another study, however, revealed conflict was more frequent and rated as more serious with married mothers and adolescents than with divorced mothers (Smetana et al., 1991c).

Conceptions of parental authority in 28 divorced and 66 married mothers and their adolescents were assessed by Smetana (1993a). Regardless of family structure, mothers and adolescents viewed moral and conventional issues as being more legitimately subject to parental jurisdiction than multifaceted and personal issues, which was consistent with previous findings. Both mothers and adolescents also treated the wrongness of moral issues as being independent of parental authority and conventional issues as being contingent on parental

authority. Early adolescents from married families, however, reasoned about the conventionality of multifaceted items more often than early adolescents from divorced families, which is consistent with research that indicates adolescents in divorced families are granted more autonomy and personal jurisdiction than are adolescents in married families (Hetherington, 1989).

It has been shown that parents display more warmth and are more involved with their biological children, and are more distant and disengaged with step children (Hetherington, 1989). Active involvement in parenting by stepfathers has been associated with high levels of conflict between the child and the stepfather, and the mother and stepfather (Hetherington, 1989; Hetherington & Clingempeel, 1992). However, McFarlane, Bellissimo, and Norman (1995) found no significant differences were evident in family function as measured by the Family Assessment Device when comparing intact, single parent, and one natural parent one step-parent families.

Gender. Irrespective of family composition, parent-child conflict involves mothers more often than fathers across adolescence (Montemayor & Hanson, 1985; Smetana, 1989; Smith & Forehand, 1986; Steinberg, 1987; Youniss & Smollar, 1985). A reasonable explanation for this seems to be that adolescents spend a greater proportion of time in leisure than in work with fathers, and equal time in leisure and work or household responsibilities with mothers (Montemayor & Brownlee, 1987) and most conflicts revolve around the issues of daily living. It has also been reported that conflict between mothers and daughters is more common than conflict between mothers and sons (Montemayor, 1982; Smetana, 1989).

Parental conflict. Exposure to high levels of parental conflict has been associated with a wide range of adjustment problems in children (Davies & Cummings, 1994; Emery, 1982; Grych & Fincham, 1990; Hetherington & Clingempeel, 1992), but the linkage between parental conflict and the parent-teen conflict has revealed inconsistencies and causal relations have not been determined. Further, it has been shown that the extent of marital conflict does not affect family problem-solving effectiveness during observed discussions (Vuchinich et al., 1993), and scores obtained for externalising and internalising symptoms in adolescents were lower when parents demonstrated the ability to resolve their conflicts successfully (Kerig, 1996). These findings suggest parental problem-solving behaviours have more impact on parent-adolescent conflict levels than marital discord, so conflict between parents was not included in the present study.

Parent psychological health. Just as aspects of adolescent social and psychological adjustment are associated with conflict, evidence now also indicates that a history of deviant behaviour or psychopathology of any family member is a risk factor for parent-adolescent conflict (Foster & Robin, 1997). For example, high levels of parent-adolescent conflict have been associated with high depressive symptoms and low self esteem in mothers (Dekovic, 1999; Silverberg & Steinberg, 1987), interpersonal hostility (Barkley et al., 1992a), and parental drug use (Rotheram-Borus, Robin, Reid, & Draimin, 1998). Although correlational research does not reveal direction of influence, further examination of the role of parent psychopathology could contribute to a broader understanding of how individual difficulties and family relationships influence each other.

Parenting style. Parents differ in the way they manage their children's or adolescent's daily lives, impose socialisation requirements on their children, and in the way they respond to their children's needs, creating an overall emotional climate represented by parenting style. During the past three decades a considerable body of research has accumulated on the relation between the effects of parenting styles on psychological well-being in childhood and adolescence (Maccoby & Martin, 1983). The research has produced a remarkably consistent picture of parenting style conducive to positive socialisation of children in the dominant culture of the United States. Specifically, factor analyses of parents' behaviours typically yield two dimensions: demandingness and responsiveness. Demandingness refers to the claims parents make on children to become integrated into the family by their maturity expectations, supervision and monitoring of children's activities and behaviour, willingness to confront a child who disobeys, and use consistent, contingent discipline. Responsiveness refers to the extent to which parents intentionally foster individuality, self-regulation, and self-assertion, by being warm and empathic, loving and supportive, and responsive to children's special needs and demands.

Baumrind (1971, 1989, 1991a, 1991b) used these orthogonal dimensions to derive her classification of four parenting styles. *Authoritarian* parents are demanding and directive but not responsive. They do not encourage verbal give and take, expect their orders to be obeyed without explanation, and tend to evaluate children's behaviour in accordance with absolute standards of conduct. *Authoritative* parents are both demanding and responsive. They monitor and guide their children with clear, firm and consistent standards. They are assertive and protective, but not intrusive or restrictive. Their disciplinary methods are

supportive rather than punitive. They encourage verbal give and take, share reasoning for decision making, and are responsive affectively and cognitively. They want their children to be assertive, socially responsible, self-regulated, and cooperative. *Permissive* parents are responsive but not demanding. They are warm, non-punitive, and lenient toward their child's impulses and desires. They do not require mature behaviour, allow considerable self-regulation, and avoid confrontation. *Rejecting-neglecting* or disengaged parents are neither demanding nor responsive. They do not monitor their children, and are not supportive. They may be actively rejecting or neglect child-rearing responsibilities altogether. The hypothesis that adolescents are most likely to be optimally competent and sustain attachment to their parents when parents are both highly demanding and highly responsive, but increase the ratio of freedom to control in order to match the developmental level of their child is supported by the literature (Baumrind, 1991b).

Authoritative parenting, particularly the warmth and acceptance components, is consistently associated with more positive adolescent outcomes including better academic performance (Bronstein et al., 1996; Dornbusch, Ritter, Leiderman, Roberts, & Fraleigh, 1987; Maccoby & Martin, 1983), more problem-focused coping (Dusek & Danko, 1994; Vuchinich et al., 1994), increased social competence, autonomy, and self-esteem (Baumrind, 1989; Baumrind, 1991b; Buri, 1989; Buri, Louiselle, Misukanis, & Mueller, 1988; Dusek & Danko, 1994; Hetherington & Clingempeel, 1992; Steinberg, Mounts, Lamborn, & Dornbusch, 1991), lower depression scores (McFarlane et al., 1995), low levels of externalising behaviour (Hetherington & Clingempeel, 1992), less deviance (Brody & Forehand, 1993), absence of coercion and conflict (Hetherington &

Clingempeel, 1992), and better relations between parents and children (Hall & Bracken, 1996; Noller & Callan, 1991). Conversely, children of authoritarian parents typically display deficits in these areas, with coercive interactions, harsh inconsistent discipline, and poor parental monitoring being associated with low self-esteem, low self-efficacy, the development of depression, and antisocial behaviour among adolescents (Ary, Duncan, Duncan, & Hops, 1999; Oliver & Paull, 1995; Patterson, 1982; Patterson, Reid, Jones, & Conger, 1975). Interestingly, adolescents' appraisals of parental authoritarianism and authoritativeness have been more strongly related to their self-esteem than parents' appraisals (Buri, 1989). Consistent with Baumrind's perspective, it has been found that an authoritarian environment characterised by high levels of rules appears associated with high levels of disagreements, and when children have a say in rule formulation fewer serious disagreements occur (Hill & Holmbeck, 1987).

Much of the work on the benefits of authoritative parenting has been conducted on samples of white, middle-class youngsters growing up in two-parent households, and is consistent with qualities of independent individuals that is valued in Western populations. Whether the positive consequences of authoritative parenting apply to other populations of adolescents and parents is an important question that has yet to be answered, but some variability has been reported. Authoritarian parenting style has been found to be utilised to a greater degree in East Asia, Africa, as well as Asian Americans and African Americans (Greenfield & Suzuki, 1997). Baumrind (1972) reported that authoritarian parenting, which is associated with fearful timid behaviour among European-American children, is associated with assertiveness among African-American

girls. Further, it has been reported that academic achievement of Asian-American students is more strongly associated with authoritarian than authoritative parenting (Dornbusch et al., 1987).

Authoritative parenting, with clear direction and open lines of communication permits discussion and participation in planning and decisions, but this parenting style is global and content free. In contrast, domain differentiated judgements of parental authority provides a more specific framework of parental demandingness regarding rules and parental responsiveness regarding adolescent autonomy as research shows that adolescents' and parents' conceptions of legitimate parental authority differ according to the conceptual domain of the issue under consideration.

To support this hypothesis, Smetana (1995) examined the effects of authoritative, authoritarian and permissive parenting styles and domain differentiated conceptions of parental authority. Analysis revealed that adolescents viewed their parents as more authoritarian and more permissive than parents viewed themselves, whereas parents viewed themselves as more authoritative than did adolescents. No significant effects for parenting style were obtained for judgements or justifications using adolescents' perceptions. However, using parents' conceptions of parental authority, significant differences were found primarily over the boundaries of adolescents' personal jurisdiction. Authoritarian parents judged moral and conventional issues as prescriptive and obligatory and were more likely than other parents to treat personal issues as conventional and legitimately subject to their authority. In contrast, permissive parents ignored conventional components of multifaceted issues, and were more lenient in their judgements of issues pertaining to prudential issues. Only authoritative parents

drew clear boundaries between moral, conventional, and personal issues in a manner consistent with domain theoretical expectations. They also defined multifaceted issues as containing both conventional and personal components. Parenting style did not differ as a function of adolescent or parent gender, but conflict levels were greater among families with authoritarian parents. These findings are consistent with Baumrind's (1989) assertion that authoritarian parents are more restrictive and value obedience, while authoritative parents negotiate with children and are responsive to their need for personal choice.

In summary, it seems apparent that parenting style influences the emotional climate, as well as adolescent socialisation and well-being. The emotional relationship between the parent and teen influences the context in which disagreements are expressed and, in turn, is likely to influence the teen's responsiveness toward parental requests and expectations.

Parent-adolescent relationship. Contemporary views assert adolescent competence is attained in relationships where individuality and separation is occurring, while still maintaining connections with parents (Grotevant & Cooper, 1986). At the same time, change from characteristic unilateral authority of the parent-child relationship occurs as parents and teenagers begin to interact more cooperatively and connectedness between parents and adolescents is based on respect for one another as persons rather than on authority (Youniss & Smollar, 1985). It has been suggested that the impact of conflict depends more on mutual respect, or relationship quality, rather than on frequency of disputes, with conflict being non-threatening in close, trusting relationships (Cooper, 1988; Laursen, 1993). There is some data to support this assertion. Among 508 families in the Netherlands, Dekovic (1999) found that negative well-being for adolescents in

terms of depression and lower self-esteem was more strongly related to negative quality of the parent-adolescent relationship rather than a high level of conflict.

Youniss and Smollar (1985) found teens perceived their parent as harming the relationship by failing to treat them with respect by means of yelling, criticising, insulting, not listening, or not paying attention, and not trying to understand them. Compared to fathers, mothers are perceived by adolescents as being more open to recognising and accepting their opinions (Barnes & Olson, 1985; Noller & Callan, 1990) and are more likely to engage in their interests (Youniss & Smollar, 1985). Similarly, a study by Paterson, Field, and Pryor (1994) found New Zealand European/Pakeha and Maori adolescents reported a higher quality of affect toward their mothers and sought them more than their fathers for support.

Twenty Italian adolescents between 13 and 15 years and their parents were interviewed by Jackson, Cicogani, and Charman (1996) to explore what strategies parents used in order to induce adolescents to accept their decisions. Parents reported that 13-year-olds could be convinced by explanation of the reasons for their decisions, but that 15-year-olds tended to present more opposition and argue against the parental position. In these situations, parents would often cut off discussions and impose their decision to maintain control over their adolescent. The adolescents' responses indicated different reasons for compliance with their parents' requests. Younger adolescents admitted accepting parental explanations and decisions as acceptable. Older adolescents reported that the way reasons were presented by parents was important, and cited the need for parents to recognise them as persons capable of making their own decisions. Some accepted decisions based on their parents' motives, others responded when account was taken of their

opinions. Others cited respect for parents, but did not identify specifically what respect entailed. In general, adolescents view the family more negatively, and report higher levels of conflict, than their parents (Montemayor, 1983; Paikoff, Carlton-Ford, & Brooks-Gunn, 1993). It has also been shown that a conflictual family environment assessed via the Family Environment Scale not only affects satisfactory parent-child relationships but also hinders the individuation process in young adults (Johnson, Wilkinson, & McNeil, 1995).

A compilation of research findings indicates that adolescents want parents who are interested in them, spend time with them, listen and understand, accept them as they are, offer guidance, trust them and treat them like an autonomous adult, have a sense of humour, and to set a good example (Rice, 1999). Clearly, parent-adolescent conflict takes place within a relational context, but very little is known about the interplay between the qualities teens want in their parents, their responsiveness to parental expectations, and conflict levels. Yet it would appear that this interplay has relevance for clinical treatment.

Interventions for the Management of Parent-Adolescent Conflict

A diverse range of interventions have been designed to decrease conflict in family relationships such as parent management training, communication and problem-solving approaches, cognitive restructuring, and family therapy interventions. A brief summary of each approach is presented.

Parent management training. Parent training programmes have been shown to improve children's behaviour and alter other aspects of family functioning but are typically geared toward families with young children and efficacy declines as age increases (Barkley, 1998; Dishion & Patterson, 1992; Forgatch & Patterson, 1989; Kazdin, 1997; Patterson & Forgatch, 1987). As

adolescents develop a sense of autonomy, they must be active participants if interventions are to be effective. Problem-solving strategies, with their explicit involvement of teens in decision making provides an appropriate developmental approach.

The effects of problem-solving skills training and parent management training was evaluated by Kazdin, Siegel, and Bass (1992) in children aged from 7 to 13 years referred for antisocial behaviour. Results revealed that, relative to each individual approach the combined treatment led to more marked changes at post-treatment and 1-year follow-up. Barkley, Edwards, and Robin (1999) have developed an intervention that combines parent management training and problem solving and communication training, based on the cognitive-behavioural family systems model previously described, to assist in the adolescent having an active part in family change. The researchers are examining the efficacy of this programme. Dishion and Andrews (1995) have reported positive results for a similar programme that were maintained for 1-year after treatment termination.

Problem solving and communication skills training. These treatments have evolved from the skills-deficit view that assumes parents and teens experience conflict because they lack adaptive communication and problem-solving skills and the teaching of these skills should therefore facilitate improved communication and greater resolution of disputes.

Treatment components. Problem-solving skills, which refer to communication behaviours that promote productive solutions to specific conflictual issues, typically follow the model of cognitive problem solving originally described by D'Zurilla and Goldfried (1971), and later revised by D'Zurilla and Nezu (1982), which includes several steps: problem orientation,

problem definition and formulation, generation of alternative solutions, evaluation and decision making, and solution implementation and verification. Robin and Foster (1989) added a renegotiation phase as many families reported that initial solutions did not work exactly as planned.

Communication skills training typically accompanies problem-solving training with components drawn from a variety of sources (e.g., Gottman, Notarius, Bonso, & Markman, 1976; Jacobson & Margolin, 1979; Robin & Foster, 1989). Different studies emphasise some skills more than others and may either implement systematic instruction or identify communication skill problems as they arise during discussions, but the following skills are commonly included.

a) Listening skills – paraphrasing; validating statements to affirm the legitimacy of another's opinion; asking questions instead of assuming what others think and feel (mind reading); listening without defensiveness in response to negative feedback.
b) Talking – expressing praise, affection and positive comments; expressing negative feelings, providing feedback, and contributing positive suggestions using non-accusatory I-statements; communicating clearly and briefly, sticking to the topic under discussion and avoiding discussions about past transgressions and conflicts; refraining from interrupting; making straightforward and tentative instead of absolutist statements.
c) Nonverbal behaviours – using appropriate voice tone, matching verbal and nonverbal messages.

Typically, skill-building approaches include instruction, modelling, behaviour rehearsal and feedback, along with homework assignments to assist generalisation of skill use to the home. Most involve 6-12 sessions. The

effectiveness of these approaches has been well supported, as will be illustrated below, but conclusions are often complicated as the specific content may vary, and different measures have been used to examine treatment impact.

Treatment studies. When Robin, O'Leary, Kent, Foster, and Prinz (1977) evaluated problem solving and communication training with self-referred mother-adolescent dyads they found greater improvements in observations of communication in clinic discussions compared to an untrained group, but not changes in reports of conflict at home (Robin, Kent, O'Leary, Foster, & Prinz, 1977). Later research by Foster, Prinz, and O'Leary (1983) and Robin (1981) evaluated a more in-depth problem solving communication package. Both studies revealed significant improvements in self-reports on the Issues Checklist and Conflict Behavior Questionnaire relative to untrained control families. Robin (1981) also reported improved problem solving and positive communication observed during analogue discussions of actual problems. Contrary to anticipated outcomes, an additional generalisation training component included by Foster et al. (1983) did not produce superior generalisation, but this may be attributable to spontaneous generalisation of the skills reported by 65% of families in skills-training group. Robin (1981) documented significant treatment effects were maintained at a 10-week follow up.

It has been shown that problem-solving training, compared with supportive communication training, produced a significantly greater reduction in emotional stress and a significantly greater increase on measures of self-esteem, life satisfaction, and problem-solving ability in a high-stressed community sample (D'Zurilla, 1990). Problem-solving training has also been shown to produce clinically significant reductions in depressive symptoms (Nezu, 1986) with the

inclusion of the problem orientation component adding significantly to the effectiveness of the approach (Nezu & Perri, 1989). A review of problem-solving training in education settings shows social problem-solving steps can be learned, but there is only limited confirmation that cognitive gains are applied to actual behaviour or generalised to other social behaviour (Coleman, Wheeler, & Webber, 1993).

These studies indicate that problem solving and communication training produced positive results, but the variable outcomes raise questions about whether skills taught are used and how knowledge of skills may affect resolution of problems. Further, which components of problem solving and communication skills training – alone or in combination – contribute to effective treatment has not been examined. It has been demonstrated, however, that structured training procedures are required for communication change and improvements in skills (Guerney, Coufal, & Vogelsong, 1981; Serna, Schumaker, Hazel, & Sheldon, 1986; Serna, Schumaker, Sherman, & Sheldon, 1991).

Cognitive restructuring. Two studies have examined problem solving communication training combined with cognitive restructuring. In the first, Robin (1981) produced improvements on observed communication and questionnaire measures of conflict and family relationships relative to waitlist controls, but the cognitive component of the intervention could not be established as no measures of cognitions were obtained.

In the second, Barkley, et al. (1992b) evaluated the relative effectiveness of behaviour management training, problem solving communication including a cognitive restructuring component, and structural family therapy for adolescents diagnosed with attention-deficit/hyperactivity disorder. All treatments resulted in

significant reductions in negative communication, conflicts, anger during conflicts, improved school adjustment, and reduced internalising and externalising symptoms. Contrary to predictions, however, ratings for parental beliefs on the perfectionism, obedience and total scores worsened significantly between pre- and post-treatment in the group including the cognitive restructuring component, which was not evident in the other treatment groups. This result suggests an adverse reaction to focusing on negative attributions. It has been proposed, however, that cognitive restructuring to alter malicious intent and blaming attributions are applicable during early sessions to engage family members in the treatment process because once negative interactions have begun in clinic families a powerful negative context is created which is not easily changed (Foster & Robin, 1998; Robin & Foster, 1989). On the other hand, cognitive interventions may be contraindicated when extreme beliefs are in fact realistic, when acculturation differs between parents and their children, or when individuals are highly rigid and resist challenging their beliefs.

Family therapies. Two other well-researched treatment strategies that have also produced changes in the interactions of families with teens are functional family therapy (Alexander & Parsons, 1982; Barton & Alexander, 1981) and multisystemic therapy (Henggeler & Borduin, 1990).

Studies evaluating functional family therapy with delinquent teen populations have documented improvements in family members' discussions (Alexander & Parsons, 1973; Barton, Alexander, Waldron, Turner, & Warburton, 1985). Similarly, when effects of multisystemic therapy have been examined in treating families of teenagers with serious antisocial behaviour, positive changes in observed communication and problem solving (Henggeler et al., 1986), as well

as self-reports of family relations have consistently been shown (Borduin, 1995; Henggeler, Melton, & Smith, 1992; Mann et al., 1990). Clear conclusions cannot be drawn from these studies however, as communication around actual disagreements was not assessed, and the individualised nature of functional family therapy and multisystemic therapy meant some families may have received communication training as part of their intervention. It is also possible that improvements in teenagers' externalising behaviours produced improved family interactions. As multisystemic therapy is an intensive community treatment approach it is not feasible to provide this treatment to all families experiencing high levels of conflict, and in many cases may not be warranted. However, these studies show that functional family therapy and multisystemic therapy can produce changes in communication, apparently without extensive didactic training in problem solving and communication skills, and challenges the notion that high levels of conflict are the result of skill deficits.

Summary

Even though there is extensive research in the area of parent-adolescent conflict, there are many gaps in our knowledge regarding interventions and factors that influence their effectiveness. Both developmental and cognitive-behavioural research has added to our knowledge of normal and clinically distressed parent-adolescent conflict, but they show little overlap in conceptual models or treatment approaches. Developmental research has primarily focused on examinations of how age, gender, pubertal status and cognitive variables such as reasoning relate to conflict. In addition, a variety of studies have examined the frequency and topics of specific conflictual issues in families with adolescents, and correlates of parent-adolescent conflict, but have not described how these issues may be

interrelated with one another. Cognitive-behavioural researchers have typically examined maladaptive family processes such as deficits in communication and problem-solving strategies. Differences in participant selection criteria, measures used, and outcome variables make integrating these literatures difficult.

There seems to be consensus that mastering of developmental tasks during adolescence leads to disruption in the family, yet no treatment approach includes assisting families with understanding what these tasks are, or how to utilise that understanding in maintaining family harmony. While it appears that studies have served to demonstrate the acquisition of conflict resolution skills, it cannot be automatically assumed that the skills will be used in the home environment. Although negative affect is associated with poorer communication and failure to resolve disputes, it is not evident from previous studies whether communication and problem-solving skills were deficient or whether individuals failed to use known skills. Communication is not necessarily consistent across situations. For example, many parents and teens that experience high levels of conflict are able to communicate and negotiate appropriately with other people. Teaching of skills cannot therefore be considered a universally effective remedy to alleviate excessive family conflict. Also, research findings have consistently shown adolescents and their parents do not hold similar perceptions regarding the family environment, who actually makes decisions about teen behaviour in the family, or levels of conflict, but divergent perceptions have not been interpreted in a meaningful way.

Information provided from previous research suggests we need to expand on traditional skills based approaches and be guided by psychological principles, which is the approach adopted in this study. The present research has a cognitive-

behavioural perspective, with principles from developmental research incorporated. Although these lines of research have proceeded somewhat independently, they each have unique strengths that could be incorporated to reach broader conclusions about the effects of various treatments for parent-adolescent conflict.

In this research project, I attempted to examine many of the potential contributors to excessive parent-adolescent conflict and variables that may facilitate or detract from successful treatment. When conducting these investigations, the divergence of responses between parent and adolescent dyads was also examined to explore the association with conflict levels. Conflict resolution must be based on mutual respect and commitment to beneficial outcomes. It is for this reason that beliefs and the underlying meaning of conflict to individuals, and perceptions of the relationship, are considered important aspects of this study. Divergent findings will be examined to identify relations with conflict levels. Further, much of the research to date has been conducted with non-clinical samples, yet the literature clearly indicates that many clinically referred families experience high levels of conflict. This study endeavoured to address this shortcoming by not excluding participants whose degree of difficulty was comparable to those likely to be seen in general clinical practice.

Finally, research to date has used samples with limited cultural diversity, and the effects of treatment programmes have not been evaluated across different ethnic groups, yet much of our clinical practice in New Zealand is based on this work. The generalisability of international research to New Zealand families has not been explored. Cultural norms and influences are important to consider in understanding family members' roles, cognitions, and behaviours, particularly as

skills-based approaches carry the inherent assumption that the skills taught are adaptive. This assumption may not be embraced among culturally diverse groups.

In the following pages each of the areas presented in the introduction will be examined in more detail across three main studies. First, preparatory pilot studies were conducted to assist in the development of instruments to be used.

Second, an investigation of levels of parent-adolescent conflict was combined with decision making perspectives, categorisation of issues into domains according to the social-cognitive framework, perceptions of parenting style and the parent-adolescent relationship, and psychological symptom patterns. Such a combination enabled exploration of some of the factors assumed to influence parent-adolescent conflict levels but not previously examined in a single study, and to investigate organised social-cognitive domains of conflictual family issues during adolescence.

The final study was designed to compare the effectiveness of two treatment approaches. This research incorporated knowledge from the social-cognitive domain perspective combined with developmental principles to devise a training protocol. The resultant Domain and Development based training protocol was compared to Problem-Solving skills training primarily based on the work of Robin and Foster (1989). In effect, the Domain and Development based intervention was designed to investigate whether changing awareness of developmental tasks and provision of a social-cognitive framework to describe the underlying meaning of conflict would have an impact on levels of conflict and bring about change in perceptions of relationship.

As problem solving interventions have been demonstrated as an effective treatment of parent-adolescent conflict, it was expected that the Problem Solving

group treatment would show reduced conflict behaviours and improved perceptions regarding relationship at post-intervention compared to pre-intervention. It was also expected that the Domain and Development group treatment would show improved changes over time that would be comparable with the Problem Solving group intervention, which would serve to demonstrate the utility of the alternative intervention approach. There was not an assumption that there would be a significant difference between the two treatment groups at post-treatment. It was surmised, however, that if families reported having good awareness of problem-solving skills and high levels of conflict at pre-treatment, those in the Domain and Development group would show greater improvement at post-treatment than those in the Problem-Solving Skills Training group.

CHAPTER 2: PILOT STUDIES

The purpose of conducting pilot studies was to obtain information from New Zealand individuals to assist in the development of instruments that would be used to examine the association between levels of conflict, assignment of issues to domain categories according to the social-cognitive development perspective, and the parent-adolescent relationship.

Pilot Study No. 1

Selection of Issues and Development of Questionnaire

Aims of Study

From the information provided in the preceding chapter, it is apparent that most investigations of parent-adolescent conflict have centred on communication and problem-solving skills or developmental factors. The usefulness of skills approaches have been demonstrated, but, to date, the promising possibilities of utilising the domain model of social-cognitive development in the assessment and treatment of parent-adolescent conflict have not been researched. Consequently, instruments are not available to explore the association between conflict and judgement of parental authority based on categorisation of issues to domains. It was therefore necessary to develop such an instrument to investigate the relationships between actual levels of conflict and domain categorisation and, in turn, consider the relevance of utilising the domain model of social-cognitive development in the clinical setting for the treatment of parent-adolescent conflict.

The first pilot study was conducted in order to (a) select issues within each domain category that would be comparable with previous research and relevant to New Zealand participants, and (b) develop an instrument that would provide information regarding allocation of issues to domain categories that could be completed by both adults and adolescents within a reasonable time frame.

Issue Selection

This first purpose of this study was to select issues of potential conflict relevant to a New Zealand population that would be categorised differentially according to the domain model of cognitive development. Thirty-two volunteer participants were staff members and students in the Psychology Department at the University of Waikato, and 22 were students aged 11 to 13 years.

Thirty-five issues were used in this pilot study that are cited in the literature as being frequent topics of conflict between parents and teens, and have been judged as belonging to different domain categories in previous research. The issues were presented separately on 3 x 5-inch cards in the form of a statement regarding the permissibility or wrongness of that issue. For example, *stealing or vandalism is wrong, listening to certain music is wrong, smoking is wrong, spending a certain amount of time on homework is right, having a tidy bedroom is right.* Each participant was presented with a set of cards and asked to sort them based on the most important reason they would give when making a decision about each issue. The cards were posted in one of five boxes that were labelled (a) *always*, (b) *only if a parent says so*, (c) *because of safety or health*, (d) *not an issue of right or wrong – it is up to the individual*, or (e) *not sure.* The first four definitions were considered to represent the *moral*, *conventional*, *safety* and *personal* domains respectively, while the *not sure* box was for issues that were not

judged as belonging to a domain. Participants were told that items were not in any particular order and the number of items for each reason may differ.

From the initial pool of issues, the four most frequently judged as belonging to the *moral, conventional, safety* and *personal* categories were selected to represent those categories. The twelve issues that most frequently differed in domain judgements were selected to represent *multi-dimensional* issues. These 28 issues are presented in Table 2.1. While these issues do not exhaust the list of potential topics that generate conflict in families with adolescents, they allow for classification of conflictual family issues into domains in a manner that has not been attempted in previous research.

Table 2.1
Judgement of Issues According to Domain Categories

Moral	***Conventional***
Stealing or vandalism	Helping with household chores
Hitting other people	Table manners
Being honest with parents	Using swear words
Keeping promises	Calling adults by their first name
Safety	***Personal***
Smoking	Space to keep private things
Eating lollies/chocolate	Taking part in sports/hobbies
Using drugs	Sleeping late at weekends
Wearing a bike helmet	Listening to music
Multifaceted (issues that overlapped domain boundaries)	
Tidy bedroom	Body piercing
Hairstyles	Clothes
Time on homework	Going round with certain friends
Time to come home at night	Watching videos
Going out to certain places	Time talking on the phone
Involvement with boy/girl friend	Drinking alcohol

Questionnaire Development

The second purpose of this pilot study was to develop an instrument that asked participants to judge the legitimacy of parental authority via the permissibility or wrongness of the issues selected, in a way that would provide the means to investigate the relationships between conflict levels and categorisation of issues to domains.

A self-report questionnaire was designed utilising a rating scale format that would allow participants to rate the degree to which they judged each issue as belonging to the *moral, conventional, safety* and *personal* domains. This served to take into account the multi-dimensional nature of many issues that overlap domain boundaries. In accord with the University of Waikato commitment to ensuring that Treaty of Waitangi principles are upheld in University research processes, this instrument was reviewed by a Maori Researcher to establish cultural appropriateness of items.

The questionnaire was initially completed by 30 male and female students (11 to 13 years) who provided feedback regarding readability of item statements and time taken to complete the questionnaire. This preparatory work showed that young adolescents could use the questionnaire. The questionnaire used, which was named Reasoning, is outlined further in Chapter 3.

Pilot Study No. 2

Focus Group Discussions:

Conflict and the Parent-Teen Relationship

Aims of Study

The second pilot study served to collect information from a New Zealand sample concerning the use of adaptive communication and problem-solving skills during conflictual discussions, and the influence the parent-adolescent relationship has on those discussions. As referred to in Chapter 1, the quality of the relationship between parents and their adolescents is not only asserted to facilitate constructive communication and problem solving, but also as being central to adolescent well-being. Yet it seems little is known about the kinds of interactions that characterise adolescents' relations with their parents, or the interplay between perceptions of the parent-adolescent relationship and levels of conflict. If use of adaptive communication and problem-solving skills and perceptions of the parent-teen relationship do influence levels of conflict, it would be advantageous to incorporate them in assessment and treatment approaches.

To develop a quantifiable self-report measure with this end in mind, I initially sought information from New Zealanders to investigate their views regarding parent-adolescent conflict. The aim was to ascertain perceptions of whether conflict levels were influenced by (a) knowledge and use of communication and problem-solving skills and (b) the quality of the parent-adolescent relationship. In particular, I wanted to find out what factors led to

conflict versus teens being responsive to parental requests. To obtain this information I conducted focus group discussions.

Method

Participants

The participants were 14 students enrolled in the first year psychology courses at a New Zealand university. Six were female adults of Maori ethnicity with teenage children, 8 were New Zealand/European teenagers (5 female, 3 male). Students received course credits for participating.

Procedure

The study protocol was reviewed by a Maori Researcher to ensure culturally appropriate procedures were followed, and approval was obtained from the Psychology Department Ethics Committee at the University of Waikato. Students were recruited via an advertisement on the departmental notice board that outlined the basic study procedure and asked for volunteers. Five discussion times were available. Three group discussions were held with teenagers, one was held for parents of teenage children.

When students assembled to take part in the discussions, I explained the procedure to them and provided them with written information regarding the procedure. Confidentiality issues were discussed and agreed to by participants, and the opportunity to ask questions was provided. Those who wished to proceed with participation in the group discussion were then asked to return in 10 minutes to sign a consent form. This format was followed to ensure participants had the opportunity to give informed consent of their own volition and did not feel coerced by the group setting. The advertisement used to recruit students appears in

Appendix A, along with the information sheet and consent form for adolescents. Parallel forms were used for parents with the wording changed where appropriate.

All of the group discussions were facilitated by myself and one other person, either the primary supervisor of the research programme or a research assistant who was enrolled in Master's level clinical psychology study. Each group began by first asking the participants to recall a recent conflict situation that was resolved satisfactorily from their point of view, and then briefly to write down what happened. Participants were then asked to think back to a serious conflict situation that was not resolved satisfactorily from their point of view and, again, briefly write down what happened. This written information was not viewed by any other person. Next, participants were invited to share their experiences with the group. The discussion focused on the following points.

(a) What occurred for the adolescents to be able to deal satisfactorily with the first conflict situation they recorded? (Aim: To identify what skills were used and behaviours of the other person.)

(b) When the conflict was not resolved satisfactorily, did the parent or the adolescent do or say things they knew were inappropriate, and what did they think would have been more constructive? (Aim: Were individuals aware of adaptive communication and problem-solving skills but did not use them?)

(c) What did the participants consider led them to doing or saying something that was inappropriate?

(d) What could satisfactory versus unsatisfactory conflictual discussion outcomes be attributed to?

(e) What contributed to teenagers being responsive to parental requests compared to them becoming engaged in disagreements?

Results

A common theme emerged from each of the four group discussions. All group participants commented that their serious unresolved conflicts were not related to lack of knowledge about adaptive communication and problem-solving strategies. Most participants acknowledged that appropriate skills known to them were typically not used in these unresolved conflicts, and that communication they knew would be destructive was used. In all cases, in both the adolescent and parent group discussions, the difference between satisfactory and unsatisfactory discussions and teen willingness to respond to parental requests was attributed to the relationship between the parent and the teen. In turn, the quality of the parent-adolescent relationship was attributed to the "respect" that the teen had for the parent. Regardless of gender, age, or ethnicity, specific parental behaviours that contributed to parents being respected by teens were identified repeatedly, many of which related to responsiveness towards the teen. The ten parental behaviours most frequently reported as influencing the parent-teen relationship and levels of conflict and were used to develop a self-report instrument named Relationship Questionnaire that is outlined further in Chapter 3.

CHAPTER 3: SURVEY STUDY

Aims of Study

The next phase of the research required that more information be obtained from New Zealand families to see whether the social-cognitive domain conceptual framework that had been developed theoretically would be confirmed with a psychometric study. In order to achieve this objective, it was decided to conduct a survey study among a community sample of parent and teen dyads using self-report measures.

The main purpose of this study was to test the assumption that conflict levels would be related to parents and teens having different perceptions of parental authority, characterised by judgement of issues as belonging to different social-cognitive domains. This study also sought to obtain information regarding parent and teen perceptions about who in the family does, and who should, make decisions about different areas of adolescent behaviour. The match or mismatch in their perspectives was examined to see whether divergent views were associated with conflict levels. A further area of examination was related to perceptions of the parent-adolescent relationship, parenting style and the psychological well-being of parents and teens in order to ascertain the association between these factors and levels of conflict reported. To provide data capable of comparison, instruments used were adapted to include the 28 potentially conflictual issues selected for the purposes of this research project as described previously in the pilot study.

Method

Participant Selection

To recruit participants, information about the research study was disseminated to adolescent students at high schools. To obtain permission to do this, I arranged meetings with the principals of five secondary schools in the Waikato and Bay of Plenty regions to seek their support. Two of the schools were in rural districts with mixed gender students. Three schools were in urban areas, one of which had mixed gender students, one had female students only and the other had all male students. Letters and other materials used to recruit participants via schools appear within Appendix B.

During each meeting with the school principal, the rationale for the research project was outlined and information regarding the procedure and role of the school was provided. All five principals supported the study and gave their permission to advertise the study at their school and assist with collection of consent forms. Letters of explanation were sent to each School Board of Trustees according to guidance from the principal. A meeting was also arranged with the counsellor at each school to provide them with information regarding the research and to ask if they would be available to address any concerns that may arise for students who completed the questionnaires. All school counsellors agreed to this.

A letter was then sent to the teachers of students in Forms 3, 4 and 5, (students aged from 13 to 16 years) that briefly outlined the purpose of the study and asked for their support by distributing brochures to students in their classroom that invited teens and their parents or caregivers to participate in the research. As shown in Appendix B the brochure provided information about the research, an assurance that participation was voluntary, and incorporated the consent form.

The brochure also advised of individuals' right to withdraw their consent at any time, and that withdrawal would not impact their relationship in any way with either their school or the University of Waikato. Details of adult and teen gender and the dyad relationship were included on the consent form as items in the questionnaires were gender and dyad specific. Families were asked to return consent forms to the school via the student. Brightly coloured labelled boxes were provided to each school and placed at the school office to collect the consent forms. To encourage the students to inform their parents about the study, all consent forms returned signed by both the teen and the parent were eligible to ender a draw for prizes, irrespective of whether family members had consented to participate. One draw was carried out per two classrooms. An independent person at the school, for example, an administrator, conducted the draw. Winning students were able to select either a music voucher (equivalent to the cost of one compact disc) or a double movie pass. Morning tea was provided to the schools to acknowledge and thank all staff for their support.

Questionnaires were posted to home addresses provided on the consent forms along with two self-addressed, postage-paid envelopes so the parent and teen could return questionnaires independently. Names were not used on questionnaires to protect confidentiality of participant information, but all consent forms and questionnaires were numbered so teen and parent responses could be matched for data analysis. Participants were invited to contact me if they had any queries or wanted assistance with completing the questionnaires. They were able to ask for a summary of findings to be forwarded to them. Participants did not receive payment for taking part, but in acknowledgment of time taken to complete

questionnaires, those who returned completed questionnaires were placed in a draw to win $100. Two draws were carried out, one for teens and one for parents.

Consent forms were received for 158 dyads and questionnaires were posted to these 316 individuals. Two hundred and sixty-two questionnaires were returned, resulting in a response rate of 83%.

Questionnaires

Six questionnaires were eliminated that did not form a dyad; that is, either a parent or teen did not complete parallel questionnaires. The 256 questionnaires remaining were checked for missing data that was dealt with using the following procedure. If 80% or more of the data was completed, mean values of the individual participants' available data for the subscale or questionnaire were calculated and inserted in order to preserve the mean of the data obtained. If 20% or more of the data was missing from an instrument, or any subscale of an instrument, measurement was considered invalid and the entire data set for the dyad was eliminated from further analysis. Questionnaires for four dyads were eliminated on this basis. Data was analysed from the remaining 124 parent-adolescent dyads.

Participant Characteristics

Gender and age. Sixty-five percent (n = 81) of the adolescent participants were female and 35% (n = 43) were male; 85% (n = 105) of the adult participants were female and 15% (n = 19) were male. The adults ranged in age from 32 to 56 years, with a mean age of 42 years, SD = 4 years, (M_{female} = 41 years, M_{male} = 44 years). Adolescent participants were between 13 years 5 months and 17 years 11 months, with a mean age of 15 years 1 month, SD = 11 months, (M_{female} = 15 years 2 months, M_{male} = 15 years 1 month).

For the purposes of examining whether age influenced outcomes, the teen participants were coded into early (13 to 14 years) and middle (15 to 17 years) adolescent age groups. Forty-one percent (n = 51; 29 females, 22 males) of the teens were early adolescents and 59% percent (n = 73; 52 females, 21 males) were middle adolescents. There were more females in both adolescent age groups, but chi-square analysis showed this difference was not statistically significant so both early and middle adolescent groups could be regarded as equivalent by gender.

Family composition. Family composition information detailing the percentage of mothers, fathers and caregivers, and the percentage of female and male teens within each family structure is presented in Table 3.1. It can be seen from the table that more adolescents were from intact families (teen living with both biological parents) than from single parent families (teen living with one biological parent), blended families (teen living with one biological parent and one non-biological parent), or living with caregivers (neither adult in the parental role was a biological parent).

Dyad. Due to the small number of parent-adolescent dyads in some family composition categories, *Dyad* was grouped so that 1 = female teen and female adult, 2 = female teen and male adult, 3 = male teen and female adult, and 4 = male teen and male adult. The number of dyads in each of these categories used for further analysis is presented in Table 3.2. From this point forward the word *parent* is used to refer to biological parent, step-parent and caregiver because all the adults responded with regard to their parenting role. Female adults are referred to as *mother* and male adults are referred to as *father*.

Table 3.1
Family Composition, Adult Parental Role, and Gender of Teens in Survey Study

Adult	Total		Female Teen		Male Teen	
	%	*n*	%	*n*	%	*n*
Intact Family						
Mother	64	79	64	52	63	27
Father	11	14	12	10	9	4
Single Parent Family						
Mother	8	10	7	6	9	4
Father	3	4	4	3	2	1
Blended Family						
Mother	10	13	9	7	14	6
Father	1	1	1	1	-	-
Step mother	1	1	1	1	-	-
Other						
Grandparent	1	1	1	1	-	-
Aunt	1	1	-	-	2	1

Table 3.2
Dyad Composition of Participants in Survey Study

Parent Gender	Female Teen		Male Teen	
	%	*n*	%	*n*
Female	54	67	31	38
Male	11	14	4	5

Ethnicity. Most of the parent sample (n = 115, 90%) endorsed the *Pakeha/European* category, with 3% (n = 4) describing themselves as *Maori*, and 7% (n = 9) designating *Other* to describe their ethnicity. Similarly, most of the adolescent sample identified themselves as *Pakeha/European* (85%, n = 111), with fewer endorsing *Maori* (4%, n = 5) or *Maori/Pakeha* as the best description of their ethnicity (2%, n = 3). *Other* was designated by 8% of the teens (n = 10).

As most of the parents and teens identified themselves as *Pakeha/European* the number of participants belonging to other ethnic groups was too small to be representative of those groups. It was therefore not considered appropriate to use ethnicity for further analysis.

Religious affiliation. More adult participants described themselves as having a current religious affiliation (73%, $n = 91$) than having *no religion* (27%, $n = 33$). A similar number of adolescent participants endorsed having a current religious affiliation (47%, $n = 58$) to those who reported not having a religious affiliation (53%, $n = 66$).

Self-Report Measures

The battery of six parallel measures was presented to parents and teens in the same order. Eight versions of the questionnaires were constructed with appropriate references to gender and dyad relationship. Parents and teens were asked to complete the questionnaires independently and to report their own perspective. They were informed that there were no right or wrong answers and were encouraged to respond to each item as honestly as possible since all responses would remain confidential. They were asked not to spend too much time on any one item because we were interested in their overall impression. Participants were reminded of the importance of responding to every item and to choose only one response for each item. The five questionnaires that were developed or adapted for the purpose of this study are presented in Appendix C in the order they were presented to participants. The version appended is for a female adolescent whose mother formed the dyad. The sixth questionnaire completed by participants, the Symptom Checklist-90-R, is not appended.

Conflict Checklist (Connelly & Evans, 1998a). This questionnaire was developed for this study and is an adaptation of Robin and Foster's (1989) Issues Checklist. These authors report the Issues Checklist has been demonstrated to have good reliability, internal consistency, convergent and discriminant validity, and to discriminate between levels of family distress.

The purpose of the revision was to design the Conflict Checklist to provide specific information on the frequency and the perceived anger-intensity level of discussions that might arise at home related to the 28 issues selected to represent the social-cognitive domains. Parents and teens indicated how often each topic is discussed on a 3-point scale ranging from *never* (1) to *often* (3) and, if so, with what degree of anger-intensity on a 3-point scale ranging from *calm* (1) to *angry* (3). According to scoring procedures used for the Issues Checklist, these reports yield three scores: (a) the total number of issues discussed irrespective of whether they relate to conflictual situations, (b) the anger intensity per issue discussed, and (c) the anger intensity level per discussion. Since the latter two scores typically correlate very highly and either can be used to replace the other (Foster & Robin, 1988), the mean anger intensity score per issue discussed was used to analyse information obtained from participants in this study.

Decision-Making Questionnaire (Connelly & Evans, 1998b). This instrument was based on the format used in the Perspectives on Adolescent Decision Making Questionnaire (Bosma et al., 1996). The Decision-Making Questionnaire comprises of the 28 issues that are a potential source of disagreement in households with adolescents, selected on the basis of the pilot study outcomes described earlier. For each of the 28 issues the parents and adolescents responded to three standard items: (a) whether the teen does make

decisions regarding the issue (*actual*); (b) whether the parent feels the teen should or should not have involvement with the issue (*parent feelings*); and (c) whether the teen should make decisions regarding the issue (*ideal*). Items were answered using a *yes/no* format. This instrument was designed to provide information about decision-making patterns for specific issues and domain categories, and whether discrepant views between parents and teens about *actual* and *ideal* decision making, and parental *feelings* about the issues, are related to actual conflict experienced.

Reasoning Questionnaire (Connelly & Evans, 1998c). This instrument was developed to assess the degree to which parents and teens judged each of the 28 issues as belonging to the *moral, conventional, safety* and *personal* conceptual domains. It was based on outcomes from pilot studies previously described. For each of the 28 issues the parents and adolescents responded to four standard items: (a) the issue is always right/wrong (*moral*); (b) the issue is right/wrong only if a parent says so (*conventional*); (c) the issue is right/wrong because if affects the teen's safety or health (*safety*); (d) it is not an issue of right or wrong – it is up to the individual (*personal*). Responses to each of the items are made on a 5-point Likert scale ranging from *strongly disagree* (1) to *strongly agree* (5). The higher the score, the stronger the judgement that an issue belongs that domain. Analysis allows exploration of the effects of systematic variations in judgements of different types of issues and domain differentiated conceptions of legitimate parental authority and adolescent personal jurisdiction and family conflict.

Parental Authority Questionnaire (Buri, 1991). The Parental Authority Questionnaire is a 30-item instrument designed to measure patterns of parental authority or disciplinary practices. Each item is stated from the point of view of

the child who appraises the patterns of authority exercised by his or her parents. It has three 10-item subscales based on Baumrind's (1971) descriptions of *authoritarian*, *authoritative* and *permissive* prototypes of parental authority. Responses to each of the items are made on a 5-point Likert scale ranging from *strongly disagree* (1) to *strongly agree* (5). The Parental Authority Questionnaire is scored by summing individual items that comprise subscale scores, with scores on each subscale ranging from 10 to 50. The higher the score, the greater the appraised level of the parental authority prototype measured.

Buri (1989, 1991) has reported very good stability with two-week test-retest reliabilities ranging from .77 to .92, and good internal consistency with alphas that range from .74 to .87 for the subscales. Discriminant-related validity has been demonstrated with authoritarianism being inversely related to permissiveness and authoritativeness, and permissiveness not being related to authoritativeness. Good construct validity is also reported, with authoritarian parenting style inversely correlated with self-esteem, authoritative style positively related to self-esteem, and permissiveness not related to self-esteem. Parental nurturance and warmth has been positively correlated with authoritative parenting and negatively correlated with authoritarian parenting, which supports criterion-related validity. The scales have been tested with high school students (mean age = 17.4 years) and university students (mean age = 18.8 years), and means and standard deviations have been published from these samples.

The Parental Authority Questionnaire items are written using past tense. For this research the items were reworded using present tense to make them relevant to teens living at home with their parents. A parallel version was also developed for parents to provide their evaluation of parenting style used. For

example, *As I was growing up my mother did not allow me to question any decision she had made* was reworded to read *My mother does not allow me to question any decisions she makes* for the teen version, and *I do not allow my teenager to question any decisions I make* for the adult version.

Relationship Questionnaire (Connelly & Evans, 1998d). This is 10-item instrument designed to measure the teen and parent perception of the parent-adolescent relationship. Items were developed according to pilot study outcomes described in Chapter 2 and primarily related to parental responsiveness towards teens. Each of the items on the adolescent version was stated from the perspective of the teen evaluating their parent's behaviour. Items on the parent version were stated for them to evaluate themselves. Responses to each of the items were made on a 4-point Likert scale ranging from *never true* (1) to *always true* (4). A total score was obtained by summing individual items that comprise the scale. Scores range from a minimum of 10 to a maximum of 40. The higher the score, the more positive the appraisal of parent-teen relationship. Responses to the Relationship Questionnaire yielded Cronbach coefficient alpha values of .84 for parents and .89 for adolescents, indicating good reliability. The average inter-item correlation was .36 for parents and .46 for teens, indicating the items measured the same construct.

Symptom Checklist-90-Revised (SCL-90-R; Derogatis, 1992). The Symptom Checklist-90-R is designed to reflect psychological distress in adults and adolescents age 13 and older. It provides a symptom profile along nine subscales: *somatisation, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation*, and *psychoticism*, plus a *global severity index score* which reflects overall

psychological distress. Each item is endorsed with a choice from *not at all* (0) to *extremely* (4) to reflect the level of distress experienced by the symptom in the previous week. Extensive research to measure psychometric properties of this instrument is summarised by Derogatis (1992) and Derogatis and Lazarus (1994). They report satisfactory internal consistency measures for the nine dimensions ranging from .77 to .90, and highly acceptable one-week test-retest reliability coefficients ranging between .80 and .90. Concurrent validity has been demonstrated and studies have confirmed that Symptom Checklist-90-R scores differentiate between patient and non-patient groups, and are sensitive to treatment-induced change. There are four formal normative groups for the Symptom Checklist-90-R, including a community non-clinical population (974 individuals) and adolescent outpatients (806 individuals), which were used for this study. Derogatis and Lazarus (1994) note a strength of this instrument is that test scores are standardised and reported in terms of *T* scores which allows for actuarial statements to be made concerning an individual's status relative to the normative samples. However, as the normative groups are comprised of predominantly White American individuals and the relevancy of these norms has not yet been established with non-American populations, results need to be interpreted with caution. For the purposes of this research, the *global severity index* was used as it combines information on numbers of symptoms and intensity of perceived distress, and as such is reported to be the best single indicator of the current level or depth of disorder (Derogatis, 1992). If a respondent has a *global severity index* score that is equal to or greater than a *T* score of 63 (using community nonpatient norms) the individual is considered at high risk for a positive clinical diagnosis (Derogatis & Lazarus, 1994).

General Procedure

Approval for the procedures carried out in this study was obtained from the Psychology Department Ethics Committee at the University of Waikato. Research procedures and questionnaire content was reviewed by a Maori researcher in the Psychology Department to ensure that cultural safety standards were met and that project findings would not result in any negative impact for Maori participants. The initial part of the procedure, that is, participant selection, has been discussed earlier in this section.

Analysis. The questionnaires were scored and quantitative data were entered into the Statistica for Windows programme for statistical analysis. Descriptive data, correlational procedures, and ANOVA analyses were carried out where appropriate and are described under each aspect of the study.

Results

Self-Report Measures

Scores obtained on each of the questionnaires are presented for the parents and the adolescents separately, then compared to reveal divergent responses. Descriptive statistics for the six measures are presented in Appendix D. Analysis has been performed to determine whether scores varied as a function of demographic characteristics. Finally, scores on each measure were correlated to identify the relationships among variables. Examination focused on whether parents and teens judgement of issues as belonging to different domain categories was related to divergent views about adolescent decision making and actual levels of conflict.

Conflict Checklist. This questionnaire provided information on (a) the *quantity* of issues discussed, and (b) the average *anger intensity* of those discussions, which was obtained by dividing the sum of *anger-intensity* ratings by the *quantity* of issues discussed. High *anger-intensity* scores are indicative of greater average anger per issue discussed.

(a) *Quantity of issues discussed.* Scores obtained indicated that most issues included in this questionnaire were topics of discussion in the families who participated in the study, although parents reported discussing more issues than teens did. The number of issues discussed by parents ranged from 6 to the maximum possible of 28 (M = 21.06, SD = 5.20), and from 5 to 28 (M = 17.36, SD = 5.08) for teens. The greater *frequency* of discussions reported by parents was statistically significant, $t(246) = 5.67$, $p < .001$.

To provide further descriptive information, the percentage of participants reporting that they *never* discussed an issue, had *calm* discussions about an issue,

or that their discussions involved *angry* affect was calculated. This information is shown in Table 3.3 for parents and Table 3.4 for teens, with issues presented in descending order of *angry* discussions for each domain category. These data show that, for the majority of issues, more parents reported having discussions that were *calm* compared to the number who reported *never* discussing the issue or having *angry* discussions with their teenager. When compared with parents, fewer teens reported *calm* discussions, and more reported that they *never* discussed an issue or that their discussions involved *angry* affect.

(b) *Anger intensity of discussions.* The parents' average *anger-intensity* level of discussions ranged from 1 to 1.93 out of the possible 3, (M = 1.30, SD = 0.22). Compared to the parents, the range of teens' average *anger intensity* of discussions was greater (1 to 2.74) and the mean score of 1.53 was higher (SD = 0.36). The *anger- intensity* level reported by teens was significantly greater, $t(246) = 6.01, p < .001$.

The percentage of parents and teens reporting that their discussions involved *angry* affect is presented in Figure 3.1. As depicted in this graph, the issues most frequently argued about, with *angry* affect, were household chores (teens = 68%, parents = 64%) and tidy bedroom (teens = 62%, parents = 58%). This was followed by language, going out, homework, hitting others, telephone use, friends, and time to come home by between 30% and 42% of the adolescents. The pattern of teens reporting more angry discussions than parents was relatively consistent across issues and particularly marked for going out, same and opposite gender friends, time in, alcohol use, drugs and smoking. Compared to the teens, parents did report having more angry discussions about telephone use, language and table manners.

Table 3.3
Percentage of Discussions Reported per Issue, Reflecting Level of Affect: Parents

Issue	Never		Calm		Angry	
	%	*n*	%	*n*	%	*n*
Moral						
Hitting others	31	38	39	48	31	38
Honesty with parent	13	16	65	81	22	27
Stealing/vandalism	29	36	56	69	15	19
Keeping promises	31	39	56	70	12	15
Conventional						
Household chores	1	1	35	43	65	80
Language (swearing)	17	21	40	49	44	54
Table manners	18	22	56	69	27	33
Adults first names	51	63	49	61	0	0
Safety						
Eating lollies/chocolate	24	30	59	73	17	21
Smoking	29	36	65	80	6	8
Using drugs	24	30	72	89	4	5
Bike helmet	56	69	40	49	5	6
Personal						
Music	15	19	73	91	11	14
Sleeping late	45	56	45	56	10	12
Sport or hobbies	12	15	81	100		9
Private space	61	76	37	46	2	2
Multi-dimensional						
Tidy bedroom	7	9	35	43	58	72
Talking on phone	23	29	34	42	43	53
Homework	10	12	56	70	34	42
Going out	10	13	71	88	19	23
Body piercing	33	41	49	61	18	22
Clothes worn	18	22	65	80	18	22
Time home	17	21	69	85	15	18
Friends	21	26	65	81	14	17
Watching videos	24	30	64	79	12	15
Opposite sex friend	29	36	60	74	11	14
Drinking alcohol	18	22	72	89	10	13
Hairstyle	26	32	65	81	9	11

Table 3.4
Percentage of Discussions Reported per Issue, Reflecting Level of Affect: Teens

Issue	Never		Calm		Angry	
	%	*n*	%	*n*	%	*n*
Moral						
Hitting others	40	49	23	28	38	47
Honesty with parent	35	44	33	41	31	39
Stealing/vandalism	44	54	34	42	23	28
Keeping promises	69	86	18	22	13	16
Conventional						
Household chores	1	1	31	38	69	85
Language (swearing)	19	23	39	48	43	53
Table manners	31	39	44	55	24	30
Adults first names	66	82	23	28	11	14
Safety						
Smoking	37	46	44	55	19	23
Using drugs	49	61	32	40	19	23
Eating lollies/chocolate	41	51	41	51	18	22
Bike helmet	57	71	33	41	10	12
Personal						
Sleeping late	58	72	26	32	16	20
Music	38	47	49	61	13	16
Sport or hobbies	27	34	63	78	10	12
Private space	77	96	15	19	7	9
Multi-dimensional						
Tidy bedroom	15	19	23	28	62	77
Going out	10	13	50	62	40	49
Homework	10	12	52	64	39	48
Talking on phone	32	40	31	38	37	46
Friends	35	43	31	38	35	43
Time home	23	29	44	54	33	41
Drinking alcohol	31	39	42	52	27	33
Body piercing	50	62	24	30	26	32
Clothes worn	30	37	44	55	26	32
Opposite sex friend	35	44	40	50	24	30
Watching videos	52	65	25	31	23	28
Hairstyle	48	60	36	45	15	19

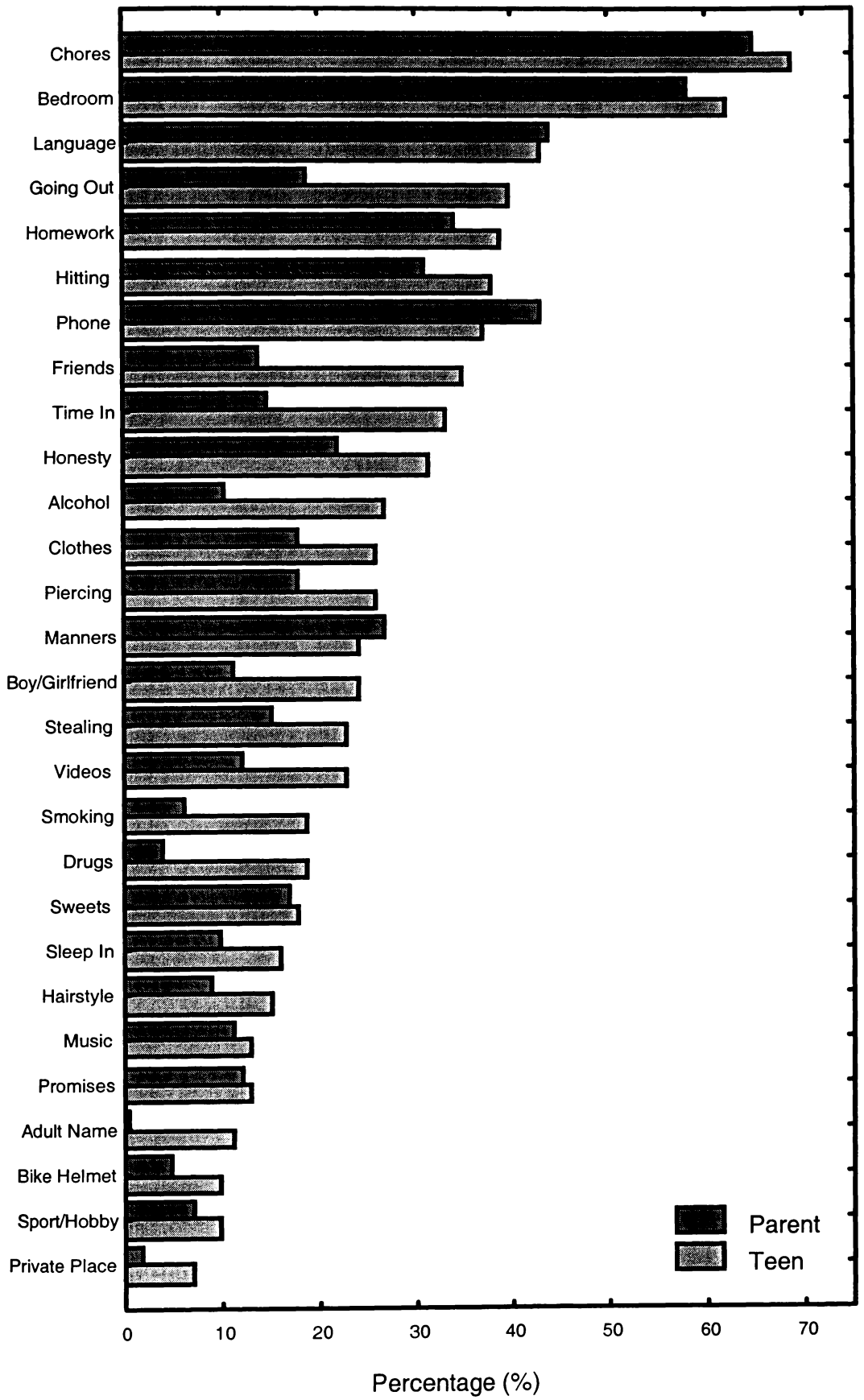

Figure 3.1. Percentage of angry discussions reported per issue.

Demographic influences. The female parents (M = 21.47, SD = 4.98) reported discussing a significantly greater number of issues with their teen than the male parents did (M = 18.84, SD = 5.91), $F(1,122) = 4.21$, $p < .05$. No other significant differences with respect to demographic characteristics were revealed for *frequency* or *anger intensity* of discussions.

Decision-Making Questionnaire. The responses to this instrument were analysed in two steps. First, attention was given to the frequencies of answers to the individual items to examine whether this yielded information about the frequency of issue-specific angry disputes. The second step was to provide information about the discrepant responses between parental views and those of their teenager to explore whether this was reflected in levels of angry discussions.

(a) *Frequency of responses.* The percentage of *yes* answers for each of the three items per issue was examined. For the parents such responses mean: (1) they perceive their teens makes their own decision about the issue in question (*actual*); (2) they have a specific perspective with regard to the behaviour (*parent feeling*); and (3) they consider the teen deciding for themselves as being normal for their age group (*ideal*). For the teens, such responses mean: (1) they see themselves as making their own decision about the particular issue (*actual*); (2) they perceive their parent as having a specific perspective (*parent feeling*); and (3) they see deciding for themselves as being normal for a teen of their age (*ideal*). The results of this analysis are summarised in Table 3.5, which presents the percentage of *yes* responses to: (a) does the teen decide (*actual*) and (b) should the teen decide (*ideal*) for each issue. Table 3.6 gives the percentage of *yes* responses to parents having a specific perspective about the issue (*parent feelings*) and the percentage of issue-specific angry disputes reported on the Conflict Checklist.

Table 3.5
Percentage of "Yes" Responses to Actual and Ideal Items on the Decision-Making Questionnaire, Per Issue

%	Actual – Teen Does Decide		Ideal – Teen Should Decide	
	Parents	Teens	Parents	Teens
91-100	Private space Sport/hobby Music Clothes Friends Hairstyle Honesty	Private space Sport/hobby Music Clothes Friends Hairstyle Honesty Sleeping late Promises Boy/girlfriend Smoking Stealing Homework	Private space Sport/hobby Music	Private space Sport/hobby Music Clothes Friends Hairstyle Eating sweets Sleeping late Promises Boy/girlfriend Bedroom
81-90	Sleeping late Homework Promises Eating sweets Phone	Hitting Eating sweets Using drugs Videos Phone Language	Clothes Friends Sleeping late Hairstyle Promises	Body piercing Videos Phone Honesty
71-80	Stealing Smoking Hitting	Bike helmet Alcohol Body piercing Bedroom	Eating sweets Honesty	Language Homework Smoking Alcohol
61-70	Boy/girlfriend Videos Bedroom	Going out Manners Adults name	Homework Phone	Going out Stealing Adults name
51-60	Adults name Using drugs Language		Boy/girlfriend Adults name Bedroom Stealing	Using drugs Hitting Manners
41-50	Body piercing Manners Bike helmet		Videos Smoking Hitting	Time home Chores
31-40	Going out Alcohol	Chores	Language Manners	Bike helmet
21-30	Chores	Time home	Body piercing Going out Bike helmet Using drugs Chores	
1-20	Time home		Time home Alcohol	

Table 3.6
Percentage of "Yes" Responses to Parent Feelings on the Decision-Making Questionnaire and Arguments with Angry Affect on the Conflict Checklist, Per Issue

%	Parent Feelings		Arguments with Angry Affect	
	Parents	Teens	Parents	Teens
91-100	Chores Bedroom Manners Language Hitting Honesty Stealing Time home Body piercing Going out Eating sweets Using drugs Bike helmet Promises Alcohol Tidy Smoking	Chores Bedroom Hitting Honesty Stealing Bike helmet Promises Using drugs Smoking Alcohol		
81-90	Videos	Going out Manners Time home Language Body piercing		
71-80	Boy/girlfriend Phone	Eating sweets Videos		
61-70	Friends	Homework	Chores	Chores Bedroom
51-60	Clothes Homework	Phone Boy/girlfriend Friends	Bedroom	
41-50	Music	Clothes	Language Phone	Language
31-40	Adults Name Hairstyle	Adults name Hairstyle Music	Homework	Going out Homework Hitting Phone Friends Time home Honesty

(table continues)

Table 3.6 *(continued)*

%	Parent Feelings		Arguments with Angry Affect	
	Parents	Teens	Parents	Teens
21-30	Sleeping late	Sleeping late	Hitting Manners Honesty	Alcohol Body piercing Clothes Manners Boy/girlfriend Stealing Videos
11-20	Sport/hobby	Private space	Going out Body piercing Clothes Eating sweets Stealing Time home Friends Promises Videos Music Boy/girlfriend	Smoking Using drugs Eating sweets Sleeping late Hairstyle Promises Music Adults name
1-10	Private space	Sport/hobby	Alcohol Sleeping late Hairstyle Sport/hobby Smoking Bike helmet Using drugs Private space Adults name	Bike helmet Sport/hobby Private space

As evident from Table 3.5, the teens generally viewed themselves as being responsible for making independent decisions about the issues. More than 91% of teens reported actually making decisions about 13 of the 28 issues, and more than 60% stated they made independent decisions about 26 of the 28 issues. The two issues not in this bracket were household chores and time to come home.

There appears to be a correspondence between teenagers reports of *actual* and *ideal* decision making, but the views of parents and teens concerning who has

the final say and what is normal was less consistent. Compared to parents, considerably more teenagers perceived it normal to make independent decisions about many of the issues, and the teens reported actually making independent decisions more often.

As can be seen by comparing *actual* and *ideal* decision-making perspectives of teens in Table 3.5 with *angry* disputes about issues shown in Table 3.6, in general, the issues of most frequent dispute are those that the teens report actually making decisions about less frequently. No clear pattern emerges from this comparison, however, as many teens do not consider they should make independent decisions about the issues of greatest dispute. For example, household chores is the issue of most frequent conflict but less than 40% of the teens report making their own decision about helping with household chores and less than 50% consider they should decide for themselves. An exception to this trend is the issue of tidy bedroom as more than 91% of the teens think making independent decisions about their room would be appropriate.

It is apparent from examination of Table 3.6 that parents frequently took a clear position with regard to many of the issues, and were also generally perceived to do so by teens. When the percentage of parents who reported having a specific perspective about issues is compared with angry discussion topics, an interesting pattern emerges. Five of the six issues teens report having angry arguments about most frequently (i.e., household chores, tidy bedroom, language used, going out, and hitting others) are among those more than 91% of parents have strong feelings about. In the same vein, the issues that few parents report taking a specific perspective about (e.g., private space, sport or hobby, sleeping late, hairstyle, adult names) are among those argued about least often. Overall, response patterns

suggest that parental feeling could be regarded as a source of conflict rather than actual adolescent decision making or adolescent desire for independent choice.

(b) *Discrepant responses.* The foregoing analysis provided descriptive information concerning the frequency of responses for different issues. The second analysis provides information on discrepant *yes/no* responses concerning *actual* and *ideal* decision making. Initially, the number of *yes/no* constellations across the 28 issues was calculated for each parent and teen dyad. The frequencies of these constellations are summarised for the sample as a whole in Table 3.7. Inspection of the resulting matrix shows that the percentage of convergent responses (*yes/yes, no/no*) was greater than divergent responses for both *actual* (78%) and *ideal* (66%) decision making, with more discrepant responses regarding who should decide than who actually does decide.

Table 3.7
Percentage of Yes/No Response Constellations on the Decision-Making Questionnaire for Actual and Ideal Items

Does the teen decide? (Actual)				Should the teen decide? (Ideal)			
		Parents				Parents	
Teens	No	4%	13%	Teens	No	7%	12%
	Yes	65%	18%		Yes	54%	27%
		Yes	No			Yes	No

As the response pattern of parent = *yes* and teen = *no* does not appear meaningful in terms of contributing to parent-adolescent conflict, only the response pattern of parent = *no* and teen = *yes* was used in further analysis. Across the 28 issues, discrepant responses for *actual* decision making ranged from 0 to 19

(M = 4.98, SD = 3.87), and from 0 to 25 (M = 7.64, SD = 4.91) for *ideal* decision making. The broad range of scores shows that some dyads responses were discrepant across most issues, but generally the number of discrepant parent and teen responses for both *actual* and *ideal* decision making was low to moderate.

Demographic influences. The frequency of discrepant responses between parents and teens for *actual* and *ideal* decision making did not differ significantly with respect to demographic characteristics.

Reasoning Questionnaire. This instrument allowed participants to rate the degree to which they considered each of the 28 issues as belonging to the *moral*, *conventional*, *safety* or *personal* domain. Responses were analysed in three steps. First, data were analysed to examine the categorisation of issues to determine whether issues were judged as belonging to different domain categories, as reported in previous research, and as grouped within the predetermined domain categories for the purposes of this research project. Second, overall response frequencies were calculated; that is, did participants rate more issues as *moral*, *conventional*, *safety* or *personal*? Third, discrepant categorisation of issues to domain categories between parents and teens was examined across all 28 issues, without grouping the issues according to predetermined domain categories.

(a) *Categorisation of issues.* To provide information regarding the categorisation of issues to domains, parents' and teens' mean ratings were first calculated separately for each issue, then these data were grouped according to my allocation of issues to domains for the purposes of this research (as presented in Table 2.1). The participants' ratings of the issues by each domain category are illustrated in Figures 3.2 to 3.6.

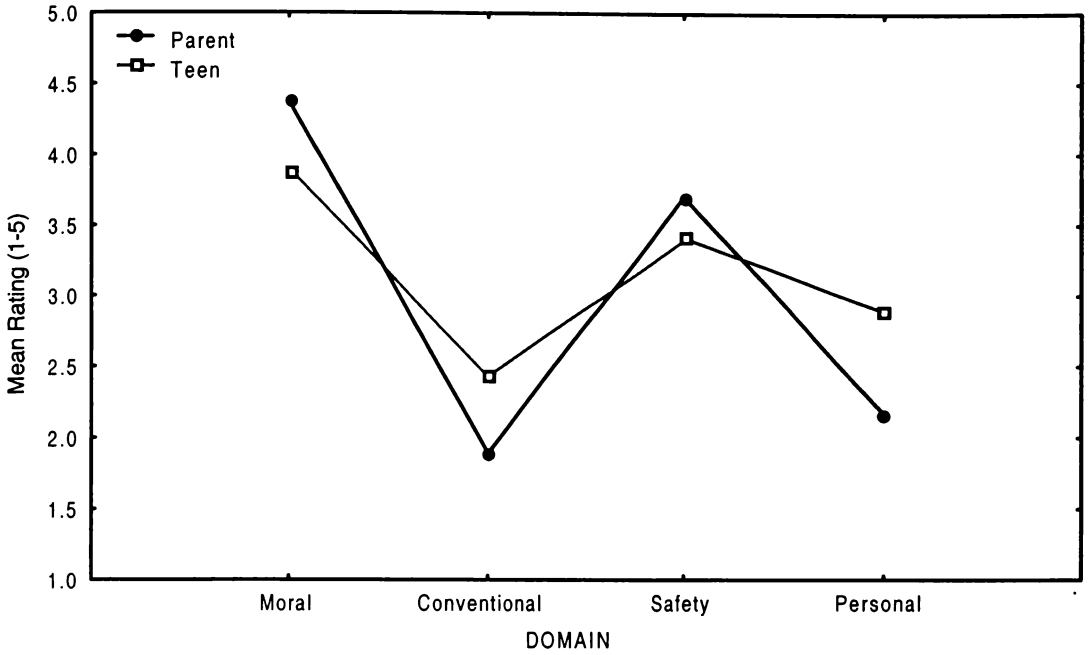

Figure 3.2. Mean ratings of moral issues to domain categories.

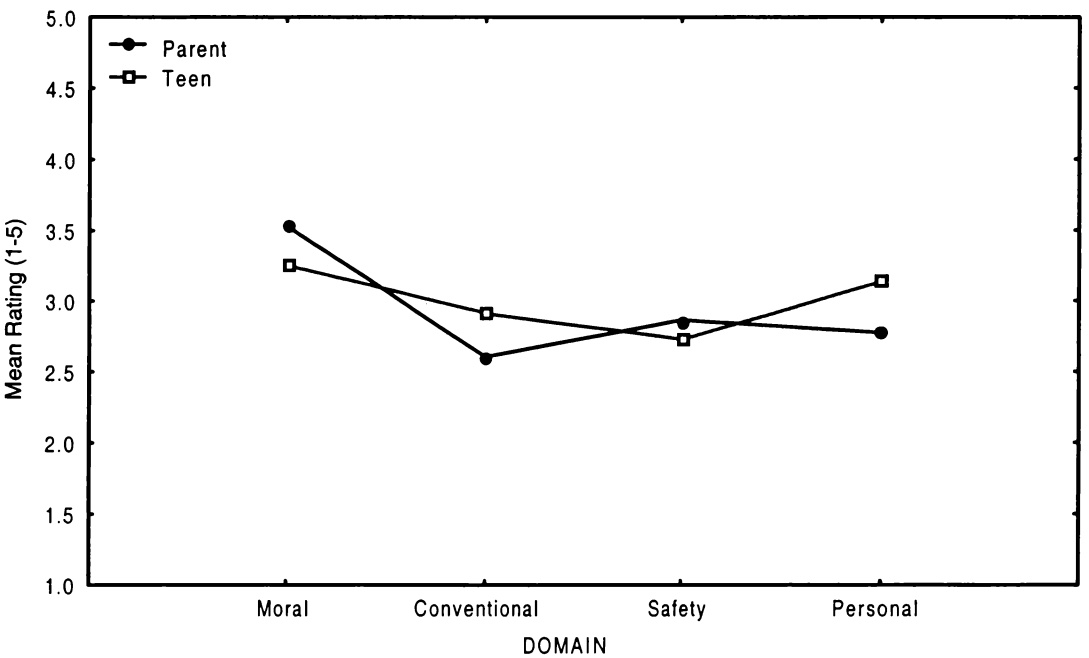

Figure 3.3. Mean ratings of conventional issues to domain categories.

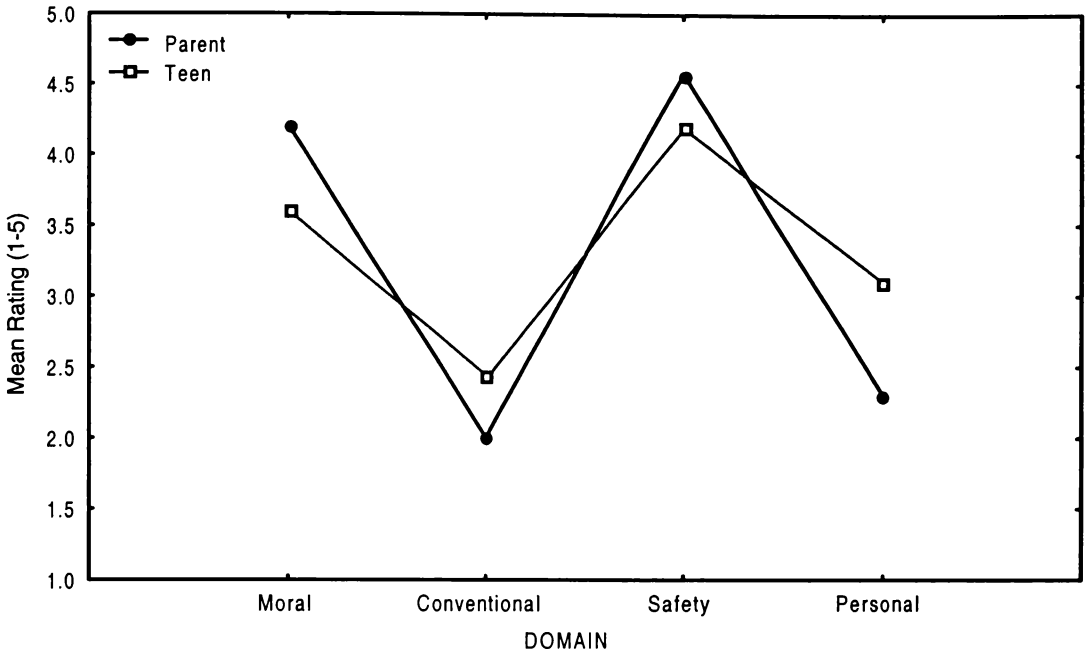

Figure 3.4. Mean ratings of safety issues to domain categories.

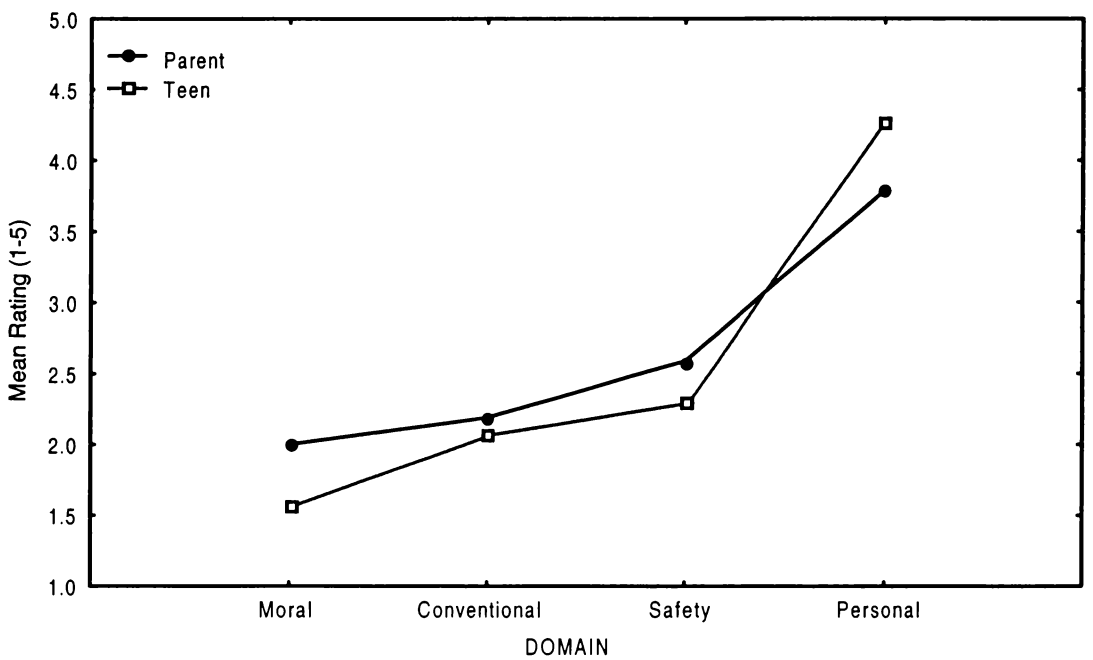

Figure 3.5. Mean ratings of personal issues to domain categories.

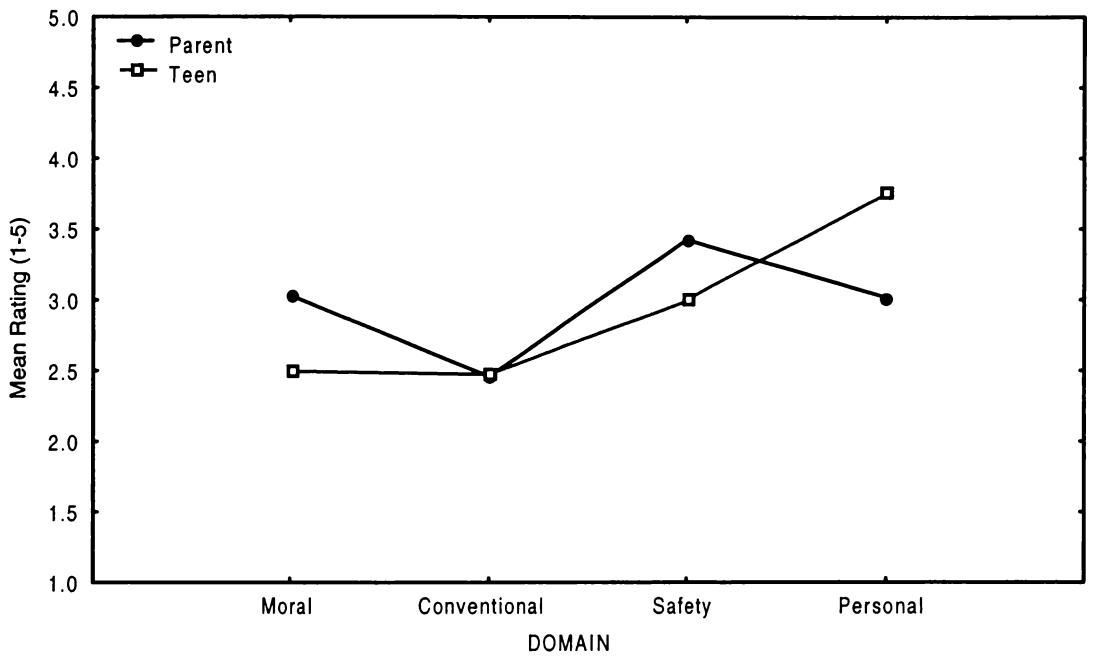

Figure 3.6. Mean ratings of multi-dimensional issues to domain categories.

Most scores were differentiated as was anticipated if one accepts that issues would be allocated to different domain categories according to reasoning for legitimate parental authority (see Appendix D for ranges, means and standard deviations of participants' ratings of issues to domain categories).

Repeated measures ANOVA analysis showed that parents' rating of issues to the domain categories was significantly different for all five predetermined groups of issues; *moral*, $F(3,369) = 386.93$, $p < .001$; *conventional*, $F(3,369) = 53.70$, $p < .001$; *safety*, $F(3,369) = 608.92$, $p < .001$; *personal*, $F(3,369) = 246.99$, $p < .001$; *multi-dimensional*, $F(3,369) = 58.89$, $p < .001$. Statistically significant differences were also revealed for the rating all predetermined groups of issues for teens; *moral*, $F(3,369) = 96.90$, $p < .001$; *conventional*, $F(3,369) = 17.72$, $p < .001$; *safety*, $F(3,369) = 133.76$, $p < .001$; *personal*, $F(3,369) = 392.48$, $p < .001$; *multi-dimensional*, $F(3,369) = 104.09$, $p < .001$. To determine which ratings differed from each other, pairwise planned comparison analysis was performed.

The *moral* issues, as shown in Figure 3.2, were judged by both parents and teens as belonging most strongly to the *moral* domain, but also somewhat to the *safety* domain. However, the rating of *moral* issues by both parents and teens to the *moral* domain was significantly higher ($p = < .001$) than the rating of these issues to the other three domain categories. Similarly, *safety* issues were judged as belonging to the *safety* domain and also to the *moral* domain by the parents and teens. But again, the rating of *safety* issues to the *safety* domain was significantly higher ($p = < .001$) than the rating of these issues to the *moral*, *conventional* or *personal* domain categories, as illustrated in Figure 3.4.

Ratings for the *conventional* issues were not as clearly differentiated (see Figure 3.3) and were rated as belonging most strongly to the *moral* domain ($p = <$

.001) by both parents and teens. Parents' degree of rating of *conventional* issues to the *conventional* domain was also statistically lower than to the *safety* ($p = < .001$) and *personal* ($p = < .01$) domains. Teens rated *conventional* issues as belonging more to the *personal* domain than to the *conventional* domain ($p = < .01$), but as belonging less strongly to the *safety* domain ($p = < .05$). As seen in Figure 3.5, a clear pattern emerged for rating of *personal* issues. They were judged as belonging to the *personal* domain at a significantly higher degree ($p = < .001$) when compared with categorisation to the *moral*, *conventional*, or *safety* domains. As illustrated in Figure 3.6, the parents rated the *multi-dimensional* issues as belonging more to the *safety*, *moral* and *personal* domains than the *conventional* domain. The parents' ratings of *multi-dimensional* issues as belonging most strongly to the *safety* domain ($p = < .001$) and least strongly to the *conventional* domain ($p = < .001$) were significantly different from the other domain category ratings. In contrast, teens judged the *multi-dimensional* issues as belonging most strongly to the *personal* domain ($p = < .001$). Teens' rating of these issues to the *safety* domain was also significantly higher ($p = < .001$) than to either the *moral* or *conventional* domains.

(b) *Response trends.* To examine response trends, (that is, did participants regard more issues as *moral*, *conventional*, *safety*, or *personal*?) the mean rating of all 28 issues to each domain category was calculated for parents and teens separately. The summary of the overall response trends is illustrated in Figure 3.7.

Parents rated issues as belonging more to the *safety* ($M = 3.43$, $SD = 0.42$) and *moral* ($M = 3.32$, $SD = 0.38$) domains than to the *personal* ($M = 2.87$, $SD = 0.51$) and *conventional* ($M = 2.29$, $SD = 0.49$) domains. A repeated-measures ANOVA showed the ratings were significantly different, $F(3,369) = 147.12$, $p <$

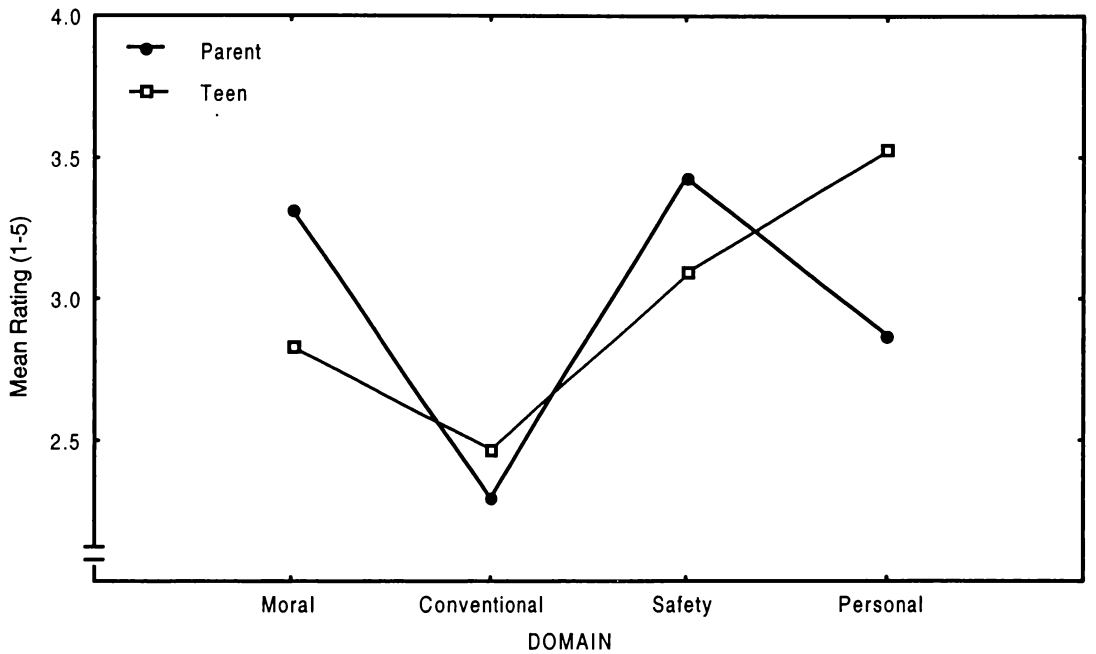

Figure 3.7. Mean response trends for categorisation of all issues.

0.001. Further analysis by planned comparisons confirmed that these differences were all significantly different from each other (p = < .01).

Teen participants categorised issues more often as belonging to the *personal* (M = 3.53, SD = 0.57) and *safety* (M = 3.10, SD = 0.55) domains than to the *moral* (M = 2.84, SD = 0.50) or *conventional* (M = 2.47, SD = 0.60) domains. A repeated-measures ANOVA showed these differences were significant, $F(3,369) = 147.11$, $p < .001$, with planned comparisons confirming the four domain ratings were significantly different from each other (p = < .001).

Planned comparison analysis determined that teens' rating of issues to the *personal* domain was significantly higher than for parents, $F(1,123) = 96.25$, $p <$ .001, while parents treated issues as belonging to the *moral*, $F(1,123) = 102.72$, p < .001, and *safety*, $F(1,123) = 33.69$, $p < .001$, domains at a significantly higher rate than teens. Rating of issues to the *conventional* domain was not as disparate, but parent ratings were significantly higher than teens, $F(1,123) = 8.13$, $p < .01$.

One-way ANOVAs were also carried out to ascertain whether response trends varied by demographic characteristics. With respect to age, as illustrated in Figure 3.8, early adolescents (13 to 14 years) rated issues as belonging more to the *moral* (M_{early} = 2.96, M_{middle} = 2.74) and *conventional* (M_{early} = 2.63, M_{middle} = 2.36), domains, and adolescents in the middle age group (15 to 17 years) rated issues as belonging more to the *personal* domain (M_{early} = 3.37, M_{middle} = 3.65). These differences were all significant at the $p < .05$ level (one-way ANOVAs). The rating of issues to the *safety* domain by early and middle adolescents was not statistically different. When the parents were divided according to their adolescent's age, there were no significant differences, as presented in Figure 3.9 for comparative purposes.

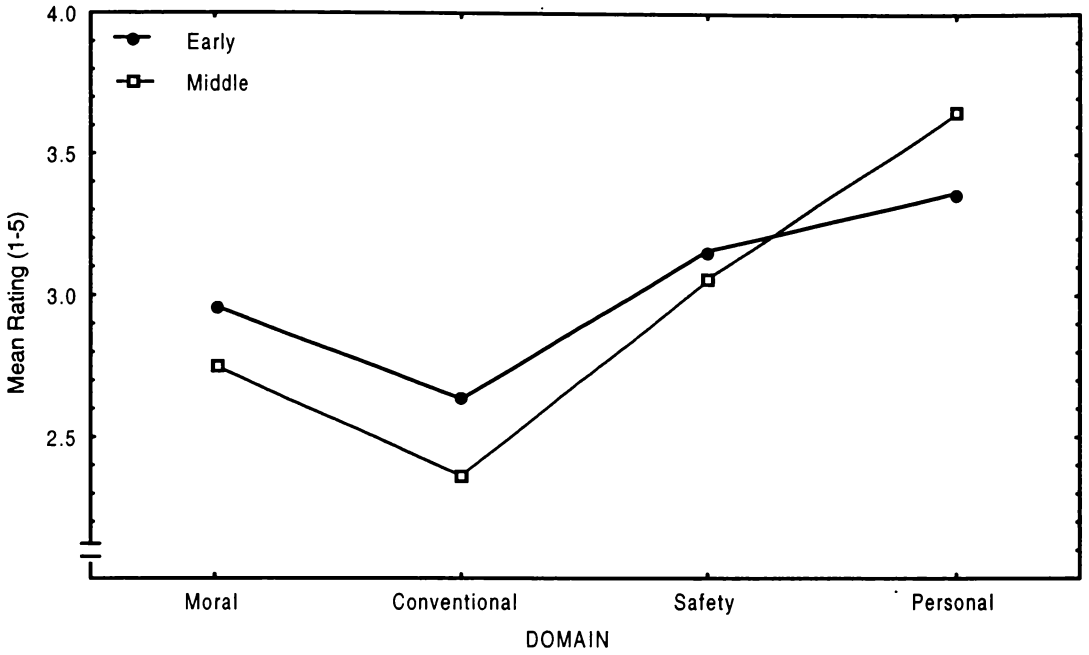

Figure 3.8. Mean response trends for categorisation of all issues by adolescent age group: Teens.

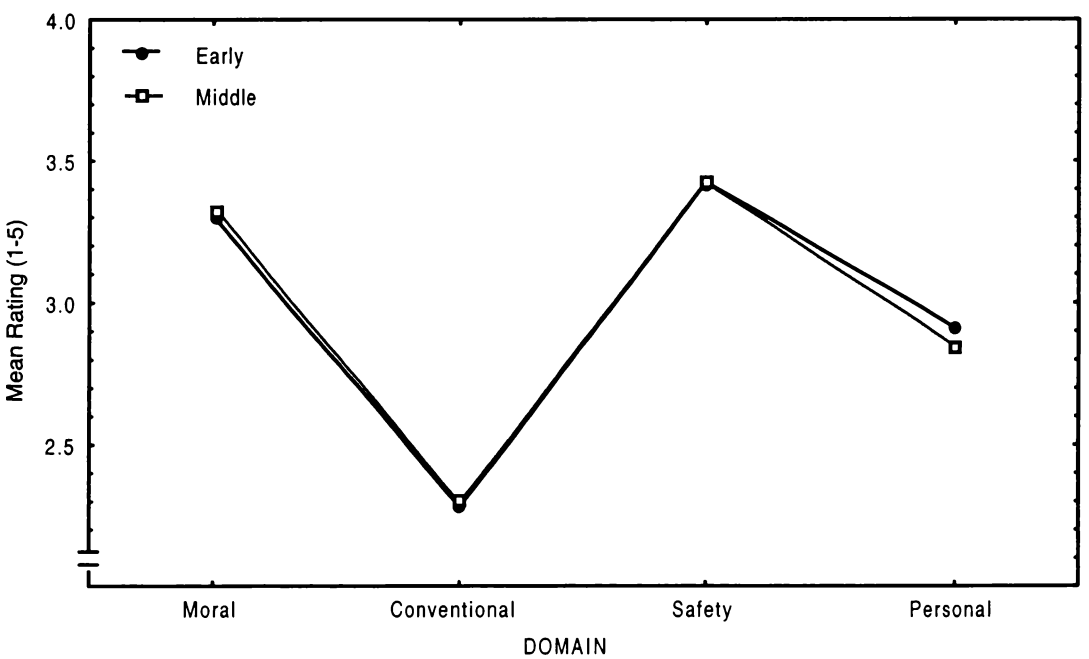

Figure 3.9. Mean response trends for categorisation of all issues by adolescent age group: Parents.

The ratings of teens that affiliated with a *religion* were higher for the *moral* ($M_{religion}$ = 3.00, $M_{no\ religion}$ = 2.69) and *safety* ($M_{religion}$ = 3.20, $M_{no\ religion}$ = 2.99) domains, and ratings of teens that reported having *no religion* were higher for the *personal* domain ($M_{religion}$ = 3.42, $M_{no\ religion}$ = 3.66). One-way ANOVA analysis determined that these differences in teen response trends according to religion for the *moral*, *safety*, and *personal* domain categories were all significant at $p < .05$. Parent response trend ratings were not significantly different according to religion. No parent or teen response trends were statistically significant with respect to other demographic characteristics.

(c) *Discrepant categorisation.* The discrepancy between parents' and teens' judgements of the degree to which issues belonged to domain categories was calculated using the formula Σ*(parent – teen) = discrepancy* for each item across the 28 issues. The issues were not grouped according to predetermined domain categories, but discrepant rating scores for each item were grouped to obtain a total discrepancy score between parents and teens for the degree to which issues had been rated as *moral*, *conventional*, *safety* or *personal*.

The discrepant scores for the *moral* domain ranged between 4 and 62 (M = 25.45, SD = 9.89) out of a possible 112, where a higher score indicates a higher level of discrepant ratings between parents and teens. Scores varied between 5 and 58 for the *conventional* domain (M = 26.57, SD = 11.32), and between 12 and 62 for the *safety* domain (M = 26.70, SD = 9.36). The greatest discrepancy of scores was evident for rating of issues as belonging to the *personal* domain, with these ranging 10 to 79 (M = 32.43, SD = 12.85).

Repeated measures ANOVA analysis of the discrepant scores was significant, $F(3,369) = 16.07$, $p < .001$. As graphically indicated in Figure 3.10,

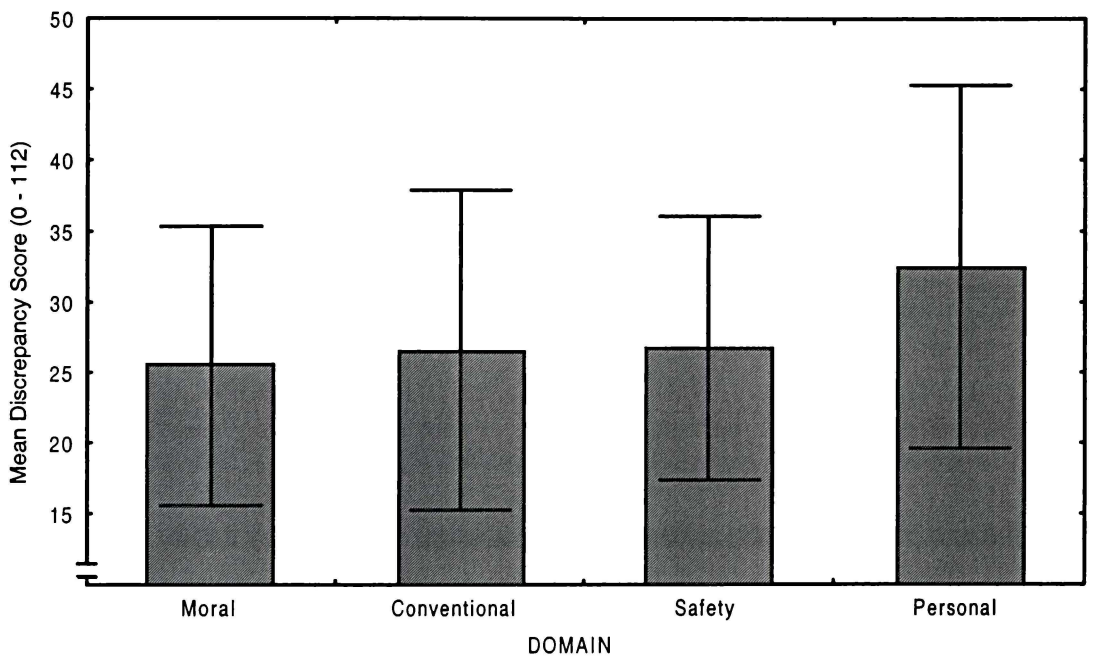

Figure 3.10. Mean discrepancy between parents' and teens' rating of issues to domain categories.

further examination via planned comparisons confirmed discrepant judgement of issues as belonging to the *personal* domain was significantly higher than the *moral*, $F(1,123) = 52.41$, $p < .001$, *conventional*, $F(1,123) = 19.70$, $p < .001$, or *safety* domains, $F(1,123) = 21.64$, $p < .001$. Discrepant responses for the *moral*, *conventional* and *safety* domains were not significantly different from each other.

Analysis of demographic characteristics showed that discrepant categorisation of issues to the *conventional* domain was significantly higher, $F(1,122) = 4.43$, $p < .05$, for early adolescents ($M = 29.10$, $SD = 10.68$) than for middle adolescents ($M = 24.81$, $SD = 11.49$). Also, discrepant rating of issues to the *personal* domain was significantly higher, $F(1,122) = 6.42$, $p < .05$, for male parents ($M = 39.16$, $SD = 18.41$) than for female parents ($M = 31.21$, $SD = 11.26$). There were no statistically significant differences found with respect to other demographic characteristics.

Parental Authority Questionnaire. This scale is comprised of three subscales, *authoritarian, authoritative* and *permissive* parenting style, with a total possible score of 50 for each scale where high scores reflect stronger perceptions of the parenting style.

Parents. As can be seen in Figure 3.11, parents rated their own parenting style as follows: *authoritarian*, $M = 27.13$ ($SD = 5.53$, range = 13 to 39); *authoritative*, $M = 40.94$ ($SD = 3.87$, range = 28 to 50); *permissive*, $M = 25.05$ ($SD = 5.33$, range = 13 to 42). A repeated measures ANOVA confirmed these parenting style differences were significant, $F(2,246) = 327.55$, $p < .001$. Further analysis by planned comparisons showed that the three parenting styles were all significantly different from each other, with parents rating themselves as more *authoritative* than *authoritarian*, $F(1,123) = 466.26$, $p < .001$, or *permissive,*

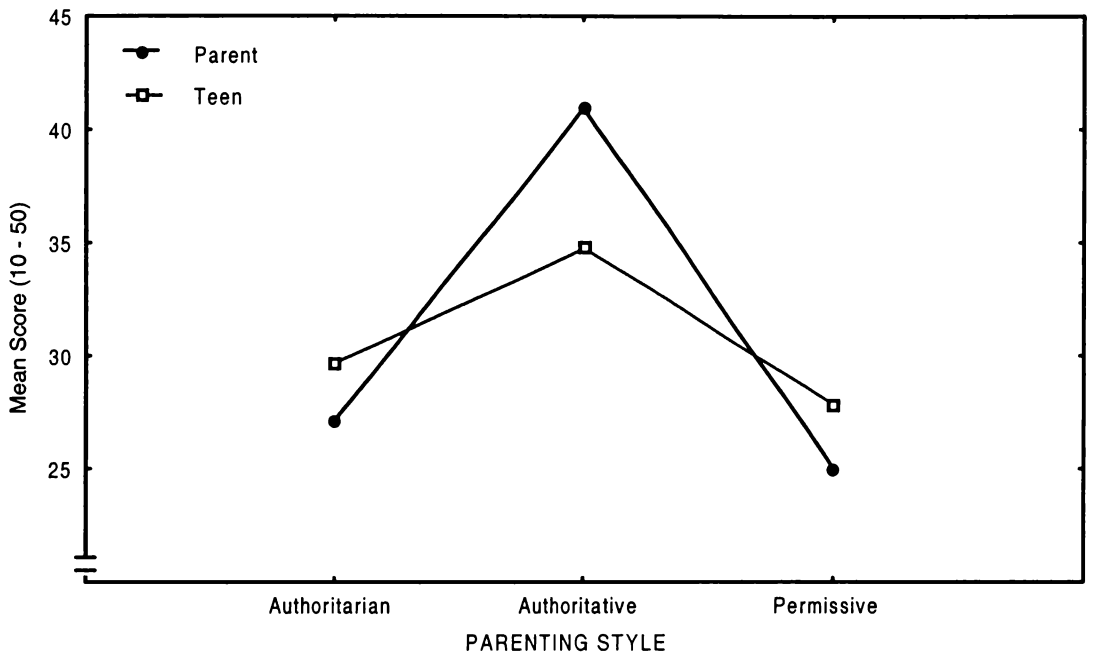

Figure 3.11. Mean ratings for parenting style on the Parental Authority Questionnaire.

$F(1,123) = 749.77$, $p < .001$, and less *permissive* than *authoritarian,* $F(1,123) = 7.12, p < .01$.

Teens. Teens rated their perception of the parenting style of their parent. Consistent with parent ratings, the teens rated parents as being higher on the *authoritative* parenting style with a mean score of 34.90 ($SD = 6.61$, range = 13 to 50), and lower on the *authoritarian,* $M = 29.77$ ($SD = 6.08$, range = 14 to 44) and *permissive* parenting styles, $M = 27.81$ ($SD = 5.05$, range = 13 to 39). Repeated measures ANOVA confirmed a significant main effect for parenting style, $F(2,246) = 43.47$, $p < .05$. Planned comparisons analysis showed teens appraisal of the parenting style of parents was significantly higher for *authoritative* parenting than for *authoritarian,* $F(1,123) = 31.77$, $p < .001$, or *permissive* parenting, $F(1,123) = 145.48$, $p < .001$. They also rated parents as being significantly lower on the *permissive* parenting style than the *authoritarian* style, $F(1,123) = 5.64, p < .05$.

Divergent scores. Although the pattern of parent and teen responses for parenting style was similar, parents' and teens' scores diverged significantly for the three subscales. Parents rated themselves higher than the teens on the *authoritative* parenting subscale, $t(246) = 8.77$, $p < .001$, and teens rated their parents higher on both the *authoritarian,* $t(246) = 3.57, p < .001$, and *permissive,* $t(246) = 4.24$, $p < .001$, parenting subscales. This divergence can be seen in Figure 3.11.

Demographic influences. One-way ANOVA analysis with respect to demographic characteristics showed that parents' and teens' perceptions of parenting style did not differ according to teen age, teen or parent religion, family

composition, or dyad, but significant effects of both teen gender and parent gender emerged.

The mean score for *authoritarian* parenting was significantly higher $F(1,122) = 5.33$, $p < .05$, for parents of female teens ($M = 27.95$, $SD = 5.33$) than for parents of male teens ($M = 25.58$, $SD = 5.66$). Consistent with this finding, female teens ($M = 30.77$, $SD = .10$) rated parents significantly higher on *authoritarian* parenting than did male teens ($M = 27.88$, $SD = 5.64$), $F(1,122) = 6.60$, $p < .01$. Analysis also revealed that mothers' rating of their parenting style was significantly higher for ($M = 41.31$, $SD = 3.56$) for *authoritative* parenting, $F(1,122) = 6.90$, $p < .01$, than the fathers' rating ($M = 38.84$, $SD = 4.82$).

Relationship Questionnaire. *Parents.* Scores obtained for the parent participants who completed this measure indicated that overall they perceived themselves as having a good relationship with their teenage children, as total scores ranged from 22 to 40 out of the possible 40 ($M = 31.99$, $SD = 4.03$).

Teens. The teen participants recorded a greater range of scores than parents (15 to 40), but the mean score obtained indicated that perceptions of the parent-adolescent relationship were typically positive ($M = 30.35$, $SD = 5.95$).

Divergent scores. The teens' scores were not as positive as parents' scores on this measure, with the parent rating of the parent-adolescent relationship being significantly higher, $t(246) = 2.54$, $p < .05$, than the teen rating.

Demographic influences. One-way ANOVA analysis revealed a significant effect for parent gender, $F(1,122) = 4.24$, $p < .05$, with mothers rating the parent-adolescent relationship more positively than fathers did ($M_{mother} = 32.30$, $SD = 3.78$; $M_{father} = 30.26$, $SD = 4.98$). No significant effects emerged for teen gender, teen age, teen or parent religion, family composition, or dyad.

Symptom Checklist-90-R. *Parents.* Parents rated their own symptoms and obtained *T* scores for the *global severity index* that ranged from 30 to 81 (M = 53.03, SD = 10.09). High scores on this scale indicate more severe psychological distress. Twenty percent of parents obtained a *T* score of > 63, relative to the normative sample, which indicates many parents were experiencing high levels of psychological distress (Derogatis & Lazarus, 1994).

Teens. Teens rated their own symptoms and obtained *T* scores on the *global severity index* ranging from 19 to 81 (M = 50.02, SD = 12.93). Similar to parents, 16% of the teens obtained a *T* score of > 63, which also suggests many teens in this sample were experiencing high levels of psychological distress.

Divergent Scores. Parents reported a significantly higher current level of psychological distress as indicated by the *global severity index* scores than teens, $t(246) = 2.04$, $p < .05$, ($M_{parent} = 53.03$, $SD = 10.09$; $M_{teen} = 50.02$, $SD = 12.93$).

Demographic influences. There were no statistically significant differences assessed via one-way ANOVA on the *global severity index* measure for parents or teens with respect to teen gender, teen age, teen or parent religion, family composition, or dyad. There was, however, a significant effect for parent gender, $F(1,122) = 6.03$, $p < .05$, with fathers (M = 58.16, SD = 11.48) reporting higher levels of psychological distress than mothers (M = 52.10, SD = 9.59).

Correlations Between Measures

The scores on each measure were correlated with each other and are shown in Table 3.8 for parents and Table 3.9 for teens.

Reasoning Questionnaire. *Response trends.* Correlation patterns between response trend scores for the four domains gives support to the assumptions that issues are judged differentially according to perceptions of legitimate parental

Table 3.8
Correlations Between Measures: Parents

	Measures	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
	Reasoning Questionnaire (Domain Categories)																	
1	Moral response trend		.02	.44*	-.58*	.25*	.19*	.03	.34*	.29*	.40*	.05	.17	.37*	.03	-.17	.02	.12
2	Conventional response trend	.02		-.02	.08	-.07	.19*	-.17	.07	.19*	.18*	-.14	.05	.22*	-.07	.06	-.01	-.05
3	Safety response trend	.44*	-.02		-.38*	.17	.15	.18	.10	.08	.23*	.18*	.22*	.12	.14	-.11	-.13	.27*
4	Personal response trend	-.58*	.08	-.38*		-.19*	.01	.02	-.47*	-.35*	-.52*	-.03	-.38*	-.23*	-.03	.30*	.19*	-.07
5	Moral discrepancy	.25*	-.07	.17	-.19*		.30*	.59*	.58*	.24*	.42*	-.02	.27*	.26*	.00	-.18*	-.04	.14
6	Conventional discrepancy	.19*	.19*	.15	.01	.30*		.26*	.27*	.20*	.23*	-.10	.08	.09	.13	-.06	.05	.10
7	Safety discrepancy	.03	-.17	.18	.02	.59*	.26*		.27*	.01	.23*	.00	.13	.10	.05	-.08	.11	.08
8	Personal discrepancy	.34*	.07	.10	-.47*	.58*	.27*	.27*		.50*	.64*	-.11	.44*	.27*	.00	-.16	-.13	.02
	Decision Making Questionnaire																	
9	Actual	.29*	.19*	.08	-.35*	.24*	.20*	.01	.50*		.66*	-.10	.33*	.29*	-.15	-.36*	-.20*	-.06
10	Ideal	.40*	.18*	.23*	-.52*	.42*	.23*	.23*	.64*	.66*		-.03	.33*	.31*	.02	-.34*	-.09	.02
	Conflict Checklist																	
11	Discussion frequency	.05	-.14	.18*	-.03	-.02	-.10	.00	-.11	-.10	-.03		-.13	.12	.09	-.09	-.10	.22*
12	Discussion intensity	.17	.05	.22*	-.38*	.27*	.08	.13	.44*	.33*	.33*	-.13		.33*	-.24*	-.18*	-.36*	.11
	Parental Authority Questionnaire																	
13	Authoritarian	.37*	.22*	.12	-.23*	.26*	.09	.10	.27*	.29*	.31*	.12	.33*		-.12	-.31*	-.02	.09
14	Authoritative	.03	-.07	.14	-.03	.00	.13	.05	.00	-.15	.02	.09	-.24*	-.12		.03	.56*	-.04
15	Permissive	-.17	.06	-.11	.30*	-.18*	-.06	-.08	-.16	-.36*	-.34*	-.09	-.18*	-.31*	.03		.07	.08
16	***Relationship Questionnaire***	.02	-.01	-.13	.19*	-.04	.05	.11	-.13	-.20*	-.09	-.10	-.36*	-.02	.56*	.07		-.27*
17	***SCL-90-R*** – Global Severity	.12	-.05	.27*	-.07	.14	.10	.08	.02	-.06	.02	.22*	.11	.09	-.04	.08	-.27*	

Note. * indicates $p < .05$.

Table 3.9
Correlations Between Measures: Teens

	Measures	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
	Reasoning Questionnaire (Domain Categories)																	
1	Moral response trend		.51*	.61*	-.65*	-.57*	-.02	-.47*	-.33*	-.08	-.23*	.04	-.36*	.12	.31*	.14	.25*	-.23*
2	Conventional response trend	.51*		.41*	-.33*	-.32*	.42*	-.24*	-.17	.01	-.04	-.04	-.17	.16	.25*	.10	.21*	-.25*
3	Safety response trend	.61*	.41*		-.52*	-.30*	.12	-.43*	-.17	.07	-.04	.04	-.15	.08	.29*	.13	.17	-.08
4	Personal response trend	-.65*	-.33*	-.52*		.49*	.13	.37*	.62*	.25*	.40*	-.12	.32*	-.09	-.28*	.04	-.16	.08
5	Moral discrepancy	-.57*	-.32*	-.30*	.49*		.30*	.59*	.58*	.24*	.42*	.05	.45*	.15	-.32*	-.17	-.29*	.36*
6	Conventional discrepancy	-.02	.42*	.12	.13	.30*		.26*	.27*	.20*	.23*	-.05	.12	.08	.05	.05	.06	-.10
7	Safety discrepancy	-.47*	-.24*	-.43*	.37*	.59*	.26*		.27*	.01	.23*	-.09	.22*	.00	-.19*	-.15	-.14	.15
8	Personal discrepancy	-.33*	-.17	-.17	.62*	.58*	.27*	.27*		.50*	.64*	-.03	.33*	.15	-.27*	-.08	-.18	.13
	Decision Making Questionnaire																	
9	Actual	-.08	.01	.07	.25*	.24*	.20*	.01	.50*		.66*	-.14	.15	.00	-.16	-.09	-.12	.08
10	Ideal	-.23*	-.04	-.04	.40*	.42*	.23*	.23*	.64*	.66*		-.04	.23*	.13	-.21*	-.22*	-.12	.09
	Conflict Checklist																	
11	Discussion frequency	.04	-.04	.04	-.12	.05	-.05	-.09	-.03	-.14	-.04		.03	.11	.03	-.01	.01	.20*
12	Discussion intensity	-.36*	-.17	-.15	.32*	.45*	.12	.22*	.33*	.15	.23*	.03		.34*	-.37*	-.40*	-.36*	.48*
	Parental Authority Questionnaire																	
13	Authoritarian	.12	.16	.08	-.09	.15	.08	.00	.15	.00	.13	.11	.34*		-.28*	-.35*	-.31*	.28*
14	Authoritative	.31*	.25*	.29*	-.28*	-.32*	.05	-.19*	-.27*	-.16	-.21*	.03	-.37*	-.28*		.39*	.66*	-.22*
15	Permissive	.14	.10	.13	.04	-.17	.05	-.15	-.08	-.09	-.22*	-.01	-.40*	-.35*	.39*		.42*	-.19*
16	***Relationship***	.25*	.21*	.17	-.16	-.29*	.06	-.14	-.18	-.12	-.12	.01	-.36*	-.31*	.66*	.42*		-.44*
17	***SCL-90-R*** – Global Severity	-.23*	-.25*	-.08	.08	.36*	-.10	.15	.13	.08	.09	.20*	.48*	.28*	-.22*	-.19*	-.44*	

Note. * indicates $p < .05$.

authority, but that domains are not exclusive, since issues can be seen as belonging to more than one domain category. The negative correlation between *personal* and *moral* response trend scores is high for parents (r = -.65) and teens (r = -.58), which reveals a marked discrimination when participants in this sample rated the degree to which issues belonged to these domain categories. Similarly, the teen response trend scores for the *personal* domain was negatively associated with both the *safety* (r = -.52) and *conventional* (r = -.33) response trend scores which also points to differential rating of issues to these domain categories. Parents' judgement of issues as belonging to the *personal* domain was also negatively associated with their rating of issues to the *safety* domain (r = -.38), but not associated with their rating of issues to the *conventional* domain. The significant positive correlation between response trend scores for the *moral* and *safety* domains evident for teens (r = .61) and parents (r = .44) suggests that participants were inclined to rate issues as belonging to both the *moral* and *safety* domains rather than just one domain category.

Discrepant categorisation. The pattern of significant correlations between the response trend scores and discrepant categorisation of issues to domains demonstrates the usefulness of grouping issues according to domains. The significant relationships between *personal* response trend score for teens and discrepant categorisation of issues to the *personal* (r = .62), *moral* (r = .49), and *safety* (r = .37) domains supports the notion that discrepant views emerge when teens tend to categorise issues as belonging to their *personal* domain of jurisdiction and parents do not. In the same vein, when parents' *personal* domain response trend scores were high, discrepant categorisation of issues to the *personal* domain was low, evidenced by the strong negative correlation (r = -.47).

For the teens, the statistical significance of the negative relationship between *moral* and *safety* response trend scores and discrepant categorisation of issues to the *moral* (r = -.57), and *safety* (r = -.43) domains suggests when teens tend to categorise issues to these domains, their categorisation of these issues is consistent with the views of their parents.

Decision-Making Questionnaire. Discrepant perspectives between parents and teens about decision making appear to relate to the judgement of issues as belonging to the *personal* domain. This is illustrated by the correlations between the *ideal* decision-making discrepancy scores and the *personal* response trend scores being positive for teens (r = .40) and negative for parents (r = -.52). There was also a high significant positive correlation between discrepant categorisation of issues to the *personal* domain and the discrepancy for *actual* (r = .50) and *ideal* (r = .64) decision making.

Conflict Checklist. *Frequency* of discussions, as reported by parents and teens about the potentially conflictual topics, was not related to *anger* levels or to other measures. In contrast, patterns emerged regarding the *anger-intensity* level of discussions.

Anger-intensity levels of discussions were higher when teens tended to categorise issues as belonging to the *personal* domain (r = .32) and lower when parents tended to categorise issues as belonging to the *personal* domain (r = -.38). The negative association between discussion *intensity* and teen *moral* domain response trend scores (r = -.36) implies anger levels were also lower when teens tended to categorise issues as belonging to the *moral* domain. There was a similar association between *anger-intensity* levels and discrepant categorisation of issues to domains. The significant positive correlation between discussion *anger* levels

and discrepant categorisation of issues to the *moral* domain was higher for teens (r = .45) than for parents (r = .27). This was reversed for *anger* level of discussions and discrepant categorisation of issues to the *personal* domain with the positive correlation being higher for parents (r = .44) than for teens (r = .33).

Parental Authority Questionnaire. Parents who perceived themselves as being *authoritarian* tended to rate issues as belonging to the *moral* domain (r = .37) and not as belonging to the *personal* domain (r = -.23), whereas those who perceived themselves as being *permissive* tended to rate issues as belonging to the *personal* domain (r = .30). *Authoritarian* parenting style, as reported by parents, was also moderately related to discrepant categorisation of issues to *moral* (r = .26) and *personal* (r = .27) domains. It appears that discrepant categorisation of issues occurred less among teens who perceived their parents as displaying an *authoritative* parenting style, shown by the significant negative correlations with *moral* (r = -.32) and *personal* (r = -.27) discrepancy scores.

There was a significant positive correlation between *authoritarian* parenting style and *anger* levels of discussions for parents (r = .33) and teens (r = .34). Conversely, *anger* level of discussions was negatively and significantly correlated with the *authoritative* and *permissive* parenting styles. This relationship was stronger for the teens than for parents for the *authoritative* parenting style (r = -.37 and r = -.24 respectively) as well as the *permissive* parenting style (r = -.40 and r = -.18 respectively).

Relationship Questionnaire. Discrepant decision-making scores, response trend scores, and discrepant categorisation of issues to domains were not related to parent perceptions of the parent-teen relationship in a meaningful way. For the teens, there was a moderate positive association between their perception of the

parent-adolescent relationship and their tendency to rate issues as *moral* (r = .25) or *conventional* (r = .21), and discrepant categorisation of issues to the *moral* domain (r = -.29). Lower perceptions of the parent-teen relationship, as reported by both parents and teens, was more strongly related to higher *anger* level of discussions (r = -.36).

There were some important differences between the Relationship and parenting style scores. This association was strongest for the *authoritative* parenting style, with the positive correlation being high for both teens (r = .66) and parents (r = .56). Teens' positive perception of their relationship with parents was positively associated with rating of parents as being *permissive* (r = .42), and negatively related to rating of parents as being *authoritarian* (r = -.31).

Symptom Checklist-90-R. The *anger-intensity* level of discussions and the *global severity index* score was positively related for teens (r = .48) but not related for parents. A high negative correlation was also revealed between the teen *global severity index* score and their perception of the parent-adolescent relationship (r = -.44). These findings reveal a very strong association between psychological well-being in adolescents and parent-adolescent conflict, as well as the importance of the parent-adolescent relationship.

Summary

The study reported in this chapter was designed to examine reports of actual conflict in New Zealand families, as well as adolescents' and parents' conceptions of decision making, and parental authority based on a domain model of social-cognitive development. The results indicated that teens and parents generally agree that conflicts occur over everyday issues such as doing chores, tidy bedroom, swearing, going out, and homework.

A large proportion of parents and teens reported that the teen actually made their own decisions about their behaviour, and for many of the issues specified, they regarded independent decision making as normal. However, compared to teens, more parents considered they had the final say, and reported having strong feelings about many of the issues. Of particular note was that the issues of greatest dispute were not those about which discrepant decision-making perspectives were reported. Rather, the highest conflict levels were associated with issues parents had strong feelings about.

Main findings from the survey study were that parents and teens did categorise issues differently according to social-cognitive domains, and that discrepant categorisation of issues was related to higher frequency and anger-intensity levels of discussions. Parents tended to judge wrongness of issues on the basis of moral and safety explanations, and teens tended to judge issues as belonging to their personal jurisdiction, which increased with adolescent age. Associations were also revealed between parenting styles, the parent-adolescent relationship, and interpreting issues in conceptually different ways.

Results from this sample of participants indicate that conflict arises when parents have strong feelings about issues, and when parents and teens have divergent conceptions of authority about family issues. It seems therefore that the social-cognitive domain perspective would be useful for the treatment of parent-adolescent conflict to provide family members with a framework for articulating and justifying their reasoning.

CHAPTER 4: TREATMENT STUDY

Aims of Study

The survey study compared parents' and adolescents' reasoning about potentially conflictual issues and explored perceptions of legitimate parental authority based on judgement of issues to domain categories. As results indicated that different judgement of issues was related to levels of conflict, the social-cognitive model of development has implications for clinical psychologists in terms of intervention. In particular, it is not known if parents and teens articulate reasoning for the wrongness or permissibility of issues during disputes, or if awareness of the other's perspective influences levels of conflict. To find out whether articulation about justifications does facilitate communication and alters levels of conflict, I designed a clinical treatment study to explore the utility of using the domain model from a cognitive-behaviour therapy perspective.

Although parent-adolescent conflict per se is not a criterion for treatment in mental health clinics in New Zealand, conflict is widespread in the general community and is frequently associated with both internalising and externalising disorders. Previous studies have focused on parent training, and communication and problem-solving training. While the efficacy of these interventions has been demonstrated, limitations have been recognised, particularly when working with adolescent clients. The literature points to social-cognitive developmental changes as being central to understanding parent-teen relationships. It seems important that intervention strategies incorporate these developmental perspectives to address the needs of families in conflict, which is the focus of the research study that follows.

Method

Participant Selection

Parents or caregivers and their teenage children (aged 13-16 years) were invited to participate in the research in the following ways.

Principals of the two middle schools and six secondary schools (also known as high schools) in the Hamilton area were initially contacted by telephone. I subsequently travelled to each school to meet with the Principal to seek his or her support in recruiting participants. At the meeting, the rationale for the study was discussed and the Principal was given information regarding the treatment programme. I also met with counsellors at each school to discuss the programme and to inquire about their availability to see teens and parents to address issues that may arise during the treatment sessions that were not within the research protocols. All of the schools agreed to support the research project by disseminating information in a manner that they considered appropriate at their school. The counsellors from each school informed families known to them whom they considered might be suitable participants. Some schools included a notice in their newsletter, while others distributed brochures (see Appendix E) to teens in the 13 to 16 years age group.

Community agencies and churches (e.g., Parentline, Link House, Presbyterian Support Services), health and education services (e.g., Child and Adolescent Mental Health Service, Child Development Centre, Specialist Education Services), and private practitioners were informed about the treatment programme. Meetings were held at each organisation and in most cases a 30-minute presentation on the rational for the study and proposed plan was given to staff during one of their referral or planning meetings. The meetings served two

purposes: first, to seek support in recruiting participants by requesting the organisations inform families known to them about the treatment programme; and second, to gain information regarding referral criteria and procedures to these services or agencies for families from the research should the need arise.

A cultural consultant was commissioned to make initial approaches to community organisations known to work with Maori families and to act as a liaison between those agencies and the researcher. The consultant accompanied the researcher to meetings with these organisations when providing information about the programme and seeking their support in recruiting participants.

A brief announcement was also placed in a local newspaper and university newsletter. The brochure advertising the treatment programme was also put on public notice boards (e.g., at the University of Waikato, the Hamilton City Council Public Libraries, and in General Practitioner's waiting rooms).

I did not approach any families directly myself, but those who had been told about the programme were asked to express their interest by either phoning me or completing and returning a page in the brochure. Initial contact with potential participants was therefore via telephone conversation. All individuals who made inquiries were thanked for their interest and provided with any further information they requested. Interested people were offered the opportunity to meet with me to discuss the programme in detail before making a commitment to attend. Other family members (whanau) and support people were welcome to attend this meeting.

Inclusion and exclusion criteria. During the initial telephone conversation I took the opportunity to confirm that inclusion criteria were met. The essential criterion for participation was conflict between parents and their

teenager. Other inclusion criteria were: (a) teens were within the age group identified (inquiries were received from a large number of parents whose children were younger or older than the identified age group); (b) at least one parent and one teen from the family agreed to attend sessions (many parents who expressed an interest in attending the programme were not able to entice their teen into attending, others just wanted to send their teen along and not attend themselves); (c) families were not to receive other treatment addressing disagreements during the course of the research project; and (d) people agreed to complete the pre- and post-treatment self-report measures. Two parents from one family were permitted to attend treatment, but in all cases only one teen was to be present at each treatment session.

Exclusion criteria were an impairment that would interfere with participation (e.g., speech or hearing impairment, intellectual disability) or inability to understand English. Where appropriate, information regarding possible alternative sources of support or treatment was provided to those who were not eligible to participate in the programme.

Participant Characteristics

Twenty-six parent-teen dyads, from 19 families, participated in this study. Two parents attended for 7 of the families who completed treatment and one parent attended from 12 families. When two parents participated in treatment, each parent completed separate measures, and the teen completed separate versions of the questionnaires for relations with each parent. This meant independent data were obtained from 26 adolescent-parent dyads and results are reported in this manner. Demographic information about the participants is provided in the following sections.

Gender and age. The parents were aged between 33 and 55 years (M = 43 years, SD = 6 years). Sixty nine percent (n = 18) of parents were female, 31% (n = 8) were male (M_{female} = 42 years, M_{male} = 44 years). Teens were aged from 13 to 16 years, with a mean of 14 years 11 months (SD = 1 year 1 month). Forty six percent (n = 12) were female and 54% (n = 14) were male (M_{female} = 15 years 3 months, M_{male} = 14 years 7 months). To examine whether age influenced response to treatment, the teen participants were coded into two age groups: young adolescents (13 to 14 years; 6 females, 9 males) and middle adolescents (15 to 16 years; 6 females, 5 males). Chi-square analysis confirmed early and middle adolescent age groups could be regarded balanced according to gender.

Family composition. Family structure was described as belonging to one of four categories: (a) intact family, the teen and their biological mother and biological father were living together; (b) single parent family, the teen lived with one biological parent; (c) blended family, the teen lived one biological parent and one non-biological parent; and (d) foster family, the teen was living with adult caregivers that were not biological parents. More dyads were from intact families (42%, n = 11) than from single parent (35%, n = 9) or blended families (15%, n = 4), and 8% (n = 2) were from a foster family. This information is presented in Table 4.1, which also shows the percentage of male and female teens within each family structure.

Dyad. Due to the small number of participants in some of the adult-teen dyad categories, *Dyad* was grouped so that 1 = female teen and female parent, 2 = female teen and male parent, 3 = male teen and female parent, and 4 = male teen and male parent. The number of dyads in each category that was used for further analysis is presented in Table 4.2.

Table 4.1
Family Composition, Parental Role of Adult Participants and Gender of Teens in Treatment Study

Adult	Total		Female Teen		Male Teen	
	%	*n*	%	*n*	%	*n*
Intact Family						
Mother	23	6	33	4	14	2
Father	19	5	25	3	14	2
Single Parent Family						
Mother	35	9	42	5	29	4
Blended Family						
Mother	8	2	-	-	14	2
Step father	8	2	-	-	14	2
Foster Family						
Foster-mother	4	1	-	-	4	1
Foster-father	4	1	-	-	4	1

Table 4.2
Dyad Composition of Participants in Treatment Study

Parent Gender	Female Teen		Male Teen	
	%	*n*	%	*n*
Female	35	9	35	9
Male	11	3	19	5

Ethnicity. Eighty-five percent (n = 22) of parents were *Pakeha/European* and 4% were *Maori* (n = 1). Twelve percent (n = 3) of the parents endorsed the category designated *Other*. Of these participants one identified as a *Pacific Islander*, one as *Australian*, and one as *Scandinavian*. Most of the adolescent participants categorised themselves as *Pakeha/European* (92%, n = 24), with 8% (n = 2) identifying themselves as *Maori*. As most parents and teens identified

themselves as *Pakeha/European* and the number of participants belonging to other ethnic groups was too small to be representative of those groups, ethnicity was not used for further analysis.

Religious affiliation. Religious affiliation was coded into two groups for analysis: those who identified as belonging to a religious group (*religious*) and those who did not (*non-religious)*. This resulted in 31% of teens (n = 8) being in the *religious* category and 69% (n = 18) in the *non-religious* category. Conversely, 69% (n = 18) of parents were in the *religious* category and 31% (n = 8) were in the *non-religious* category.

Family backgrounds. The foregoing demographic information provides a formal description of clients who attended treatment, but it does not describe family circumstances or experiences of individuals. Although not formally measured, information obtained during the initial interview and during the course of therapy gives a picture of considerable variation among families.

Employment was diverse. Among the mothers, some were in full-time employment, others worked part-time, and some did not have employment outside the family home. All fathers were in full-time employment. Parent occupations included accountants, middle, senior and executive managers, small business owners, farmers, nurses, shop assistants, and labourers. Economic status also varied, with some families reporting they were financially privileged, while others were dependent on the welfare state for support. Several families categorised themselves as "average" New Zealand families with regular employment, moderately comfortable incomes, and no extraordinary background. Others, however, reported struggling with disturbed backgrounds and described difficult current circumstances.

A number of mothers revealed a significant history of partner abuse, although none reported being in relationships that were physically abusive at the time of attending treatment. In some cases teens had witnessed their mother's being physically and/or verbally abused. Information obtained also indicated some teens had been subject to physical abuse and verbal aggression, while others had a history of being physically "punished". A history of childhood abuse was also disclosed by some male and female parents.

One female teen was working in a rest home for the elderly as part of a community service sentence for stealing. Another male teen was affiliated to a teenage gang. Although he no longer wanted to be a gang member, departure was not straightforward and he was working with school counsellors to make this change safely.

Several teens had a history of mental health concerns, some of whom had previously attended the Child and Adolescent Mental Health Service for depression, another had a history of sexual abuse. One teen had been diagnosed with attention-deficit/hyperactivity disorder, and had been involved with deliberate fire setting that had destroyed property.

In addition to subsequent data analyses and descriptions in following sections, I will outline clinical impressions regarding how the diverse range family circumstances appeared to influence responsiveness to treatment.

Self-Report Measures

The central goals of treatment were to reduce conflict and improve satisfaction with the relationship. Measures used were considered to reflect the domains of interest such as social and affective dimensions of family environment, communication and conflict behaviour, awareness of teen

development and use of social-cognitive domains for decision making, and problem-solving skills. Three of the measures used in the previous Survey Study were completed at pre-treatment: the Parental Authority Questionnaire, the Relationship Questionnaire, and the Symptom Checklist-90-R. The Relationship Questionnaire was also completed at post-treatment. In addition to these instruments, four further measures were completed independently by teens and parents before and after treatment: the Family Environment Scale (Moos & Moos, 1986), the Conflict Behavior Questionnaire (Robin & Foster, 1989), the Domains and Development Questionnaire (Connelly & Evans, 1998e), and the Social Problem-Solving Inventory-Revised (D'Zurilla, Nezu, & Maydeu-Olivares, 1997). All questionnaires were presented in consistent format and order, with gender and dyad relationship language modified to be appropriate for individual participants. Teens, parents, and the therapist completed measures to evaluate therapy when treatment had been completed. Questionnaires developed for this study, the Domains and Development Questionnaire and evaluation instruments, appear in Appendix F. Two evaluation versions are appended: the Participant Evaluation and Therapist Evaluation of teen.

Family Environment Scale (FES; Moos & Moos, 1986). The Family Environment Scale is a 90-item questionnaire that comprises 10 subscales designed to assess social and affective dimensions, and basic organisational structure of families. The version assessing one's immediate family (Real) is considered to be relevant to the assessment of family interaction (Foster & Robin, 1988). The instrument's authors report internal consistency reliability estimates range from 0.61 to 0.78, and test-retest reliabilities within an 8-week interval between testings vary from .68 to .86 (Moos & Moos, 1986). Construct validity

has been supported by several studies comparing subscale scores with other instruments measuring similar dimensions of the family environment (Foster & Robin, 1997). Normative data are based on responses from a varied sample of 500 distressed and 1,125 nondistressed families in U.S.A. (Moos & Moos, 1986). For the purposes of this research project, participants' scores have been converted to *T* scores based on the nondistressed family data.

Although the Family Environment Scale was not specifically developed for parent-teen relationships, the six subscales considered relevant to aspects of family conflict were utilised: *cohesion, expressiveness, conflict, independence, organisation,* and *control* (Foster & Robin, 1988). Measurements of *cohesion, expressiveness* and *conflict* assess the commitment, help and support family members provide each another; direct communication and expression of feelings; and the amount of expressed anger, aggression, and conflict among family members. *Independence* assesses the extent to which family members are assertive and make their own decisions. The *organisation* and *control* subscales measure structure in planning family activities and responsibilities and the extent to which set rules and procedures are used to run family life. High *cohesion* and *expressiveness* and low *conflict* predict better adjustment, and children are likely to show more personal and social competence in families that value *independence* (Moos, 1994). It has been found that when compared to *normal* families, scores from *distressed* families differ significantly in predicted directions. That is, scores for distressed families are higher on *conflict* and *control* subscales, and lower on *cohesion, expressiveness,* and *independence* subscales (Moos & Moos, 1986). *Organisation* characteristics of the family environment tends to remain relatively stable over time, but *cohesion, expressiveness, conflict*, and *control* tend to change

and have been reported to be sensitive to changes in family environments during treatment (Moos & Moos, 1986).

Conflict Behavior Questionnaire (CBQ; Robin & Foster, 1989). The Conflict Behavior Questionnaire is a measure of perceived negative communication and conflict in parent-adolescent interactions. Parents and teens complete parallel versions. Items reflect positive and negative behaviours, and are scored *mostly true* or *mostly false*. The parent version contains 75 statements, 53 regarding their appraisal of the teen's behaviour (e.g., *My teenager often seems angry at me*) and 22 regarding their perception of interaction with their teen (e.g., *I enjoy spending time with my teenager*). The adolescent version contains 73 items, 51 regarding their appraisal of the parent (e.g., *During discussions my mother doesn't listen to my side of the story*) and 22 identical to the parent form regarding the teen's perception of interaction with their parent. Two scores are obtained for each participant, appraisal of the other's behaviour and appraisal of the dyad. High scores indicate a more negative appraisal and low scores indicate a positive appraisal. Raw scores are converted to *T* scores for non-distressed and distressed families, based on original data obtained from families in the U.S.A. Scores have been found to discriminate distressed from non-distressed families (Prinz, Foster, Kent, & O'Leary, 1979; Robin, 1981; Robin & Foster, 1984). The Conflict Behavior Questionnaire is sensitive to change following treatment (Foster, Prinz, & O'Leary, 1983; Robin, 1981) and scores correlate moderately with other tests measuring similar constructs (Foster & Robin, 1988). Robin and Foster (1989) report internal consistency coefficients of 0.90 and above for mother and teen responses on each scale. Test-retest reliability over a 6-8 week interval from wait-list control families has ranged from 0.61 to 0.85 (with one

exception of adolescent appraisal of mother, which correlated at 0.37). Agreement between parent and teen perceptions of the relationship differs consistently with distressed dyads averaging between 66-68% agreement compared with 84% agreement for non-distressed dyads.

Domains and Development Questionnaire (Connelly & Evans, 1997e). This questionnaire was developed to use as a response to treatment measure for this research study. Items were designed to assess consideration given to adolescent development and use of the domain framework when discussing topics of potential conflict. In order to develop an instrument that was parallel to the inventory used to assess problem-solving skills, items were written to reflect five relevant components: (1) *positive adolescent orientation* (2 items); (2) *negative adolescent orientation* (2 items); (3) *adolescent development* (4 items); (4) *adolescent roles and responsibilities* (6 items); and (5) use of *domain categories* for reasoning (6 items). Parents and teens completed the same 20-item questionnaire (see Appendix F). Participants rated how well each item described family discussions and decision making using a 5-point scale from *not at all true of me* (0) to *extremely true of me* (4). Items describing negative functioning were reverse scored, then responses were summed to obtain score for each constellation of items. A total score for the Domains and Development Questionnaire was calculated according to the formula used to derive the *total index score* from the Social Problem-Solving Inventory-Revised, with *negative adolescent orientation* being reverse scored. Scores range from 0 to a maximum of 20. Higher scores indicate that more consideration was given to adolescent development and reasoning or perceptions of legitimate parental authority according to the social-cognitive domain categories.

Responses to the Domains and Development questionnaire yielded Cronbach coefficient alpha values of .81 for parents and .79 for teens indicating acceptable reliability. The average inter-item correlations of .20 for parents and .18 for teens were low which suggests some items may have been ambiguous or did not measure the dimension very well. For instance, the inter-item correlation for the same three items was below .30 for both parents' and teenagers' responses.

Social Problem-Solving Inventory-Revised (SPSI-R; D'Zurilla et al., 1997). The Social Problem-Solving Inventory-Revised is a 52-item instrument linked to a problem-solving model that assumes problem-solving outcomes are largely determined by two processes: (a) problem orientation, and (b) problem-solving strategies. Problem orientation is the motivational part of the process involving cognitive-emotional schemas that reflect how a person feels about problems and their ability to solve them. Problem-solving strategies refers to the systematic search for a solution through the rational application of strategies and techniques designed to maximise the probability of finding the most adaptive solution. Based on a factor analytic study (Maydeu-Olivares & D'Zurilla, 1996) the Social Problem-Solving Inventory-Revised consists of five major scales that measure different but related problem-solving dimensions: (1) *positive problem orientation* (5 items), (2) *negative problem orientation* (10 items), (3) *rational problem solving* (20 items), (4) *impulsivity/carelessness style* (10 items), and (5) *avoidance style* (7 items). The *rational problem-solving* scale is broken down into four subscales, each with five items: (a) *problem definition and formulation*, (b) *generation of alternative solutions*, (c) *decision making*, and (d) *solution implementation and verification*.

Using a 5-point rating scale, participants report how they typically respond to current real-life problems, ranging from *not at all true of me* (0) to *extremely true of me* (4). Responses are summed to derive an actual score for each subscale. A total *social problem-solving index* score based on the five subscales is obtained by reverse scoring the *negative problem orientation, impulsivity/careless style*, and *avoidance style* scales according to the following formula: SPS = PPO/5 + RPS / 20 + (40 – ICS)/10 + (28 – AS)/7. Higher *social problem-solving index* scores indicate more constructive or facilitative problem solving, whereas lower scores indicate more ineffective or dysfunctional problem solving.

D'Zurilla et al. (1997) report internal consistency estimates for the total *social problem-solving index* score as .95 among a sample of American university students (n = 138). Three-week test-retest reliability has been estimated to be .93 and .89 for the university students and a group of nursing students (n = 221) respectively. Social Problem-Solving Inventory-Revised scores are reported to correlate significantly with other social problem-solving measures, and with measures of general psychological symptomatology such as the Symptom Checklist 90-Revised (Derogatis, 1983).

Participants for this research completed the version requiring reading level Flesch-Kincaid rating = 6.3.

Measurement variables. In summary, participants completed seven assessment instruments. Two questionnaires were completed before treatment only: the Parental Authority Questionnaire and the Symptom Checklist-90-R. These instruments were used to explore whether pre-treatment parenting style patterns (*authoritarian, authoritative, permissive*), and psychological well-being indicated by the Symptom Checklist-90-R *global severity index* score, were

related to the conflict levels and perception of the parent-adolescent relationship after participation in the treatment programme.

Five questionnaires were completed at pre- and post-treatment, which yielded 11 variables: six from Family Environment Scale (*cohesion, expressiveness, conflict, independence, organisation, control*); two from Conflict Behavior Questionnaire (*appraisal of other, appraisal of dyad*); one from Relationship Questionnaire (*total score*); one from Domains and Development Questionnaire (*total score*); and one from Social Problem-Solving Inventory-Revised (*total index score*).

Client and therapist evaluations of treatment. Teens, parents, and the therapist completed measures to evaluate therapy when treatment had been completed. The measures were designed to solicit participant and therapist views about the procedures and the progress that teens and parents had made. Items were based on evaluation inventories developed by Kazdin, Siegel, and Bass (1992), but modified to be relevant to adolescents and the treatment programme. Two versions of the evaluation questionnaires (Participant Evaluation and Therapist Evaluation of Teen) and scoring keys appear in Appendix F.

The Participant Evaluation measure was designed to obtain views from participants about the procedures and the progress they had made. Parents and teens separately completed the same version of the evaluation questionnaire, which includes 18 items rated on a 5-point scale that form two 8-item subscales.

The first subscale (9 items) was designed to measure *treatment acceptability*. For example: *How much did you enjoy the sessions? Are you glad you participated in the programme?* The second scale (9 items) asked clients to evaluate their *progress in treatment*. For example: *How much did you learn about*

talking and listening to each other when discussing concerns or differences? How much have your discussions improved as a result of having attended the programme? There was also a section for clients to write any further comments about the programme.

Therapist Evaluation of the Parent and the Therapist Evaluation of the Teen measures included 15 parallel items rated on a 5-point scale that form two subscales. The first subscale (6 items) was designed to evaluate client *responsiveness* to treatment. For example: *How cooperative was this parent? Did this teen want to change how they interacted with their parent?* The second scale (9 items) measures the therapist's evaluation of client *improvement*. For example: *Was there a change in how much the parent was prepared to compromise when discussing concerns and differences? How much have this teen's discussions improved compared to when they first started?*

General Procedure

Approval to conduct the study was obtained from the Department of Psychology Ethics Review Committee at the University of Waikato. General approval was also sought and obtained from an advisor in the Psychology Department on Maori issues to ensure the general protocol, materials used, and treatment programmes met cultural safety standards. The initial part of the procedure, that is, participant selection, has been discussed earlier in this section.

Treatment conditions. All families attending the treatment programmes were seen in a rented office in a refurbished house that was used by a clinical psychologist in private practice. Appointments were available between 4 p.m. and 9 p.m., Monday to Thursday so participants did not have to take time away from work or school to attend sessions. Treatment was provided individually to each

family by myself as a trainee clinical psychologist and doctoral candidate. I was trained in the two treatment programmes under supervision (see treatment integrity below).

As sessions were conducted outside normal business hours, one adult person, other than the participants and therapist, was present on the premises at all times to ensure safety of the participants, the therapist, and security of the premises. This person also supervised younger siblings when families were not able to organise suitable babysitting arrangements, and provided transport to and from the premises for two families who did not have their own transport and would not have been able to attend sessions without this assistance. One family was provided with financial support for babysitting expenses and one family was given petrol vouchers to assist with travel expenses.

All families attended an initial interview session for approximately 1½ to 2 hours, then received a minimum of five weekly sessions of 50-60 minutes. Two further sessions were available for participants who considered this would be beneficial. In general, the opportunity to attend additional sessions was not discussed with the family until Session 5.

Treatment group assignment. Families were assigned to one of the two treatment groups according to the day of the week they attended sessions. That is, two days were allocated to the Problem-Solving group and two days were for the Domain and Development group. As families selected their own appointment time and had no prior knowledge of which treatment group they would be attending, group assignment was essentially random. To ensure equivalent expectations about treatment, teens and parents were told during the initial interview that both treatments were considered to be effective in addressing their conflicts, and there

was no reason to believe that one treatment was relatively more beneficial than the other.

Treatment integrity. A session-by-session manual and an associated text was prepared for each treatment group, and reviewed by the supervisor, to guide therapy. To ensure that treatment approaches were delivered consistently, only one treatment approach was used each day, which meant all families attending sessions on a given day were in the same treatment group. To foster correct execution of treatment, handout materials were prepared for the participants and referred to during sessions. Session outlines and process materials were consistently used and I completed a checklist at the end of each session to monitor which treatment components had been utilised (see Appendix G). In addition, documentation of each session summarised what had occurred during that session, and detailed levels of cooperation and progress made by the teen or parent. During the treatment phase, I attended supervision meetings twice weekly. Treatment sessions were not monitored by an independent observer due to time constraints and non-availability of suitable senior psychology trainees.

Initial session. During Session 1 the rationale for the research and dissemination of results, confidentiality regarding information provided and exceptions to confidentiality principles, the scope and limitations of the treatment programme, participant and therapist responsibilities, and major activities that would take place in therapy were discussed. This information was also provided to participants in writing. Teens and parents had the opportunity to ask questions and to discuss their participation before individually signing consent forms. Where appropriate, consent was also obtained to communicate with counsellors and health providers that families were involved with.

The remainder of the initial session was used to obtain relevant teen and family history, identify specific concerns and individual family goals, and to complete pre-treatment assessment. This was accomplished by first talking with the parent and teen together to observe interactions and behaviour, then talking with the teen and parent separately while the other person completed the questionnaires in a separate room. Talking with the teen independently meant I had the opportunity to address their feelings and concerns about attending treatment, as typically parents had insisted they come along and the teen was not an enthusiastic participant.

The information provided to participants, the consent form, and the initial interview outline appears in Appendix H.

Common features among treatments. Several features regarding case management and individualisation of treatment were common to both treatment groups.

First, within the sessions, instructions, modelling, practice, role playing, corrective feedback, and social reinforcement were used to develop skills. The sessions involved a collaborative approach (parent and teen as active participants) to engage individuals in treatment, and reduce resistance. Cartoons, drawings and analogies were used to illustrate points to create an enjoyable and non-critical environment for the presentation, learning, and practising of the strategies relevant to each treatment group.

Second, outside of the sessions, the teen and parent were assigned tasks, referred to as *home practice*, to apply the steps to increasingly difficult situations in everyday life. Tasks were designed to achieve treatment goals and increase generalisation. Each treatment session began with a discussion, and where

appropriate a re-enactment of the previous week's home practice, as well as social reinforcement and token incentives at the session (i.e., small chocolate or muesli bars), to foster and monitor completion of the home practice. Each treatment session concluded with a new home practice task being assigned for the coming week.

Third, teens and parents were generally seen together during treatment sessions. The opportunity was available, at the request of either the participants or the therapist, for the therapist to speak with participants individually within a session. This option was primarily implemented when one of the participants became disengaged from the process. Where ongoing safety issues within a family were a concern (e.g., physical abuse of teen), each session was structured to have individual time with the participants.

Fourth, Communication Skills training was presented to both treatment groups during Session 2, irrespective of treatment group assignment. Primarily, the approach followed procedures described by Robin and Foster (1984, 1989), supplemented by strategies presented in the marital communication literature (e.g., Gottman, Notarius, Conso & Markman, 1976; Jacobson & Margolin, 1979), and in the communication literature (e.g., Verderber & Verderber, 1992). The goal was to replace ineffective or negative communication during family disputes, such as accusations, interruptions, lectures, put-downs, and inattention, with positive communication such as verification of meaning, active listening, I-messages, and validation. The importance of understanding via the *intent* (what the speaker intends to convey) being equal to the *impact* (the message received by the listener) was highlighted. Consideration was given to the influence of the context in which communication occurs (e.g., who is present, the mood of the people

communicating, previous interactions, perceptions, attributions and beliefs), as well as nonverbal communication. Communication was recognised as being an *interaction* with each person being involved in the communication being responsible for their part in that process. Emphasis was placed on actively observing and verbally acknowledging the other person's positive behaviours. Participants received written handouts that highlighted the main points of the communication skills presented (see Appendix I). The key communication skills were displayed on a white-board in the room during every treatment session and referred to using a "catch-it and correct-it" approach when inappropriate communication was used. In addition, guidelines for expressing negative reactions, questions to consider before expressing concerns about another person's behaviour, and common negative communication and suggested alternative responses were addressed. The positive communication procedures were implemented to provide a means by which inappropriate communication during sessions could be interrupted and corrected to: (a) assist participants identify when they were communicating in a manner that was likely to provoke a negative response; (b) provide the opportunity to model and practice positive communication; and (c) reduce the likelihood of family conflict escalating during sessions.

Fifth, in Session 3 the relevant skills and strategies were presented to families according to the treatment group to which they had been assigned.

Sixth, during subsequent sessions, treatment was individualised to address each family's specific concerns or problems within the guidelines prescribed in the manuals relevant to the treatment group to which they had been assigned.

Where relevant, consideration was given to family routines, sibling relations, and other home and school circumstances.

Finally, all participants completed assessment instruments individually during the final week of treatment. The evaluation forms were completed at the end of the final session. Families had the opportunity to meet with me and get information and materials provided to the other group after post-treatment assessment was completed.

Problem Solving group. Fifty percent of the dyads (n = 13) were assigned to the Problem Solving group. The treatment followed the principles described by Robin and Foster (1989). Modifications and extensions were made to focus on the dyadic relationship, to emphasise situations in everyday life, to include opportunities to individualise the content to address concerns and situations about which the family reported distress, and to extend training to the home. The treatment combined cognitive and behavioural techniques to teach problem-solving skills (e.g., identifying the issue, generating alternative solutions, engaging in consequential thinking, and selection then implementation of satisfactory solutions) to manage disputes and difference of opinions in the home. The programme did not specifically target restructuring of irrational, extreme, or rigid beliefs held by teens or parents about their own or the other's behaviour. If these concerns arose they were addressed within the problem-solving framework. See Appendix J for materials provided to participants.

Domain and Development group. (n = 13 dyads). The goal of this intervention approach was to assist individual family members recognise and understand how their thoughts and beliefs about adolescence influenced their interpretation of adolescent behaviour, as well as their interactions and

perceptions of each other. Particular focus was on how conceptions of adolescence influenced expectations regarding parental authority, and the way in which parental authority is applied. To achieve the intervention goal, two components were included: (a) identification of adolescent developmental tasks and goals, and (b) understanding the source of parent-adolescent conflict from a social-cognitive development perspective, and utilising the domain model as a framework to interpret the mismatch between parents' and teens' social-cognitive reasoning about issues of dispute.

The first component was based on principles derived in the adolescent development literature. Family members were assisted in identifying developmental tasks faced by adolescents, and encouraged to increase their awareness of the changing roles and responsibilities of teens and parents during this transition, with attention given to changes applicable to their own family depending on the developmental level of the teen.

Material for the second and major component was drawn from social-cognition research conducted by Turiel and Smetana on the discrimination made between personal issues and those that are of a moral, conventional, or safety nature. As previously described, their research has demonstrated that the adolescent's developing social reasoning has important implications for understanding sources of family conflict as perspectives of legitimate parental authority differ according to conceptual domains. Although parents and teens generally agree on who has legitimate authority of each domain category, their judgement of issues as belonging to the conceptual domains is discrepant.

To ensure the model was relevant to individual families, the initial step was for each family to develop definitions for the four conceptual domains.

During following sessions, parents and teens identified and discussed actual issues of dispute, and sought to resolve their conflicts by articulating their perspectives and justifying their positions of parental versus personal authority within the domain framework. Consistent with the Problem Solving group, cognitive restructuring of beliefs was not specifically targeted, but extreme and rigid cognitions were addressed within the domain framework protocol used for this intervention. See Appendix K for participant handout materials.

Analysis. The questionnaires were scored and quantitative data were entered into the Statistica for Windows programme for statistical analysis. Subsequent descriptive and data analysis are described under each aspect of the study. Clinical impressions are also outlined.

Results

The primary aim in this part of the research project was to examine whether a cognitive-behavioural intervention approach based on the domain model of social-cognitive development reduced levels of conflict between parents and teens and improved perceptions of family relationships. The second aim was to compare the Domain and Development treatment approach with a standard Problem Solving treatment approach.

Before response to treatment data were analysed, preliminary investigations were carried out. This included information regarding: (a) participant attrition; (b) comparison of data from normative samples and individuals participating in this treatment study; (c) investigation of the degree to which parent and teen self-report measures diverge at pre-treatment, and the relationship between divergent perspectives and conflict; (d) correlation analysis to identify association between variables, and (e) examination of the demographic characteristics of the participants in each treatment condition.

After response to treatment data were analysed, post-intervention investigations included examination of discrepancies among parents and teens reports and the association between conflict and discrepant reports, and correlation analysis to identify whether the relationships among measures differ before and after treatment. Then, impact of treatment for clients was considered in terms of statistically reliable change and clinical significance, and clinical impressions of the two intervention approaches are presented. Finally, data are presented regarding participant and therapist evaluations of treatment.

Participant Attrition

Thirty-one parent-teen dyads completed pre-treatment assessments and began treatment. Of these, 84% (n = 26 dyads) completed treatment. Of the five dyads that terminated early from treatment, three were from the Problem Solving group and two were from the Domain and Development group. These five dyads were from three families.

One family (mother and daughter, and step-father) withdrew due to a marital separation. In this case the family reported that the mother-daughter relationship was satisfactory, but there were high levels of conflict between the stepfather and stepdaughter. As the teen had no contact with her stepfather when he and her mother were living apart, the family chose to withdraw from treatment. The second family (mother, father, and son) withdrew on advice of the psychiatrist acting for the teenager who was addicted to drugs, was actively suicidal, and experiencing negative side effects from anti-depressant medication. The mother described themselves as "a family in crisis", as they reported also experiencing high levels of conflict with an older son. The psychiatrist considered it would be in this family's best interests for them all to attend treatment together, which was not available as part of the treatment programme. The third family, which comprised a solo mother and her son, discontinued treatment when the teen refused to attend sessions with his mother because he saw "no point" in changing his behaviour and expressed no interest in improving the relationship with his mother. Pre-treatment data from the five dyads that did not complete treatment have not been included in subsequent analysis.

Comparisons at Pre-Intervention with Normative Samples

Pre-intervention scores obtained were compared with *non-distressed* family population data where available to allow a comparison between the families who participated in the treatment study and *normal* family samples. This served as a guide to compare family environment variables and to ascertain whether families attending treatment have reported high levels of family conflict. Scores from normative samples and treatment group participants are appended along with graphical illustration of these data (see Appendix L).

Family Environment Scale. For the subscales identified as discriminating between normal and distressed families, treatment group participant scores were more negative than the initial normal family sample (Moos & Moos, 1986). That is, scores for treatment study participants were higher on *conflict* and *control* and lower on *cohesion*, *expressiveness*, and *independence.* Treatment group *organisation* scores were also lower but less divergent from normative scores than the other subscales. The scores and standard deviations from the parents and teens in this study indicate they were a heterogeneous group, some of whom were experiencing significant conflict and poor quality of relationship reflected by low *cohesion* and *expressiveness* scores. Family structures were reported as relatively organised and set rules and procedures to run family life seemed to be valued. Independent decision making was not regarded as highly as among the normative family sample.

Conflict Behavior Questionnaire. The two scores obtained for each family member, *appraisal of other* and *appraisal of dyad,* were more negative (higher) for treatment group parents and teens than the normative family sample (Robin & Foster, 1989). There was also greater variability of scores for the

treatment group participants. Clinical cut-off scores have not been published, but examination of the distribution of scores showed that 65% (n = 17) and 69% (n = 18) of the parent *appraisal of teen* and *appraisal of dyad T* scores respectively were > 2 *SD* above the mean. For teen *appraisal of parent*, 58% (n = 15) obtained a *T* score > 2 *SD*, and for teen *appraisal of dyad* 46% (n = 12) obtained a *T* score > 2 *SD*. The data obtained on the Conflict Behavior Questionnaire indicates that treatment group participants reported experiencing considerably higher levels of conflict and negative communication than was reported by nondistressed family samples.

Parental Authority Questionnaire. Teens' perceptions of their parents' style of parenting behaviour was compared with normative samples of high school students (M = 17 years 9 months) and university students (M = 18 years 10 months) (Buri, 1991). Although the teens in the treatment groups were younger (M = 14 years 11 months) than teens from the normative samples, a consistent pattern emerged. Teens in the treatment groups perceived their mothers and fathers to be more authoritarian than was reported by both normative samples. Treatment group teens also reported their parents as being more authoritative than the high school students but less authoritative than the older university students. Treatment group scores obtained for parental permissiveness were comparable to the scores for the older university students, but higher than the scores for high school students.

When compared to the New Zealand general community sample participants in the Survey Study (Chapter 3) parents in the treatment group rated themselves as being more *authoritarian* and less *authoritative*, but the ratings were not statistically different. Parents' scores for *permissiveness* from the survey

sample and the treatment group were consistent. Teens from the survey sample and the treatment group rated their parents similarly for *authoritarian* parenting style, but as less *permissive*, although scores on these subscales were not significantly different. However, teens in the treatment group rated their parents as being significantly less *authoritative* than teens in the survey sample, $t(148) = 2.00, p < .05$.

Relationship Questionnaire. Compared to the general community sample participants in the Survey Study (Chapter 3), scores for parents and teens in the treatment study were lower, indicating perceptions of the parent-adolescent relationship were less positive. Statistical analysis confirmed treatment group Relationship scores were significantly lower for parents, $t(148) = 2.32, p < .05$, and for teens, $t(148) = 3.70, p < .001$.

Symptom Checklist-90-R. Higher scores on this scale indicate more severe psychological distress, and where an individual has a *global severity index T* score of equal to or greater than 63 they are considered at high risk for a positive diagnosis (Derogatis & Lazarus, 1994). Many of the participants were in this range, as 39% of parent and 27% of teen *global severity index T* scores were greater than 63. Histograms showing the distribution of scores presented in Appendix L indicate more participants were experiencing high levels of psychological distress than would be expected in a normal population sample.

Social Problem-Solving Inventory-Revised. In general, participants in the treatment study reported good awareness and use of problem-solving skills as scores obtained by parents and teens were consistent with normative samples (D'Zurilla, Nezu, & Maydeu-Olivares, 1997).

Summary of comparisons with normative samples. Comparison with normative sample data suggests that the parents and teens in this treatment research study were from distressed families. They reported experiencing very high levels of conflict and negative communication, and also negative perceptions of their family environments based on the Family Environment Scale. Parenting behaviours were rated by parents as being more authoritarian and by teens as being less authoritative than the New Zealand community sample. A large portion of parents and teens reported poor psychological health according to the Symptom Checklist-90-R. In contrast, parents and teens rated their level of problem-solving skills as being comparable with nondistressed samples.

Pre-Intervention Comparisons Between Parents and Teens

The range of scores, means and standard deviations from self-report measures completed by parents and teens at pre-treatment are presented in Table 4.3. As concurrent views have been obtained from parents and teens, the extent to which they diverge in their self-reports of the same events at pre-treatment was compared via independent *t*-tests. Results of analyses also appear on Table 4.3.

Family Environment Scale. Scores obtained by individuals in this study were converted to *T* scores using the initial *normal* family conversion table (Moos & Moos, 1986). As Table 4.3 shows, and as mentioned above when comparing treatment families with normative data, many parents and teens in this sample obtained scores that indicated they perceived their family environment as being negative. The teen participants scored more negatively than parents for all six subscales. That is, teens scores were lower for *cohesion, expressiveness, independence* and *organisation,* and higher for *conflict* and *control*, but *t*-test analysis showed these differences were not statistically significant.

Table 4.3
Ranges, Means and Standard Deviations from Self-Report Measures at Pre-Treatment: Parents and Teens

Measure	Parents				Teens				*t*
	Range		*M*	*SD*	Range		*M*	*SD*	
	Min	Max			Min	Max			
Family Environment Scale									
Cohesion	1	68	34.81	19.28	1	60	24.54	18.13	1.98
Expressiveness	15	66	42.27	11.00	15	54	36.46	11.94	1.82
Conflict	32	75	58.35	13.32	43	81	62.69	11.21	1.27
Independence	20	62	42.54	10.82	20	70	35.85	14.40	1.89
Organisation	20	64	47.00	11.68	20	59	46.08	11.58	<1.00
Control	26	70	55.00	11.25	37	76	61.31	13.20	1.85
Conflict Behavior Questionnaire									
Appraisal of Other	54	106	77.81	14.39	44	115	72.88	19.24	1.04
Appraisal of Dyad	39	123	80.19	22.64	40	115	72.58	21.84	1.23
Parental Authority Questionnaire									
Authoritarian	15	43	28.42	5.78	17	40	29.69	6.12	<1.00
Authoritative	27	49	39.77	4.61	17	44	32.04	6.77	4.82***
Permissive	18	35	25.62	4.10	16	39	26.54	5.66	<1.00
Relationship Questionnaire									
Total Score	24	36	30.00	3.79	14	35	25.65	5.56	3.29**
Symptom Checklist-90-R									
Global Severity Index	30	80	59.31	10.96	28	72	53.31	12.25	1.86
Domains and Development Questionnaire									
Total Score	7.6	15.2	11.32	1.92	7.1	12.9	10.47	1.56	1.75
Social Problem-Solving Inventory-Revised									
Total Score	6.5	18.8	13.90	2.90	4.3	16.3	9.77	2.93	5.11***

Note: * $p = < .05$, ** $p = < .01$, *** $p = < .001$.

Conflict Behavior Questionnaire. Participant scores were converted to *T* scores based on data for *non-distressed* families (Robin & Foster, 1989). High scores reflect more negative appraisal. As shown on Table 4.3, many families were experiencing high conflict levels, and reported strong negative perceptions of the *other* person (M_{parent} = 77.81, M_{teen} = 72.88) and of the *dyad* relationship (M_{parent} = 80.19, M_{teen} = 72.58). Parent appraisals were more negative than the teens for both the *appraisal of other* and *appraisal of dyad* subscales, but these differences were not statistically significant.

Parental Authority Questionnaire. Scores on this measure range from 10 to 50, with high scores reflecting a stronger appraisal level of the parental authority style. Parents rated their own parenting behaviours as higher on *authoritative* than either *authoritarian* or *permissive* parenting behaviours (see Table 4.3). A repeated measures ANOVA revealed a main effect of parenting style, $F(2,50) = 54.60$, $p < .001$, and planned comparisons analysis confirmed *authoritative* parenting style was significantly higher than *authoritarian*, $F(1,25) = 62.73$, $p < .001$, or *permissive*, $F(1,25) = 129.00$, $p < .001$, parenting styles according to parent ratings.

Teens perceived their parents as being more *authoritative* than *authoritarian* or *permissive,* which was reflected in a significant main effect of Parenting Style, $F(2,50) = 5.28$, $p < .01$. Planned comparisons analysis showed teens' perception of *permissive* parenting style was significantly lower than *authoritarian*, $F(1,25) = 3.09$, $p < .05$, or *authoritative* parenting styles.

The pattern of rating *authoritative* parenting higher than *authoritarian* or *permissive* parenting was consistent for parents and teens, but *t*-test analysis showed parents perceptions of *authoritative* behaviours were significantly higher

than their teens, $t(50) = 4.82$, $p < .001$. Ratings of *authoritarian* and *permissive* parenting styles by parents and teens were not significantly different.

Relationship Questionnaire. Although treatment group Relationship scores were lower than those obtained from the survey study sample, many parents from the treatment group reported having a positive relationship with their teenager as parent scores ranged from 24 to 36, where 40 is the maximum score. The range of teen scores was greater, 14 to 34, indicating some teens perceived the parent-adolescent relationship to be positive while others considered the relationship to be very negative. As shown in Table 4.3, parents ($M = 30.00$) viewed the parent-adolescent more favourably than did teens ($M = 25.65$). This difference was found statistically significant via *t*-tests, $t(50) = 3.29$, $p < .01$.

Symptom Checklist-90-R. *Global severity index* *T*-scores obtained by parents (range = 30 to 80, $M = 59.31$), and teens (range = 28 to 72, $M = 53.31$), indicates some individuals were experiencing considerable psychological distress (higher *T* scores) while others reported positive psychological well-being. Parents reported a greater range of scores and obtained a higher mean *T*-score than teens, but this difference was not statistically different.

Domains and Development Questionnaire. Scores obtained on this instrument (where the maximum score of 20 is positive) suggest that parents and teens reported having a generally positive view about teenagers, and adolescent developmental level and domains of responsibility were taken into consideration when making decisions regarding teen behaviour. Scores obtained by parents and teens for the groups of items are presented in Appendix M, but only the total score from this questionnaire was used in further analyses. The parent and teen scores were not significantly different from each other.

Social Problem-Solving Inventory-Revised. Correlations computed revealed all subscales of the Social Problem-Solving Inventory-Revised correlated highly (r = .75 to .87) with the *total index score*. Therefore, to reduce redundancy in the analyses, only the *total index score* (range 0 to 20) was included in further data analyses. High scores indicate adaptive problem-solving skills. Pre-treatment data suggested that the parents and teens were not deficient on social problem-solving ability, but the parent score (M = 13.90) was significantly higher than the teen score (M = 9.77), $t(50) = 5.11$, $p < .001$.

Correlations of divergent parent-teen scores with conflict. For the three measures where parent and teen scores diverged significantly, that is, the *authoritative* subscale on the Parental Authority Questionnaire, the Relationship Questionnaire, and the Social Problem-Solving Inventory-Revised, a divergence score was obtained by calculating the absolute difference between parent and teen scores, irrespective of the direction of that difference. The divergence score was then correlated with Conflict Behavior Questionnaire scores to examine the association between divergent scores and conflict levels. Correlational analysis presented in Table 4.4 showed that *authoritative* parenting style and divergent perceptions of the parent-adolescent Relationship were related with teen scores on both the *appraisal of other* and *appraisal of dyad* subscales of the Conflict Behavior Questionnaire. The positive correlations reflect an association between greater divergence and higher levels of conflict. Conflict Behavior Questionnaire scores were not related to divergent scores for the Social Problem-Solving Inventory-Revised for either parents or teens, and not associated with the parent scores on the Relationship Questionnaire or *authoritative* parenting style.

Table 4.4
Correlations Between Divergent Parent-Teen Scores and Conflict Behavior Questionnaire Scores at Pre-Treatment

Measure	Conflict Behavior Questionnaire			
	Parents		Teens	
	Other	Dyad	Other	Dyad
Parental Authority Questionnaire				
Authoritative	.29	.34	.46*	.57*
Relationship Questionnaire				
Total Score	.29	.20	.40*	.51*
Social Problem-Solving Inventory-Revised				
Total Score	-.21	-.12	-.08	.12

Note. * $p < .05$.

Summary of pre-intervention comparisons between parents and teens. Teens generally perceived the family environment as being more negative than parents, while parents reported higher levels of conflict behaviour than teens, but comparisons between parent and teen pre-treatment data indicate these scores were not significantly discrepant. Parent and teen reports were also similar for psychological well-being, *authoritarian* or *permissive* parenting style, and consideration given to developmental level and domains of authority. Teens did perceive the parent-adolescent relationship as significantly more negative than did parents, and rated parents as being significantly less *authoritative* than parents did themselves, and these discrepancies were related to teens' reports of conflict levels. Although the parents reported having greater knowledge and use of problem-solving skills than teens, this difference was not related to conflict levels according to the Conflict Behavior Questionnaire.

Correlations Between Measures at Pre-Treatment

The scores on each measure at pre-intervention were correlated with each other and are shown in Table 4.5 for parents and Table 4.6 for teens.

Family Environment Scale. The pattern of significant correlations on this measure for teens indicates that high levels of expressed anger and conflict are associated with a low degree of commitment and support, limited independent decision making, and high importance being placed on organisation, structure, and rules to run family life. This is shown by the negative correlations between *conflict* and *cohesion* (r = -.72), *conflict* and *independence* (r = -.42), and *conflict* and *organisation* (r = -.44), and the positive correlation between *organisation* and *control* (r = .58). On the other hand, commitment, support, and encouragement to directly express feelings is associated with assertive independent decision making, as *independence* is positively correlated with *cohesion* (r = .56) and *expressiveness* (r = .60). This pattern was not evident for parents as the negative relationship between *conflict* and *cohesion* (r = -.44) was the only significant correlation among the subscales.

Conflict Behavior Questionnaire. Parent scores for *appraisal of teen* were not related to scores on any other measure, but negative *appraisal of dyad* was associated with low *cohesion* (r = -.41) and low *independence* (r = -.43) assessed via the Family Environment Scale. Consistent with the pattern of responding on the Family Environment Scale for teens, high conflict behaviours according to *appraisal of parent* and *appraisal of dyad* were associated with low *cohesion* (r = -.69, and r = -.57 respectively). Teens' negative *appraisal of parent* was also associated with low *independence* (r = -.48).

Table 4.5
Correlations Between Measures at Pre-Treatment: Parents

	Measures	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
	Family Environment Scale															
1	Cohesion		-.06	-.44*	.28	.36	-.23	-.14	-.41*	-.33	.21	.08	.45*	.19	.59*	.21
2	Expressiveness	-.06		.07	.26	-.23	-.05	.17	.18	-.19	.10	.32	.02	-.22	-.04	.57*
3	Conflict	-.44*	.07		-.32	-.36	.03	.34	.45*	-.23	-.23	.06	-.37	.05	-.39*	.05
4	Independence	.28	.26	-.32		.01	-.25	.05	-.43*	-.41*	.10	.34	.35	-.51*	.52*	.40*
5	Organisation	.36	-.23	-.36	.01		.20	-.02	-.22	.07	.21	-.41*	.43*	.04	.07	-.18
6	Control	-.23	-.05	.03	-.25	.20		-.07	.11	.29	-.06	-.30	-.10	.00	-.22	.11
	Conflict Behavior Questionnaire															
7	Appraisal of Other	-.14	.17	.34	.05	-.02	-.07		.55*	-.01	-.03	.05	-.12	.03	.03	-.19
8	Appraisal of Dyad	-.41*	.18	.45*	-.43*	-.22	.11	.55*		.36	-.01	-.03	-.46*	.34	-.36	-.23
	Parental Authority Questionnaire															
9	Authoritarian	-.33	-.19	-.23	-.41*	.07	.29	-.01	.36		.02	-.35	-.20	.05	-.28	-.22
10	Authoritative	.21	.10	-.23	.10	.21	-.06	-.03	-.01	.02		-.06	.45*	.30	.17	-.04
11	Permissive	.08	.32	.06	.34	-.41*	-.30	.05	-.03	-.35	-.06		.00	.04	.23	.16
12	***Relationship Questionnaire***	.45*	.02	-.37	.35	.43*	-.10	-.12	-.46*	-.20	.45*	.00		-.19	.46*	.02
13	***SCL-90-R*** – Global Severity	.19	-.22	.05	-.51*	.04	.00	.03	.34	.05	.30	.04	-.19		-.22	-.34
	Domains and Development Questionnaire															
14	Total Score	.59*	-.04	-.39*	.52*	.07	-.22	.03	-.36	-.28	.17	.23	.46*	-.22		.29
	Social Problem-Solving Inventory-Revised															
15	Total Score	.21	.57*	.05	.40*	-.18	.11	-.19	-.23	-.22	-.04	.16	.02	-.34	.29	

Note. * indicates $p < .05$.

Table 4.6
Correlations Between Measures at Pre-Treatment: Teens

	Measures	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
	Family Environment Scale															
1	Cohesion		.32	-.72*	.56*	.36	-.15	-.69*	-.57*	-.27	.51*	.41*	.73*	-.12	-.18	.31
2	Expressiveness	.32		.03	.60*	-.29	-.38	-.15	.00	-.35	-.02	.52*	.25	.08	-.12	-.07
3	Conflict	-.72*	.03		-.42*	-.44*	-.20	.61*	.56*	.02	-.49*	-.20	-.52*	.26	.00	-.18
4	Independence	.56*	.60*	-.42*		.09	-.11	-.48*	-.35	-.15	.28	.49*	.53*	.05	-.20	.22
5	Organisation	.36	-.29	-.44*	.09		.58*	-.29	-.35	.19	.60*	-.06	.32	.15	.34	-.13
6	Control	-.15	-.38	-.20	-.11	.58*		-.08	.00	.63*	.18	-.23	-.14	.54*	.53*	-.35
	Conflict Behavior Questionnaire															
7	Appraisal of Other	-.69*	-.15	.61*	-.48*	-.29	-.08		.77*	.25	-.54*	-.44*	-.82*	.04	.09	-.11
8	Appraisal of Dyad	-.57*	.00	.56*	-.35	-.35	.00	.77*		.22	-.63*	-.28	-.72*	.28	-.02	-.21
	Parental Authority Questionnaire															
9	Authoritarian	-.27	-.35	.02	-.15	.19	.63*	.25	.22		.04	-.21	-.24	.54*	.46*	-.14
10	Authoritative	.51*	-.02	-.49*	.28	.60*	.18	-.54*	-.63*	.04		.22	.70*	.05	.34	.12
11	Permissive	.41*	.52*	-.20	.49*	-.06	-.23	-.44*	-.28	-.21	.22		.51*	.06	.19	-.09
12	***Relationship Questionnaire***	.73*	.25	-.52*	.53*	.32	-.14	-.82*	-.72*	-.24	.70*	.51*		-.08	-.01	.26
13	***SCL-90-R*** – Global Severity	-.12	.08	.26	.05	.15	.54*	.04	.28	.54*	.05	.06	-.08		.42	-.34
	Domains and Development Questionnaire															
14	Total Score	-.18	-.12	.00	-.20	.34	.53*	.09	-.02	.46*	.34	.19	-.01	.42*		-.45*
	Social Problem-Solving Inventory-Revised															
15	Total Score	.31	-.07	-.18	.22	-.13	-.35	-.11	-.21	-.14	.12	-.09	.26	-.34	-.45*	

Note. * indicates $p < .05$.

Parental Authority Questionnaire. Parents who rated themselves as having an *authoritarian* parenting style did not value assertive independent decision making, evidenced by the significant negative relationship with *independence* (r = -.41) on the Family Environment Scale. Teens' rating of parenting behaviours was associated with other measures in the predicted directions. There was a positive relationship between *authoritarian* parenting style and *control* (r = .63), which represents high levels of set rules and procedures used to run family life. Similarly, teens who rated their parents as low on *authoritative* parenting reported higher conflict behaviours via the Conflict Behavior Questionnaire, revealed by the negative correlation with *appraisal of parent* (r = -.54), and *appraisal of dyad* (r = -.63). On the other hand, teens' reports of *authoritative* parenting was associated with high *cohesion* (r = .51) and *organisation* (r = .60), and lower levels of *conflict* (r = -.49) according to the Family Environment Scale.

Relationship Questionnaire. Parents who reported having positive perceptions of the relationship with their teen also reported high family *cohesion* (r = .45) and *organisation* (r = .43), and rated their parenting behaviours as *authoritative* (r = .45). Low Relationship scores for parents were associated high reports of negative *appraisal of teen* (r = -.46).

High conflict behaviours were strongly related to teens having a negative perception of the parent-adolescent relationship. This was revealed by the negative correlation between Relationship scores, where low scores are negative, and *appraisal of parent* (r = -.82) and *appraisal of dyad* (r = -.72), where higher scores indicate more negative appraisal. On the other hand, teens who perceived the relationship with their parent as positive reported having a *cohesive* (r = .73)

family environment where *conflict* levels were low (r = -.52) and *independence* was valued (r = .53). Teens' positive parent-adolescent Relationship scores were also strongly related to *authoritative* parenting behaviours (r = .70).

Symptom Checklist-90-R. Poor psychological well-being of teens was associated with *authoritarian* parenting (r = .54) and high levels of set rules and procedures, borne out by the positive relationship with the *control* subscale (r = .54) on the Family Environment Scale. High levels of conflict were not related to low psychological well-being of either parents or teens.

Domains and Development Questionnaire. High scores on this instrument obtained by parents, which indicate attention is given to teen developmental level and differing areas of parental authority, were positively associated with family *cohesion* (r = .59), valuing *independence* (r = .51), and positive perceptions of the parent-adolescent relationship (r = .46), while being negatively associated with *conflict* (r = -.39). High teens scores on this instrument were associated with high *control* (r = .53) scores and *authoritarian* parenting (r = .46), which is not consistent with hypotheses. As this is a pre-intervention assessment, however, the result may not accurately reflect the area of inquiry, as teens have not yet had the opportunity to participate in social-cognition training.

Social Problem-Solving Inventory-Revised. Parents who reported high levels of problem-solving skills also obtained high scores on *expressiveness* (r = .57) and *independence* (r = .40). Problem-solving skills reported by teens were not related to family environment variables, conflict behaviours, parenting style, perceptions of the parent-adolescent relationship or psychological well-being.

Summary of correlations between measures at pre-treatment. Although the relationship among pre-treatment scores obtained on measures was generally

stronger for teens than parents, a consistent pattern emerged for both. Poor parent-adolescent relationships were associated with high levels of conflict. In turn, high levels of conflict and poor parent-adolescent relationships were associated with a family environment that was organised, structured, and where set rules to run family life were valued. Higher conflict behaviours were also reported among families characterised by low cohesion and support, and where expression of feelings and independence were not encouraged.

Authoritarian parents did not value independent decision making in their teens, and teens associated authoritarian parents with a controlled environment. Conversely, authoritative parenting style was related to the parent-adolescent relationship and the family environment being perceived as positive. Parental and teen psychological well-being was not related to high conflict levels or the parent-adolescent relationship, but for teens psychological well-being was associated with an authoritarian parenting style and a controlling family environment.

Parents who valued independence and described their family as cohesive also reported considering teen developmental level and areas of parental jurisdiction when making decisions about their teen's behaviour. Expressiveness and independence were valued by parents who reported high problem-solving behaviours, but teens problem-solving skills were not associated with family environment variables, conflict behaviours, or the parent-adolescent relationship.

Demographic Characteristics

Analyses examined whether participants in the two treatment conditions differed at pre-treatment on demographic characteristics. The groups were compared using one ANOVA for continuous variables and chi-square tests for categorical variables, the results of which are shown in Table 4.7. Analysis

showed the two treatment groups could be regarded as equivalent on demographic variables as no significant differences emerged.

Table 4.7
Demographic Information for Participants in Each Treatment Group

Variable	Problem Solving				Domain and Development				F or χ^2
	n	%	*M*	*SD*	*n*	%	*M*	*SD*	
Parent: Age x Gender									
Mothers	9	50	44.56	6.89	9	50	40.56	4.93	2.01
Fathers	4	50	45.25	8.30	4	50	43.50	2.08	<1.00
Teen Age									
Early Teens	8	62	14.20	0.63	7	38	14.00	0.43	<1.00
Middle Teens	5	54	16.08	0.61	6	46	15.95	0.53	
Teen Gender									
Female	5	42			7	58			<1.00
Male	8	57			6	43			<1.00
Family Composition									
Intact	5	45			6	55			2.20
Solo	4	44			5	56			
Blended	2	50			2	50			
Other	2	100			0	0			
Dyad									
F-Teen, F-Parent[a]	4	44			5	56			<1.00
F-Teen, M-Parent[b]	1	33			2	67			
M-Teen, F-Parent	5	56			4	44			
M-Teen, M-Parent	3	60			2	40			
Religion – Parent									
Religion	7	38			11	61			2.89
No Religion	6	75			2	25			
Religion – Teen									
Religion	2	25			6	75			2.88
No Religion	11	61			7	38			

Note. [a] F = female. [b] M = male.

Analysis of Response to Treatment

To address the research questions regarding whether each intervention approach reduced levels of conflict between parents and teens and improved perceptions of family relationships, repeated measures ANOVA were performed on the dependent variables to examine response to treatment over time. Treatment Group (G) was the between-group factor (2 groups) and Time of Assessment (T) was the repeated measures factor (pre- and post-intervention). Significant main effects and interaction effects were further analysed using pairwise comparisons.

The means and standard deviations at pre- and post-treatment for each treatment group from the self-report measures appear in Table 4.8 for parents and Table 4.9 for teens. Significant main effects and significant planned comparison analysis are also presented on these tables. Even though many of the ANOVAs were not significant, Figures are presented to illustrate all analyses (i.e., Treatment Group x Time of Assessment) for each measure to show a general trend for participants to improve in response to intervention.

Family Environment Scale: *Parents.* The scores for each treatment group at pre- and post-intervention for the six subscales: *cohesion, expressiveness, conflict, independence, organisation* and *control* are shown in Figures 4.1 to 4.6 respectively. Inspection of these graphs shows that the three Relationship Dimension subscales improved at post-intervention for both treatment groups. That is, *cohesion* and *expressiveness* scores were higher and *conflict* scores were lower. Analysis showed a main effect of Time for *cohesion*, $F(1, 24) = 4.91$, $p < .05$, and *conflict*, $F(1, 24) = 4.11$, $p < .05$, but not for *expressiveness.* Pairwise planned comparison yielded no statistically significant changes for *cohesion,* but

Table 4.8
Means and Standard Deviations from Self-Report Measures for Each Treatment Group at Pre- and Post-Intervention: Parents

Measure	P-Solving		Domain		Main Effect[a]		Contrast[b]
	M	*SD*	*M*	*SD*			
Family Environment Scale							
Cohesion					T*	2>1	
Pretreatment	38.77	19.23	30.85	19.26			
Posttreatment	47.85	15.67	41.08	12.56			
Expressiveness							
Pretreatment	40.77	10.17	43.77	11.98			
Posttreatment	48.31	8.29	45.15	13.20			
Conflict					T*	2<1	P2<P1*
Pretreatment	55.46	14.66	61.23	11.69			
Posttreatment	47.62	13.33	59.23	13.98			
Indepencence							
Pretreatment	44.15	10.05	40.92	11.72			
Posttreatment	46.77	13.41	45.31	12.56			
Organisation							
Pretreatment	48.23	13.31	45.77	10.17			
Posttreatment	51.92	11.04	46.54	8.61			
Control							
Pretreatment	55.85	9.62	54.15	13.02			
Posttreatment	52.15	12.60	54.31	12.10			
Conflict Behavior Questionnaire							
Appraisal of Teen					T**	2<1	P2<P1**
Pretreatment	80.62	15.38	75.00	13.34			
Posttreatment	64.92	20.37	66.62	17.52			
Appraisal of Dyad					T**	2<1	P2<P1*
Pretreatment	75.62	23.12	84.77	22.10			D2<D1**
Posttreatment	62.85	22.48	68.62	20.64			
Relationship Questionnaire							
Pretreatment	30.77	4.15	29.23	3.39	T**	2>1	
Posttreatment	31.92	3.35	30.92	4.19			
Domains and Development Questionnaire							
Pretreatment	12.19	1.95	10.46	1.51	T***	2>1	D2>D1***
Posttreatment	13.19	2.56	13.96	2.14	GxT**		
Social Problem-Solving Inventory-Revised							
Pretreatment	14.05	3.19	13.75	2.71			
Posttreatment	15.09	1.93	14.38	2.50			

Note. [a]Results for the two-way (Treatment Group [G] x Time of Assessment [T]) analysis of variance with repeated measures on the second factor. G indicates a statistically significant main effect for Treatment Group, T for Time of Assessment, and G x T indicates a significant interaction of Treatment Group x Time of Assessment. P = Problem Solving group, D = Domain and Development group. Pre-treatment = 1, Post-treatment = 2. * $p < .05$. ** $p < .01$. *** $p < .001$.
[b]Significant results of the pairwise comparisons for any significant main effects.

Table 4.9
Means and Standard Deviations from Self-Report Measures for Each Treatment Group at Pre- and Post-Intervention: Teens

Measure	P-Solving		Domain		Main Effect[a]		Contrast[b]
	M	*SD*	*M*	*SD*			
Family Environment Scale							
Cohesion					G*	P>D	
Pretreatment	32.00	20.56	17.08	11.89	T*	2>1	
Posttreatment	39.85	21.51	27.00	15.75			
Expressiveness					G*	P>D	
Pretreatment	38.23	11.48	34.69	12.59	GxT*		
Posttreatment	43.08	13.21	28.15	12.00			
Conflict					T**	2<1	P2<P1**
Pretreatment	60.31	12.89	65.08	9.13			
Posttreatment	51.23	16.05	61.62	9.39			
Indepencence							
Pretreatment	41.00	13.59	30.69	13.78			
Posttreatment	44.92	16.71	39.69	12.63			
Organisation							
Pretreatment	50.23	10.72	41.92	11.27			
Posttreatment	53.00	10.40	45.54	15.74			
Control							
Pretreatment	63.46	14.14	59.15	12.38			
Posttreatment	55.15	16.73	60.92	14.84			
Conflict Behavior Questionnaire							
Appraisal of Parent					T*	2<1	
Pretreatment	69.31	24.48	76.46	12.01			
Posttreatment	62.85	22.74	69.46	18.13			
Appraisal of Dyad					T**	2<1	D2<D1**
Pretreatment	63.23	22.71	81.92	17.00			
Posttreatment	56.85	24.59	67.46	22.43			
Relationship Questionnaire							
Pretreatment	27.31	5.02	24.00	5.77			
Posttreatment	27.77	5.60	25.54	4.33			
Domains and Development Questionnaire							
Pretreatment	10.73	1.63	10.22	1.51	T**	2>1	P2>P1**
Posttreatment	12.47	1.41	10.97	2.54			
Social Problem-Solving Inventory-Revised							
Pretreatment	10.80	2.14	8.73	3.31	G*	P>D	
Posttreatment	11.78	2.19	9.31	1.70			

Note. [a]Results for the two-way (Treatment Group [G] x Time of Assessment [T]) analysis of variance with repeated measures on the second factor. G indicates a statistically significant main effect for Treatment Group, T for Time of Assessment, and G x T indicates a significant interaction of Treatment Group x Time of Assessment. P = Problem Solving group, D = Domain and Development group. Pre-treatment = 1, Post-treatment = 2. * $p < .05$. ** $p < .01$. *** $p < .001$.
[b]Significant results of the pairwise comparisons for any significant main effects.

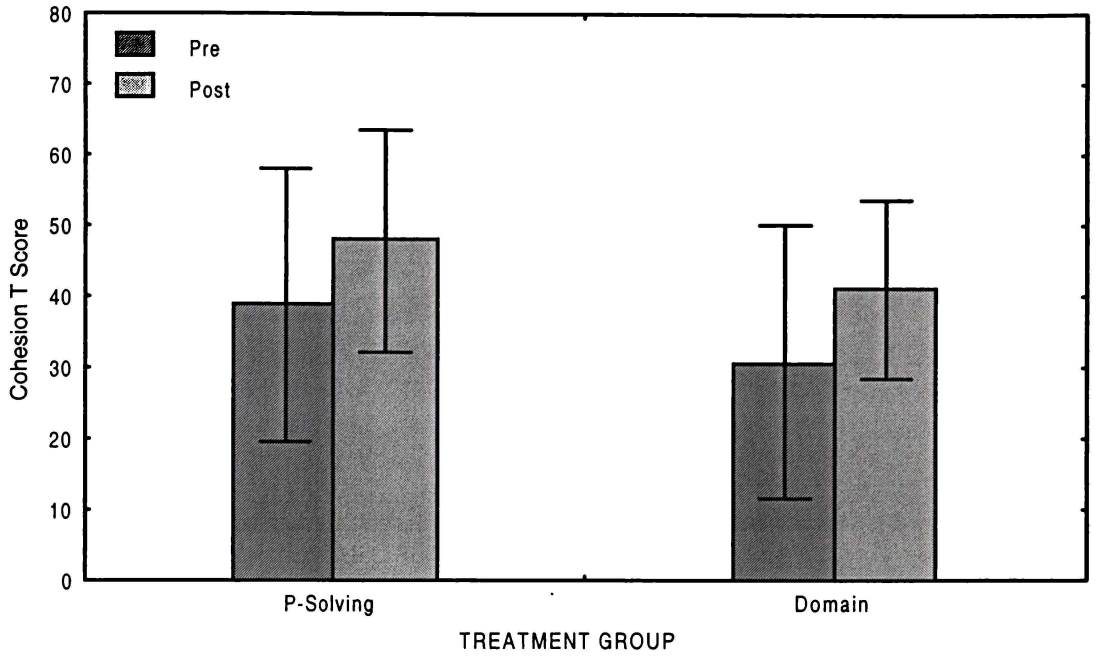

Figure 4.1. Mean scores on the cohesion subscale of the Family Environment Scale for each treatment group at pre- and post-intervention: Parents.

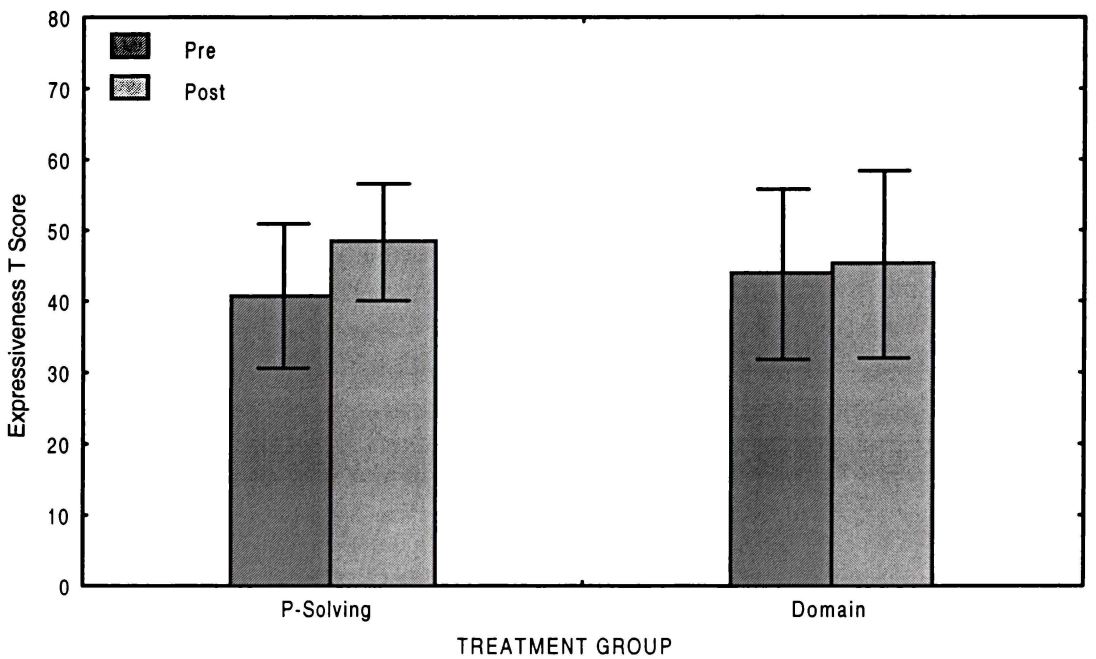

Figure 4.2. Mean scores on the expressiveness subscale of the Family Environment Scale for each treatment group at pre- and post-intervention: Parents.

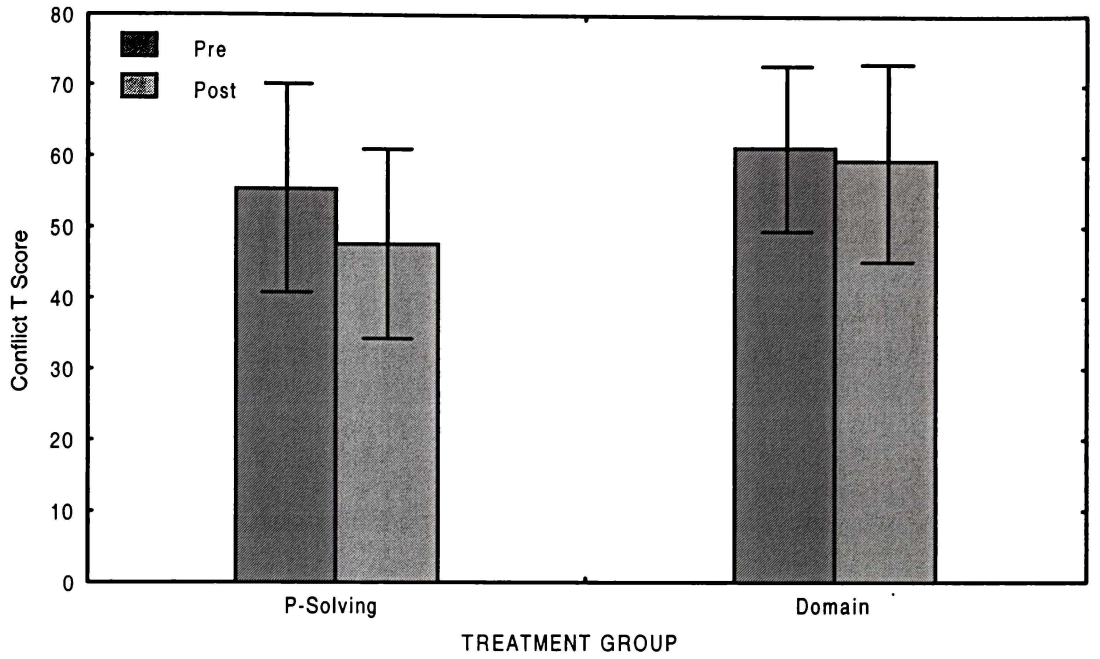

Figure 4.3. Mean scores on the conflict subscale of the Family Environment Scale in each treatment group at pre- and post-intervention: Parents.

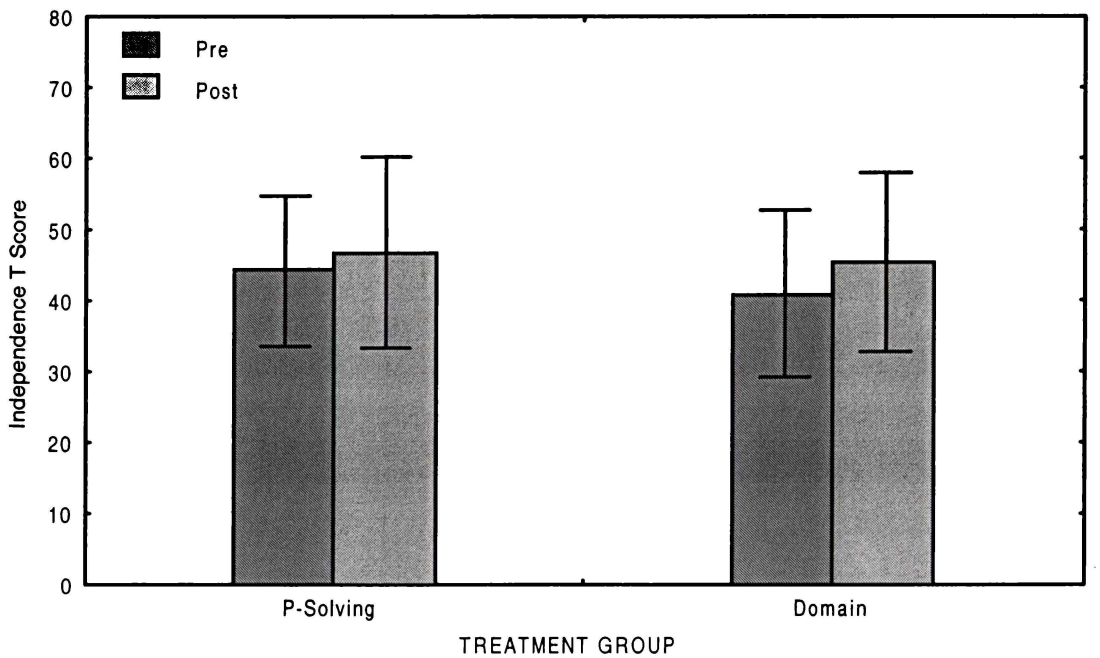

Figure 4.4. Mean scores on the independence subscale of the Family Environment Scale for each treatment group at pre- and post-intervention: Parents.

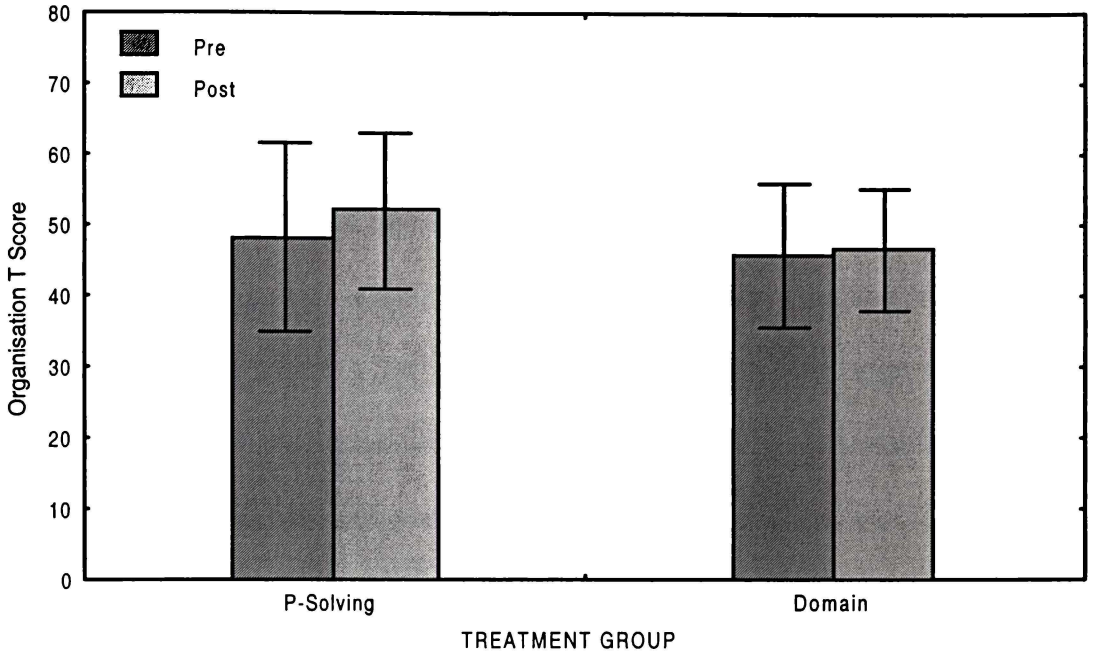

Figure 4.5. Mean scores on the organisation subscale of the Family Environment Scale for each treatment group at pre- and post-intervention: Parents.

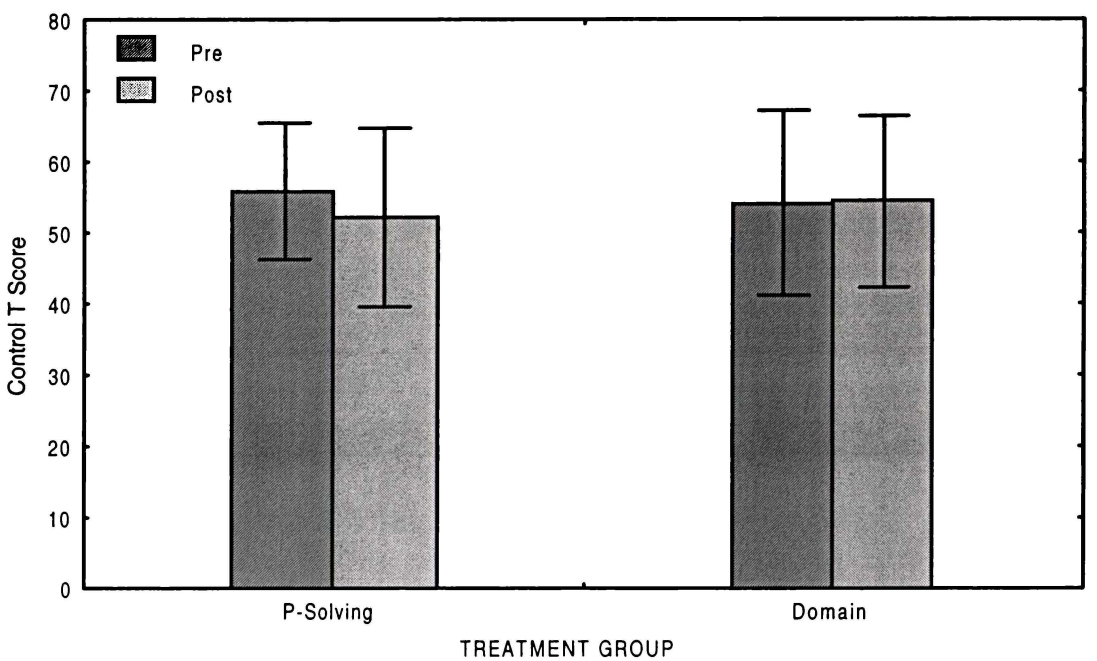

Figure 4.6. Mean scores on the control subscale of the Family Environment Scale for each treatment group at pre- and post-intervention: Parents.

confirmed the Problem Solving group mean for *conflict* was significantly lower at post-treatment, $F(1, 24) = 5.23, p < .05$.

There were no significant main effects for the other subscales and no interaction effects, but an improved post-intervention trend was apparent for the Problem Solving group with higher scores on *independence* and *organisation*, and lower scores on *control*. The *independence* score was also improved for the Domain group at post-treatment, but *organisation* and *control* scores remained consistent between pre- and post-treatment.

Teens. As illustrated in Figures 4.7, 4.8, and 4.9, which display the Relationship Dimension subscales, teens from the Domain group reported positive changes with increased *cohesion* and decreased *conflict* after treatment, but obtained a lower score on the *expressiveness* sub-scale. The Problem Solving group reported improved scores on all three of these subscales. ANOVA analysis showed a significant main effect of Time for *cohesion*, $F(1,24) = 4.88, p < .05$, and *conflict*, $F(1,24) = 4.69, p < .05$. *Cohesion* was increased at post-treatment and *conflict* was reduced. Planned comparisons analysis of these effects confirmed *conflict* was significantly lower for the Problem Solving group at post-treatment, $F(1,24) = 8.36, p < .01$, but did not confirm other improved scores from pre- to post-intervention as being significantly different. A significant Group by Time interaction for *expressiveness* was revealed, $F(1,24) = 6.17, p < .05$, due to the *expressiveness* score at post-intervention being increased for the Problem Solving group and decreased for the Domain group. Pairwise planned comparisons showed the mean scores were not significantly different at pre-treatment, but the Problem Solving group mean for *expressiveness* was significantly higher than the Domain group mean at post-treatment, $F(1,24) = 9.08, p < .01$.

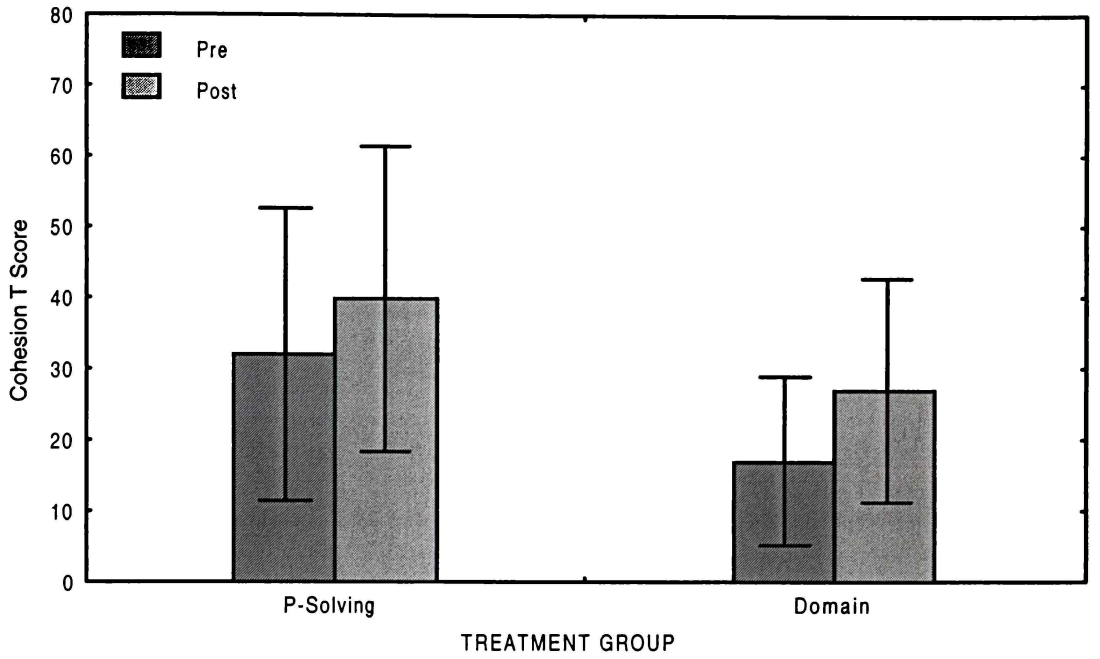

Figure 4.7. Mean scores on the cohesion subscale of the Family Environment Scale for each treatment group at pre- and post-intervention: Teens.

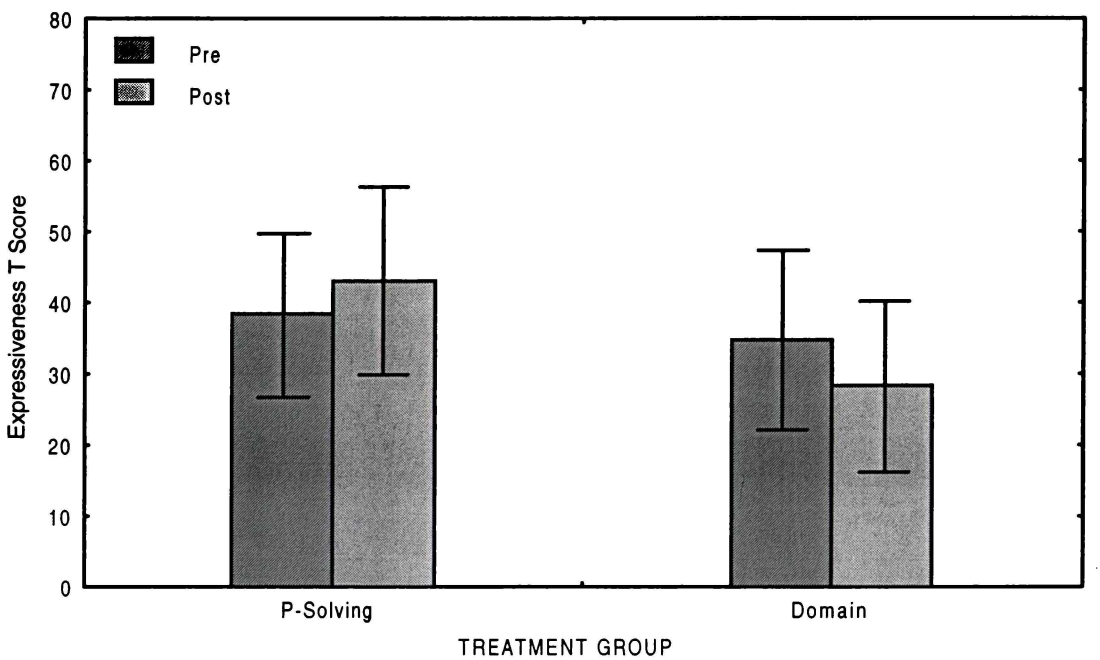

Figure 4.8. Mean scores on the expressiveness subscale of the Family Environment Scale for each treatment group at pre- and post-intervention: Teens.

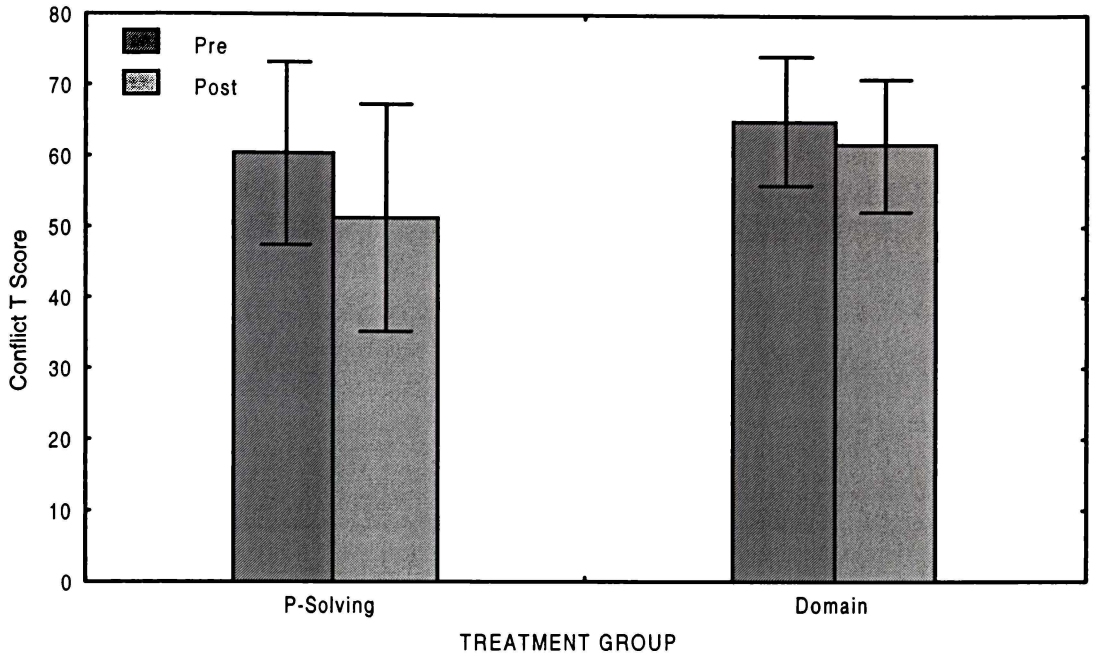

Figure 4.9. Mean scores on the conflict subscale of the Family Environment Scale for each treatment group at pre- and post-intervention: Teens.

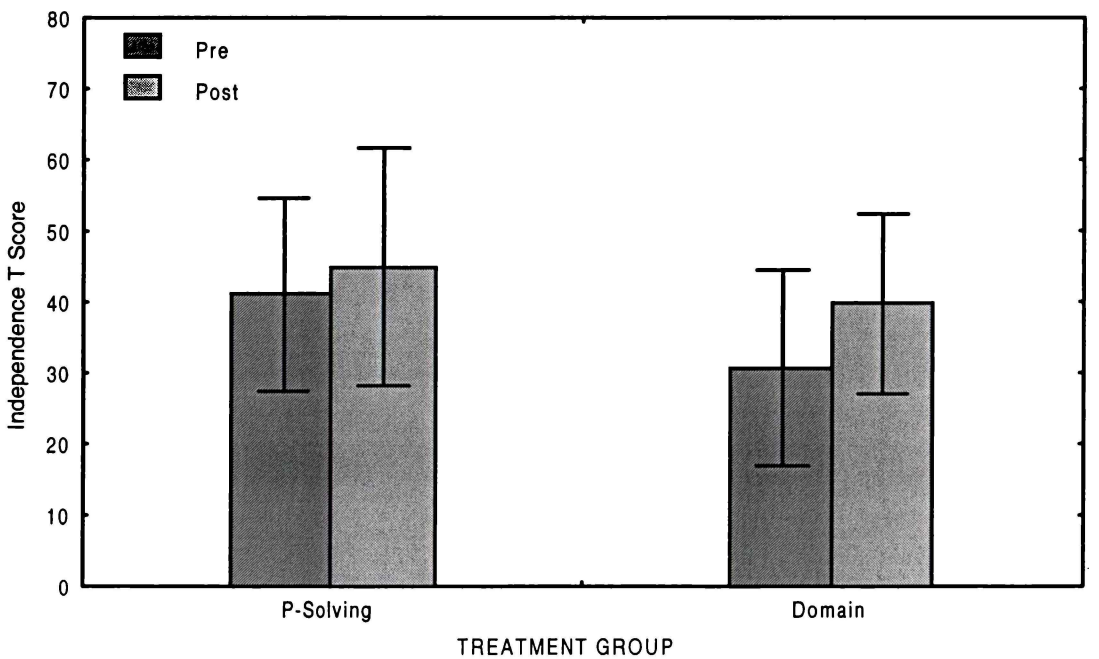

Figure 4.10. Mean scores on the independence subscale of the Family Environment Scale for each treatment group at pre- and post-intervention: Teens.

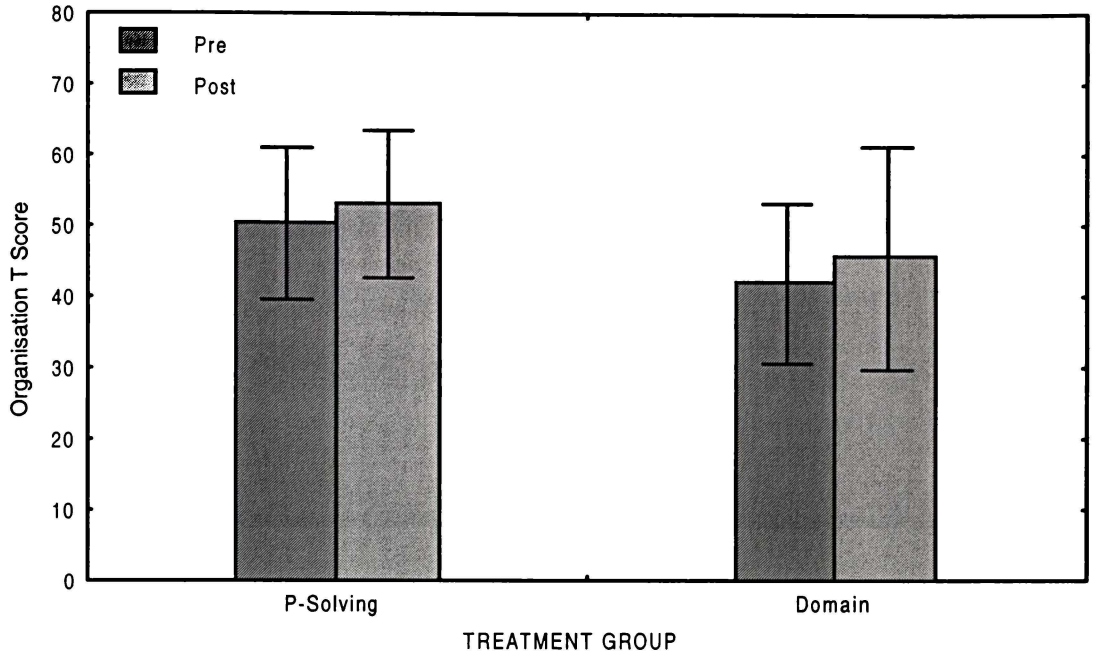

Figure 4.11. Mean scores on the organisation subscale of the Family Environment Scale for each treatment group at pre- and post-intervention: Teens.

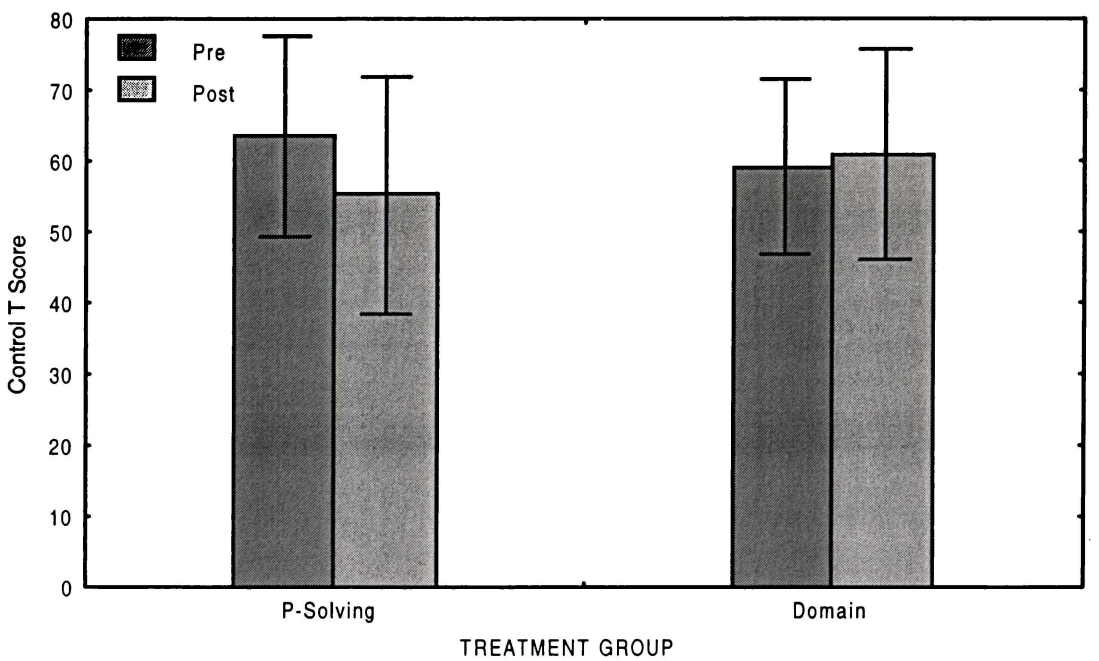

Figure 4.12. Mean scores on the control subscale of the Family Environment Scale for each treatment group at pre- and post-intervention: Teens.

As shown in Figures 4.10 and 4.11, means for *independence* and *organisation* were higher at post-treatment for teens in both groups, with the greatest change being the increased *independence* score for the Domain group. Figure 4.12 illustrates the level of *control* reported was reduced after treatment for the Problem Solving group, but slightly increased for the Domain group. These differences for *independence, organisation,* and *control* did not reach statistical significance.

Conflict Behavior Questionnaire. *Parents.* Reduced conflict and negative communication reported by parents at post-intervention is depicted in Figure 4.13 for *appraisal of other* and Figure 4.14 for *appraisal of dyad.* This is reflected in a significant main effect of Time for both *appraisal of teen*, $F(1,24) = 12.72$, $p < .01$, and *appraisal of dyad*, $F(1,24) = 13.76$, $p < .01$, with parents from both treatment groups obtaining improved scores after treatment. There were no significant effects for Treatment Group and no interaction effects.

Pairwise planned comparisons confirmed a significant improvement between pre- and post-treatment means for the Problem Solving group for *appraisal of teen*, $F(1,24) = 10.81$, $p < .01$, and *appraisal of dyad*, $F(1,24) = 5.37$, $p < .05$. For the Domain group, there was a significant improvement between pre- and post-treatment means for *appraisal of dyad*, $F(1,24) = 8.59$, $p < .01$, but the improved score for *appraisal of teen* was not statistically significant.

Teens. Consistent with parent ratings of their interactions, teens perceived conflict and negative communication to be reduced at post-intervention. This is illustrated in Figures 4.15 and 4.16 for *appraisal of other* and *appraisal of dyad* respectively. Analyses showed a main effect of Time with respect to both *appraisal of parent*, $F(1,24) = 5.54$, $p < .05$, and *appraisal of dyad*, $F(1,24) =$

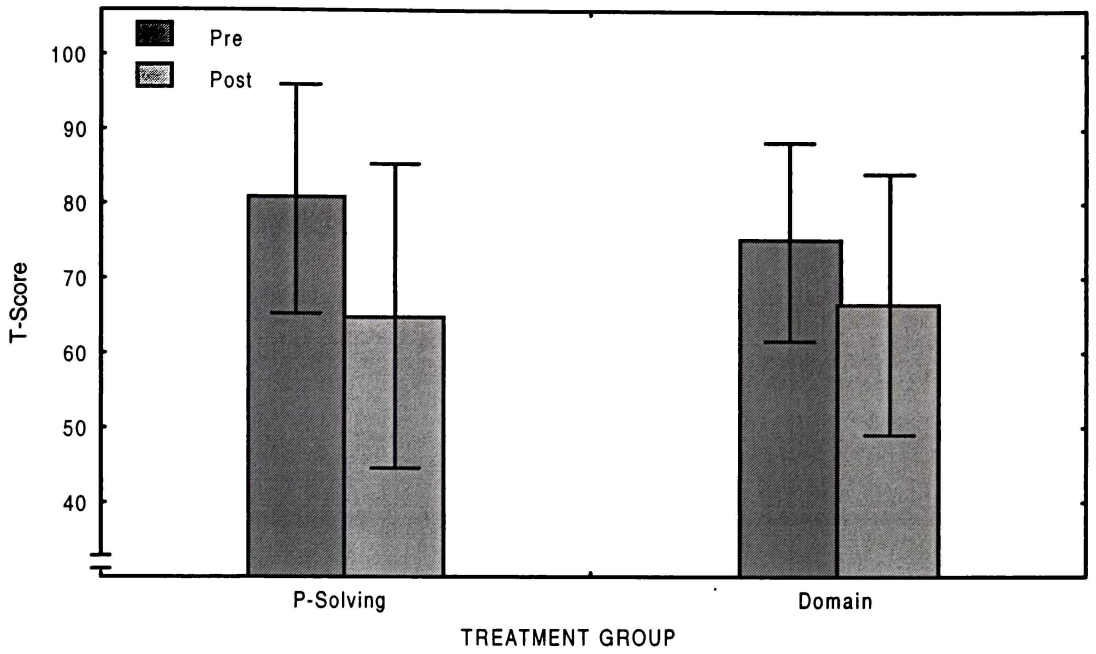

Figure 4.13. Mean scores for appraisal of other from the Conflict Behavior Questionnaire for each treatment group at pre- and post-intervention: Parents.

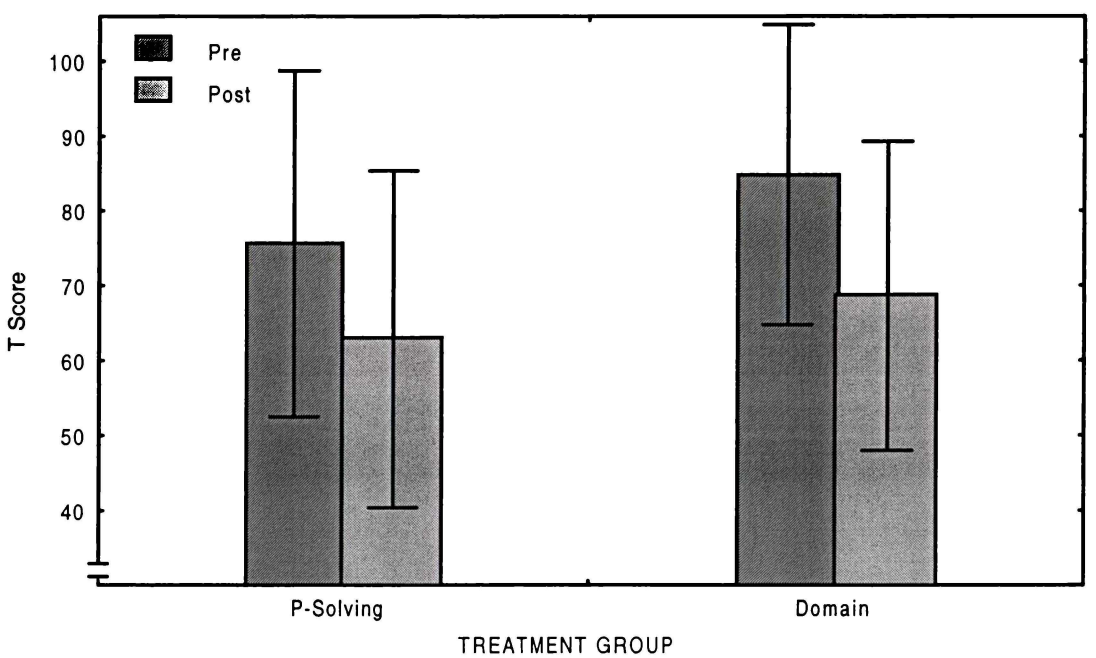

Figure 4.14. Mean scores for appraisal of dyad from the Conflict Behavior Questionnaire for each treatment group at pre- and post-intervention: Parents.

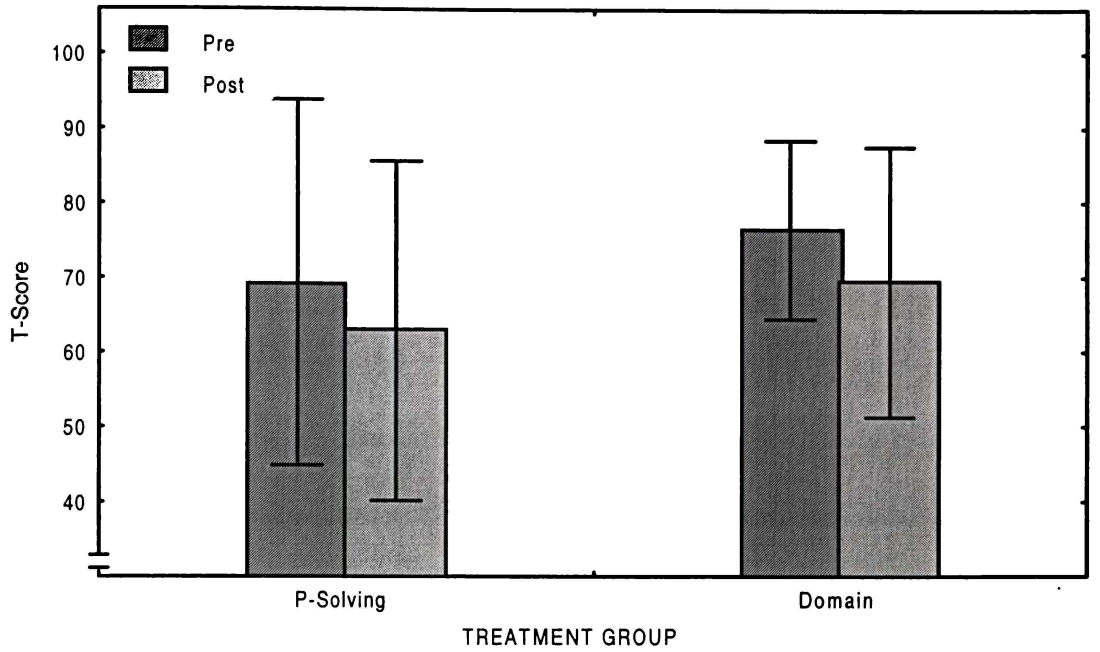

Figure 4.15. Mean scores for appraisal of other from the Conflict Behavior Questionnaire for each treatment group at pre- and post-intervention: Teens.

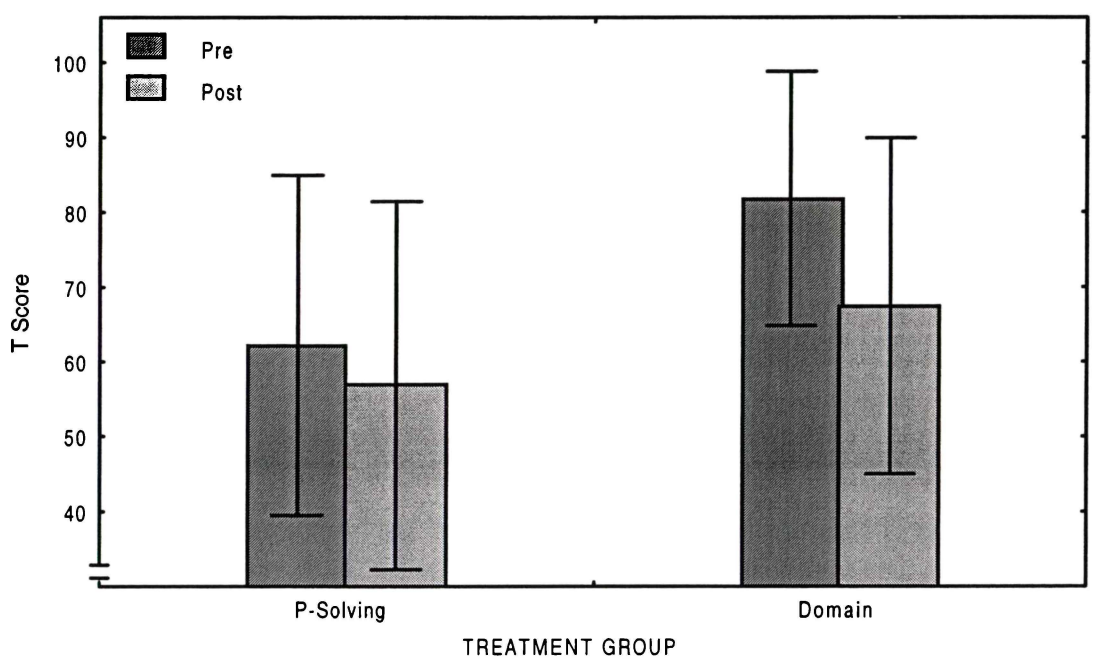

Figure 4.16. Mean scores for appraisal of dyad from the Conflict Behavior Questionnaire for each treatment group at pre- and post-intervention: Teens.

9.93, $p < .01$, with both appraisal scores being significantly less negative at post-treatment. Treatment Group effects and interaction effects were not statistically significant.

Pairwise planned comparisons showed that the Domain group mean for *appraisal of dyad* improved significantly between pre- and post-intervention, $F(1,24) = 9.56$, $p < .01$, but the improved score for *appraisal of parent* for this treatment group was not statistically significant. Pre- and post-intervention changes for the Problem Solving group were not significantly different.

Relationship Questionnaire. *Parents and Teens.* The parent and teen scores for each treatment group, pre- and post-intervention, are depicted on Figure 4.17 and Figure 4.18 respectively. As shown in these graphs, post-intervention scores were more improved for parents and teens in the Domain group than for the Problem Solving group. Statistical investigation showed no significant main effects of Group or Time and no interaction effects for teen participants. A significant main effect of Time was revealed for parents, $F(1,24) = 4.09$, $p < .05$, but pairwise planned comparisons did not confirm a significant change for either treatment group between pre- and post-treatment.

Domains and Development Questionnaire. *Parents.* Parents reported giving greater consideration to teen development and domain jurisdiction of authority after treatment: the means increased between pre- and post-intervention on this measure, as illustrated in Figure 4.19. The improved post-treatment scores for both treatment groups resulted in a significant main effect of Time, $F(1,24) = 33.74$, $p < .001$, but there was no significant effect of Treatment Group. Pairwise planned comparisons of this finding showed the Domain group post-intervention

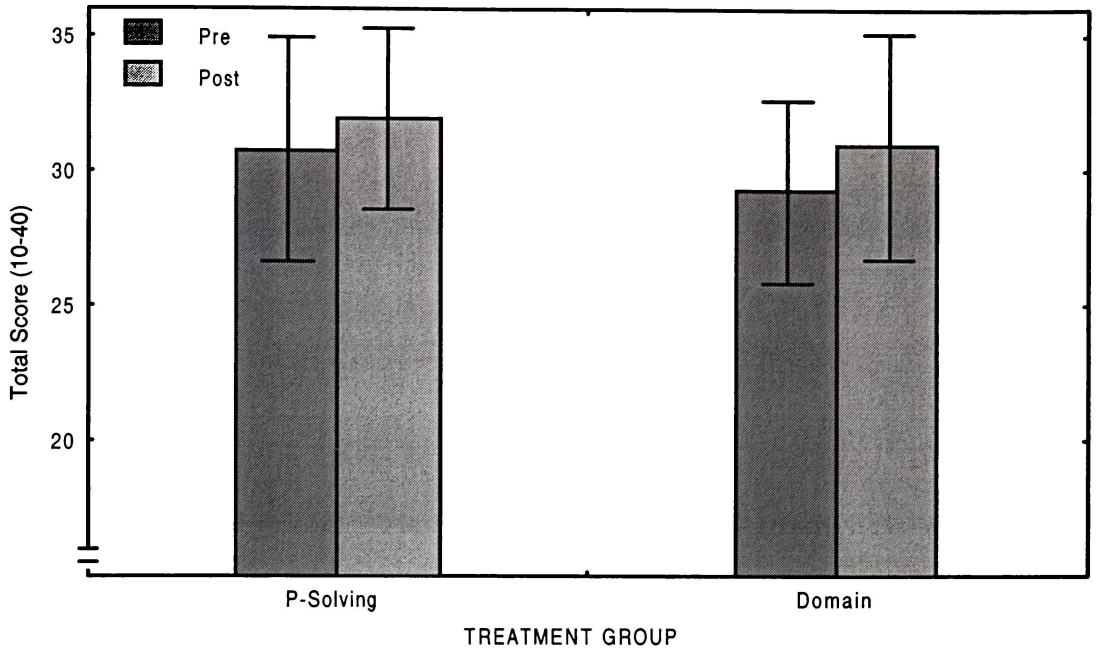

Figure 4.17. Mean scores from the Relationship Questionnaire for each treatment group at pre- and post-intervention: Parents.

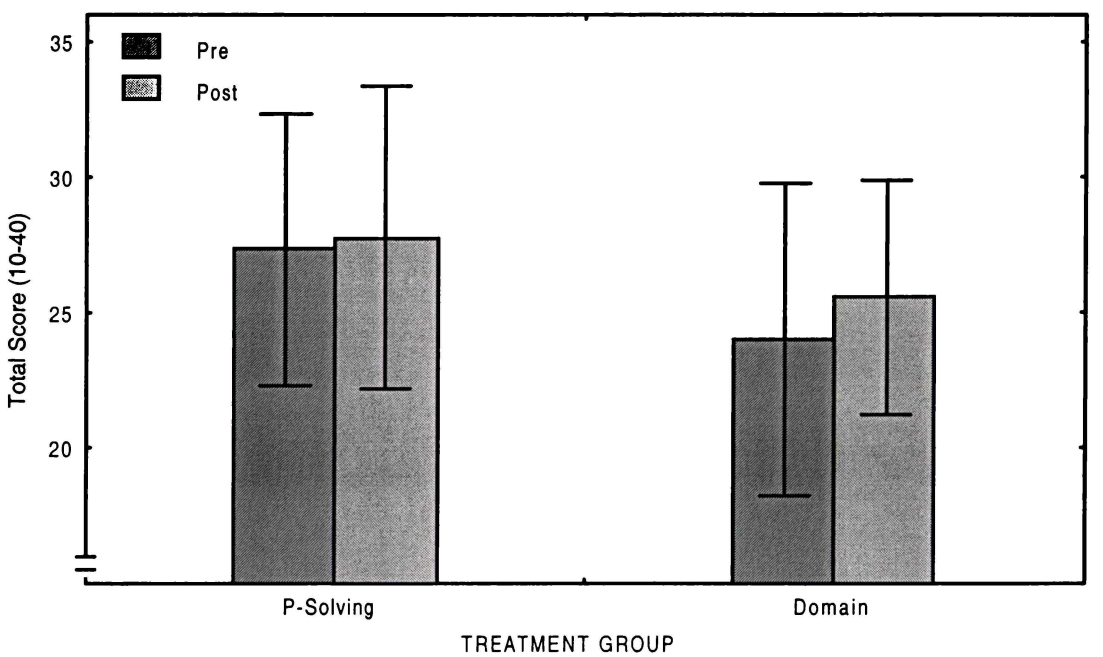

Figure 4.18. Mean scores from the Relationship Questionnaire for each treatment group at pre- and post-intervention: Teens.

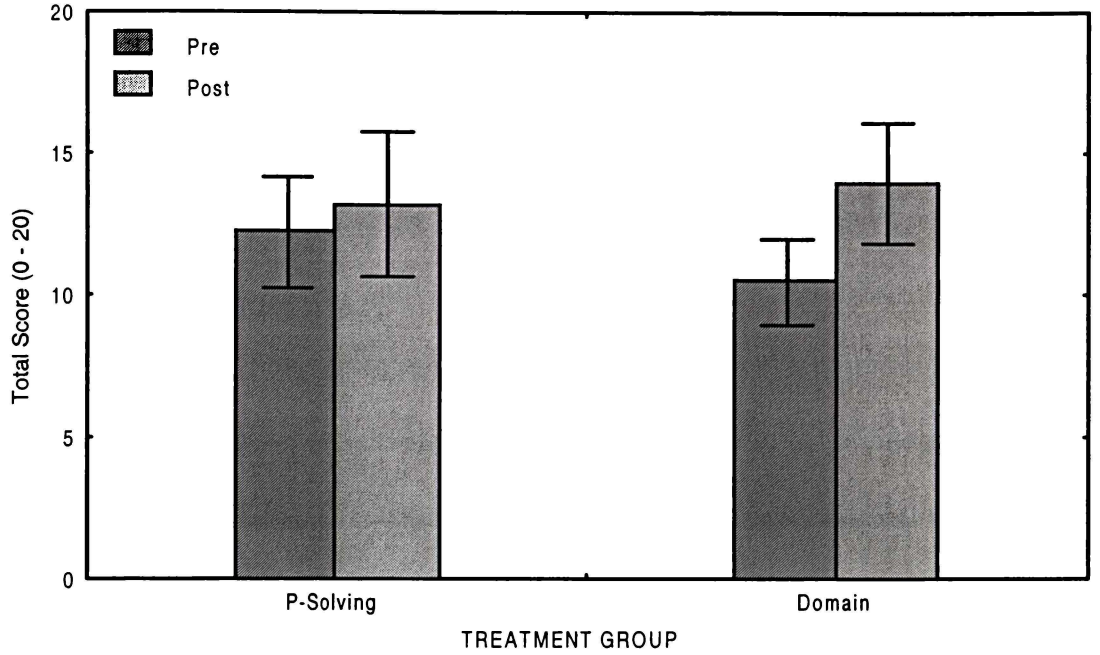

Figure 4.19. Mean scores from the Domains and Development Questionnaire for each treatment group at pre- and post-intervention: Parents.

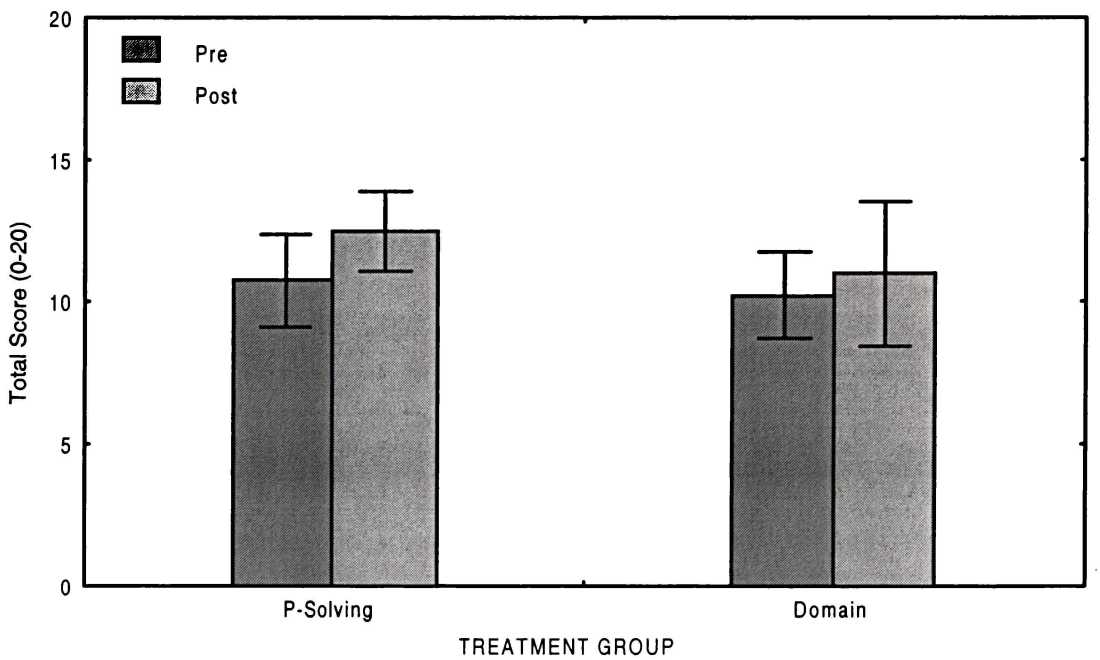

Figure 4.20. Mean scores from the Domains and Development Questionnaire for each treatment group at pre- and post-intervention: Teens.

mean was significantly higher, $F(1,24) = 40.78$, $p < .001$, but the higher mean for the Problem Solving group was not significantly different from pre-treatment.

There was a significant Group x Time interaction, $F(1,24) = 10.39$, $p < .01$, as the Domain group mean was lower than the mean for the Problem Solving group before treatment, and higher after treatment. This interaction is also reflected by the Problem Solving group mean being significantly higher, $F(1,24) = 6.35$, $p < .05$, at pre-treatment than the Domain group mean, although the higher mean score obtained by the Domain group at post-treatment was not significantly different from the Problem Solving group.

Teens. As seen from Figure 4.20, teens in both treatment groups reported increased consideration of developmental level and domain jurisdiction during decision making at post-treatment according to this assessment instrument, resulting in a significant main effect of Time, $F(1,24) = 10.52$, $p < .01$. Pairwise planned comparisons showed that while post-intervention scores were improved for both treatment groups, the change for the Domain group did not reach statistical significance, but did for the Problem Solving group, $F(1,24) = 10.20$, $p < .01$. No significant Treatment Group or interaction effects were revealed.

Social Problem-Solving Inventory-Revised: *Parents and Teens.* The small increase between pre- and post-intervention means for the *total index* score on this instrument are shown in Figure 4.21 for parents and Figure 4.22 for teens. Analysis showed the changed scores at post-intervention were not statistically different from pre-intervention as no significant main effects of Time were revealed and there was no interaction effect.

There was a significant main effect of Group, $F(1,24) = 6.95$, $p < .05$, with respect to the teen Problem Solving group mean being higher than for the Domain

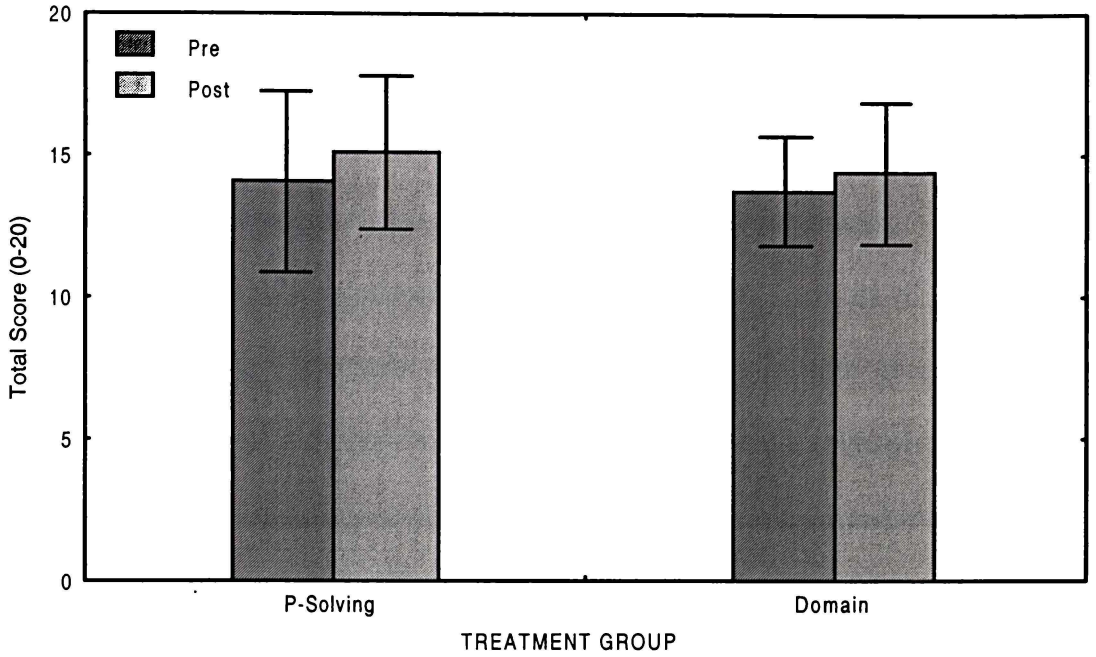

Figure 4.21. Mean scores on the total index from the Social Problem-Solving Inventory-Revised for each treatment group at pre- and post-intervention: Parents.

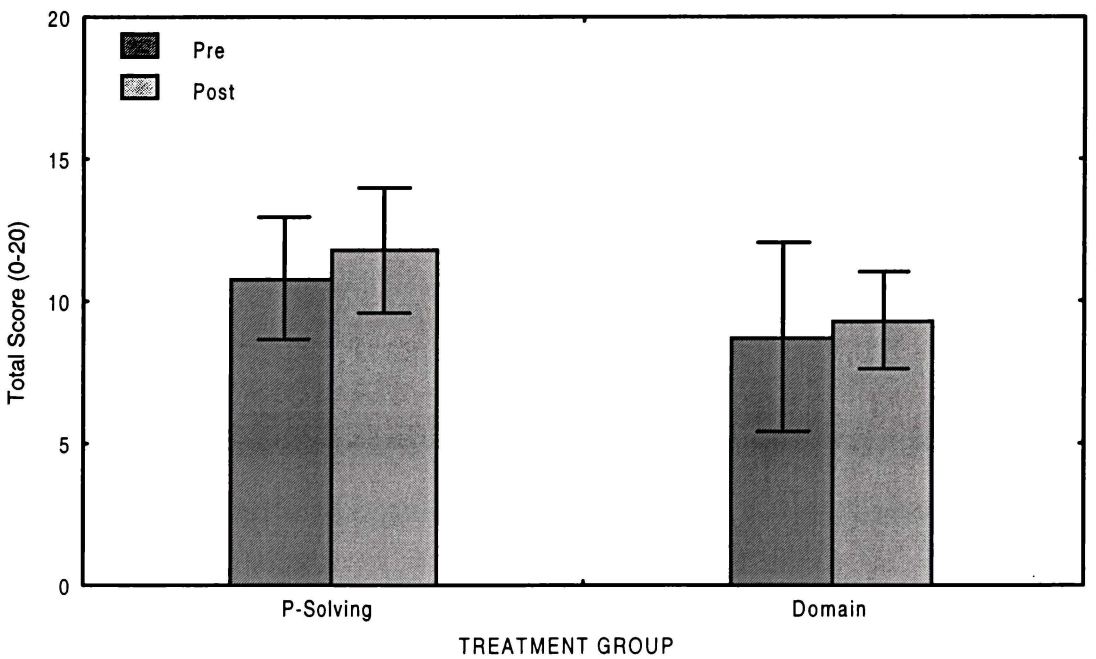

Figure 4.22. Mean scores on the total index from the Social Problem-Solving Inventory-Revised for each treatment group at pre- and post-intervention: Teens.

group. This main effect reflects the lower mean score of the Domain group at both pre- and post-intervention, and does not reflect a greater response to treatment as inspection of mean scores presented in Table 4.9 shows mean scores for both treatment groups increased by a similar margin at post-intervention.

Summary of analysis of response to treatment. Analysis of response to treatment over time generally showed that participants in both groups changed from the beginning of therapy to the end, with both groups showing improvement. After treatment, family environment tended to show improved *cohesion*, *expressiveness*, *independence* and *organisation*, and less *conflict* and *control*. Improved scores of each treatment group were often comparable on the family environment variables, but parents and teens from the Problem Solving group did report experiencing significantly less *conflict* according to the Family Environment Scale at post-treatment compared to participants in the Domain group.

Perceptions of negative communication and conflict in parent-adolescent interactions assessed via the Conflict Behavior Questionnaire were improved after treatment for parents and teens from each treatment group. Significant improvements were revealed for parents from the Problem Solving group for both *appraisal of teen* and *appraisal of dyad* subscales. The improved *appraisal of teen* score for parents from the Domain group did not reach statistical significance, but their *appraisal of dyad* was significantly more positive after treatment. Although teens also reported less negative conflict behaviours at post-intervention, the change was not generally as great as for parents. Improved teen scores for *appraisal of parent* did not attain statistical significance for either treatment group. Teens' *appraisal of dyad* was not statistically improved for those in the

Problem Solving group but was significantly more positive for teens in the Domain group after treatment.

The parent-adolescent relationship was perceived as being more positive by parents and teens in both groups at the end of treatment, but the improvements did not attain statistical significance.

Scores on the Domains and Development Questionnaire showed that parents in the Domain group gave significantly more consideration to adolescent development and use of the domain framework when discussing issues of potential conflict after treatment, but parents in the Problem Solving group did not. The reverse was the case for teen participants, which was unexpected. That is, the improved post-treatment score was significant for teens in the Problem Solving group but not for teens in the Domain group.

Problem-solving knowledge and use of skills, assessed by the Social Problem-Solving Inventory-Revised did not improve significantly for either treatment group from pre- to post-intervention.

Post-Intervention Analysis

Analysis was carried out to address the question regarding what factors may influence outcomes. As goals of treatment were reduced conflict behaviours and improved perceptions of the parent-adolescent relationship, the Conflict Behavior Questionnaire and Relationship Questionnaire were considered the primary response to treatment measures. The Domains and Development Questionnaire and the Social Problem-Solving Inventory-Revised were used to assess skills and strategies addressed in each intervention approach and were used to examine whether reported knowledge about each of these strategies influenced levels of family conflict and quality of relationships after treatment.

First, consistent with pre-intervention analysis, parent and teen scores were compared via independent *t*-tests to identify the extent to which they diverged at post-treatment and whether discrepant scores were related to conflict levels. Then one-way analysis of variance was used to examine whether post-treatment outcomes varied according to demographic variables. Third, correlation analyses was performed to identify the association between post-treatment measures. In addition, the association between parenting style and psychological well-being at pre-treatment and post-treatment outcomes was examined.

Post-Intervention Comparisons Between Parents And Teens

The range of scores, means and standard deviations from self-report measures completed by parents and teens at post-treatment are presented in Table 4.10. Also presented on this table are results from *t*-test analysis, which shows statistically significant divergence between parents' and teens' scores.

Family Environment Scale. The teens' scores were more negative than parents' scores across the sub-scales. That is, teens' scores were lower for *cohesion, expressiveness, independence,* and higher for *conflict* and *control.* Parent and teen scores for *organisation* were consistent with each other. Statistical analysis showed that parent score for *cohesion* (M_{parent} = 44.46, M_{teen} = 33.42), $t(50) = 2.42$, $p < .05$, and *expressiveness* (M_{parent} = 46.73, M_{teen} = 35.62), $t(50) = 3.12$, $p < .01$, were significantly more positive. Differences reported on the other four other sub-scales were not significant.

Conflict Behavior Questionnaire. The score obtained by parents for *appraisal of dyad* ($M = 65.73$) was more negative (higher) than that obtained by the teens ($M = 62.15$). Conversely, *appraisal of other* was more negative for teens

Table 4.10
Ranges, Means and Standard Deviations from Self-Report Measures at Post-Treatment: Parents and Teens

Measure	Parents				Teens				*t*
	Range		*M*	*SD*	Range		*M*	*SD*	
	Min	Max			Min	Max			
Family Environment Scale									
Cohesion	9	68	44.46	14.33	1	68	33.42	19.59	2.32*
Expressiveness	21	66	46.73	10.92	15	60	35.62	14.52	3.12**
Conflict	32	81	53.42	14.63	32	81	56.42	13.93	<1.00
Independence	20	70	46.04	12.75	20	70	42.31	14.75	<1.00
Organisation	31	64	49.23	10.08	20	70	49.27	13.61	<1.00
Control	32	76	53.42	14.63	26	76	56.42	13.93	<1.00
Conflict Behavior Questionnaire									
Appraisal of Other	41	106	65.77	18.64	44	109	66.15	20.43	<1.00
Appraisal of Dyad	39	115	65.73	21.35	33	115	62.15	23.69	<1.00
Relationship Questionnaire									
Total Score	23	39	31.42	3.75	16	37	26.65	5.04	3.87*
Domains and Development Questionnaire									
Total Score	8.17	17.3	13.57	2.35	7.5	15.7	11.72	2.15	2.97*
Social Problem-Solving Inventory-Revised									
Total Score	8.23	19.0	14.73	2.22	5.59	15.9	10.54	2.30	6.70***

Note: * $p = < .05$, ** $p = < .01$, *** $p = < .001$.

(*M* = 66.15) than for parents (*M* = 65.77). Neither of these differences, however, was statistically significant.

Relationship Questionnaire. Parents perceived the relationship between themselves and their teen as being more positive than was reported by the teens

(M_{parent} = 31.42, M_{teen} = 26.65), with the parent score being significantly higher, $t(50) = 3.87, p < .001$.

Domains and Development Questionnaire. At post-treatment, the score obtained by parents (M = 13.57) on this instrument was significantly higher than the score obtained by teens (M = 11.72), $t(50) = 2.97, p < .01$.

Social Problem-Solving Inventory-Revised. According to scores obtained on this measure, parents reported significantly greater knowledge and use of problem-solving strategies than did teens (M_{parent} = 14.73, M_{teen} = 10.54), $t(50)$ = 6.70, $p < .001$.

Correlations of divergent parent-teen scores with conflict. Where parent and teen scores were significantly discrepant, a discrepancy score was obtained by calculating the absolute difference irrespective of the direction of that difference. Correlations were then performed between discrepancy scores and the Conflict Behavior scores to examine whether divergent perspectives were associated with reported levels of conflict. Correlational analysis that is presented in Table 4.11 showed discrepant reports of family *cohesion* was not related to conflict levels. Nor were conflict behaviours associated with discrepant scores on the two instruments used to assess skills of each treatment approach, that is the Domains and Development Questionnaire and the Social Problem-Solving Inventory-Revised. The degree of divergence for scores regarding perceptions of the parent adolescent relationship and *expressiveness* were, however, positively correlated with *appraisal of other* and *appraisal of dyad* scores reported by teens, indicating greater levels of conflict were associated with greater discrepancy in scores. The discrepant parent-adolescent Relationship score was also associated with parents' negative *appraisal of teen.*

Table 4.11
Correlations Between Divergent Parent-Teen Scores and Conflict Behavior Questionnaire Scores at Post-Treatment

Measure	Conflict Behavior Questionnaire			
	Parents		Teens	
	Other	Dyad	Other	Dyad
Family Environment Scale				
Cohesion	-.12	-.09	.07	.13
Expressiveness	.17	.19	.40*	.40*
Relationship Questionnaire				
Total Score	.46*	.28	.42*	.53*
Domains and Development Questionnaire				
Total Score	-.15	-.17	.27	.36
Social Problem-Solving Inventory-Revised				
Total Score	-.25	-.18	-.12	-.04

Note. * $p < .05$.

Summary of post-intervention comparisons between parents and teens. Consistent with pre-intervention assessment data, teens generally perceived family environment more negatively than did parents, with *cohesion*, *expressiveness* and the parent-adolescent Relationship scores being significantly lower. Parents obtained significantly higher scores than teens on the Domains and Development and the Social Problem-Solving Inventory-Revised measures, but these differences were not related to higher conflict behaviour levels. Divergent *expressiveness* scores were associated with teen reports of conflict, and divergent parent-adolescent Relationship scores were associated with greater levels of conflict reported by parents and teens.

Demographic Influences

There were no statistically significant differences revealed on the Conflict Behavior Questionnaire or Relationship Questionnaire with respect to any of the

demographic variables for either parents or teens at post-treatment. Nor were any statistical differences revealed on post-treatment scores on the Domains and Development Questionnaire or the Social Problem-Solving Inventory-Revised. This analysis indicates that conflict levels, the parent-adolescent relationship, and scores obtained on the measures of each intervention approach at post-treatment were not influenced by demographic characteristics.

Correlations Between Measures at Post-Treatment

The scores on each of the five measures completed at post-treatment were correlated with each other and are shown in Table 4.12 for parents and Table 4.13 for teens. Significant associations among variables consistent with those before treatment are noted, but attention is focused on scores that were not related at pre-treatment but were significantly related at post-treatment. To examine associations between parenting style and psychological well-being and scores obtained at post-treatment, additional correlational analysis was performed between pre-intervention scores on the Parental Authority Questionnaire and the Symptom Checklist-90-R, and post-intervention scores on the Conflict Behavior Questionnaire, the Relationship Questionnaire, the Domains and Development Questionnaire, and the Social Problem-Solving Inventory-Revised.

Family Environment Scale. Consistent with pre-interevention, high *conflict* was strongly related to low *cohesion* for both parents and teens. Significant additional relationships revealed at post-treatment for teens were high levels of *expressiveness* being positively associated with family *cohesion* (r = .42), and low *control* being strongly related to high *expressiveness* (r = -.65) and high *independence* (r = -.60). At post-treatment, parents scores for high *independence* were also related to low *control* (r = -.42).

Table 4.12
Correlations Between Measures at Post-Treatment: Parents

	Measures	1	2	3	4	5	6	7	8	9	10	11
	Family Environment Scale											
1	Cohesion		.06	-.62*	.29	.38	.01	-.73*	-.62*	.34	.49*	.15
2	Expressiveness	.06		.11	.30	-.07	-.32	-.18	-.29	.17	.24	.48*
3	Conflict	-.62*	.11		-.24	-.38	.23	.52*	.50*	-.19	-.45*	.10
4	Independence	.29	.30	-.24		.09	-.42*	-.09	-.18	.08	.02	.29
5	Organisation	.38	-.07	-.38	.09		.41*	-.07	-.08	.50*	.21	.13
6	Control	.01	-.32	.23	-.42*	.41*		.17	.37	.12	-.21	-.04
	Conflict Behavior Questionnaire											
7	Appraisal of Other	-.73*	-.18	.52*	-.09	-.07	.17		.78*	-.27	-.68*	-.13
8	Appraisal of Dyad	-.62*	-.29	.50*	-.18	-.08	.37	.78*		-.34	-.68*	-.24
	Relationship Questionnaire											
9	Total Score	.34	.17	-.19	.08	.50*	.12	-.27	-.34		.60*	.65*
	Domains and Development Questionnaire											
10	Total Score	.49*	.24	-.45*	.02	.21	-.21	-.68*	-.68*	.60*		.25
	Social Problem-Solving Inventory-Revised											
11	Total Score	.15	.48*	.10	.29	.13	-.04	-.13	-.24	.65*	.25	

Note. * indicates $p < .05$.

Table 4.13
Correlations Between Measures at Post-Treatment: Teens

	Measures	1	2	3	4	5	6	7	8	9	10	11
	Family Environment Scale											
1	Cohesion		.42*	-.74*	.34	.42*	-.27	-.67*	-.69*	.71*	.42*	.12
2	Expressiveness	.42*		-.50*	.49*	-.07	-.65*	-.30	-.24	.53*	.53*	.42*
3	Conflict	-.74*	-.50*		-.57*	-.50*	.28	.73*	.77*	-.80*	-.65*	-.11
4	Independence	.34	.49*	-.57*		-.10	-.60*	-.32	-.33	.57*	.32	.18
5	Organisation	.42*	-.07	-.50*	-.10		.38	-.43*	-.53*	.47*	.61*	-.08
6	Control	-.27	-.65*	.28	-.60*	.38		.20	.05	-.27	-.25	-.27
	Conflict Behavior Questionnaire											
7	Appraisal of Other	-.67*	-.30	.73*	-.32	-.43*	.20		.91*	-.73*	-.46*	.02
8	Appraisal of Dyad	-.69*	-.24	.77*	-.33	-.53*	.05	.91*		-.76*	-.52*	.07
	Relationship Questionnaire											
9	Total Score	.71*	.53*	-.80*	.57*	.47*	-.27	-.73*	-.76*		.68*	.08
	Domains and Development Questionnaire											
10	Total Score	.42*	.53*	-.65*	.32	.61*	-.25	-.46*	-.52*	.68*		.04
	Social Problem-Solving Inventory-Revised											
11	Total Score	.12	.42*	-.11	.18	-.08	-.27	.02	.07	.08	.04	

Note. * indicates $p < .05$.

Conflict Behavior Questionnaire. Parent scores for *appraisal of teen* were not related to *cohesion* before treatment, but after treatment high negative scores obtained by parents on *appraisal of teen* and *appraisal of dyad* were both strongly associated with low *cohesion* (r = -.73 and r = -.62 respectively) assessed via the Family Environment Scale. The same relationships were shown between teens' negative *appraisal of dyad* scores and *cohesion* (r = -.67 and r = -.69 respectively) which was consistent with the association between these variables at pre-intervention.

Relationship Questionnaire. Teens' scores on the Relationship Questionnaire were strongly associated with high family *cohesion* and *independence* and low *conflict* before and after treatment. Teens' positive Relationship scores were also strongly associated with low conflict behaviours on the Conflict Behavior Questionnaire pre- and post intervention. In addition, after treatment, teens' positive Relationship scores were related to high levels of *expressiveness* (r = .53) and *organisation* (r = .47) Parents' positive Relationship scores were related to *organisation* both before and after treatment, which reflects importance being placed on clear structure in planning family responsibilities.

Domains and Development Questionnaire. Consistent with pre-treatment assessment, high post-treatment scores on this instrument obtained by parents were positively associated with Relationship and *cohesion* scores, and negatively associated with *conflict* on the Family Environment Scale. In contrast to results from correlational analysis before treatment where Conflict Behavior Questionnaire scores were not related to Domain and Development scores, high correlations were obtained after treatment for parents' *appraisal of teen* and *appraisal of dyad* (r = .-68 for both subscales).

Pre-intervention scores obtained by teens on the Domain and Development Questionnaire were not meaningfully related to family environment or conflict variables, but significant relationships emerged at post-intervention. High teen scores on the Domains and Development Questionnaire were strongly associated with high *cohesion* (r = .42), *expressiveness* (r = .53) and *organisation* (r = .61) and low levels of *conflict* (r = -.65) assessed on the Family Environment Scale, as well as on the Conflict Behavior Questionnaire subscales of *appraisal of parent* (r = -.46) and *appraisal of dyad* (r = -.52). For teens, there was also a strong positive correlation at post-treatment between attention given to teen development and social-cognitive domains of authority and perceptions of the parent-adolescent relationship (r = .68).

Social Problem-Solving Inventory-Revised. Parents that reported high levels of problem-solving skills also reported placing high value on direct expression of feelings pre- and post-treatment. The relationship between problem-solving skills and *expressiveness* was also evident for teens at post-treatment (r = .42), and parents' problem-solving skills were positively associated with parent-adolescent relationship after treatment (r = .65).

Parental Authority Questionnaire. Table 4.14 summarises how parenting style, measured by the Parental Authority Questionnaire before treatment, correlates with conflict and the parent-adolescent relationship after treatment.

Analysis showed there was a significant association between parenting styles and treatment response measures. Parents who rated themselves high on *authoritarian* style had negative views regarding parent-adolescent interactions measured by *appraisal of dyad* as these scores correlated positively (r = .56). According to the adolescent participants, *authoritative* parenting behaviours were

strongly associated with more positive perceptions of parents and of parent-teen interactions, as teen scores for *authoritative* parenting were negatively correlated with *appraisal of other* (r = -.55) and *appraisal of dyad* (r = -.65) (where high appraisal scores are more negative) and positively correlated with the total score (r = .63) on the Relationship Questionnaire (where high scores are more positive).

Table 4.14
Correlations Between Parenting Style and Response to Treatment Measures

Measure	Conflict Behavior Questionnaire				Relationship Questionnaire	
	Parents		Teens		Parents	Teens
	Other	Dyad	Other	Dyad		
Parental Authority Questionnaire						
Authoritarian	.29	.56*	.17	.13	-.21	-.20
Authoritative	.12	.02	-.55*	-.65*	.16	.63*
Permissive	-.14	-.17	-.26	-.20	.18	.34

Note. * $p < .05$.

An interesting pattern emerged regarding the association between parenting style scores and post-treatment responses from the Domains and Development Questionnaire and the Social Problem-Solving Inventory-Revised. As indicated by the significant negative correlation (r = -.45), shown on Table 4.15, parents who rated themselves high on *authoritarian* parenting behaviours obtained low scores on the Domains and Development Questionnaire, which suggests that adolescent development and the domain category framework was not utilised by authoritarian parents. On the other hand, teens that rated their parents high on *authoritative* parenting style also reported applying the domain

framework to decision making (r = .75). No association between parenting style and problem-solving skills was reported by parents or teens.

Symptom Checklist-90-R. Psychological well-being assessed before treatment was not associated with post-intervention levels of conflict or perceptions regarding quality of parent-teen relationships. Results of correlation analysis between the Symptom Checklist-90-R, the Conflict Behavior Questionnaire, and the Relationship Questionnaire are shown on Table 4.16.

Table 4.15
Correlations Between Parenting Style and Measures of Each Intervention Approach

Measure	Domains and Development Questionnaire		Social Problem-Solving Inventory-Revised	
	Parents	Teens	Parents	Teens
Parental Authority Questionnaire				
Authoritarian	-0.45*	0.26	-0.32	-0.28
Authoritative	0.08	0.75*	-0.05	-0.12
Permissive	0.30	0.15	0.15	-0.05

Note. * $p < .05$.

Table 4.16
Correlations Between Symptom Checklist-90-R Scores and Response to Treatment Measures

Measure	Conflict Behavior Questionnaire				Relationship Questionnaire	
	Parents		Teens		Parents	Teens
	Other	Dyad	Other	Dyad		
Symptom Checklist-90-R						
Global Index Score	.14	.08	.27	.05	.07	.05

Summary of correlations between measures at post-treatment. Consistent with associations among measurement variables before treatment, relationships between scores obtained by teens were generally stronger than for parents, but, again, consistent patterns did emerge. The correlations among subscales of the Family Environment Scale were in predicted directions. That is, high levels of *conflict* were associated with low levels of *cohesion, expressiveness,* and *independence.* Teens who reported their family was run by set rules and procedures, also reported *expressiveness* and *independence* were not valued. Similarly, parents who reported having high *control* of rules and procedures did not value *independence* or assertiveness among family members.

Analysis revealed no association between parents' perceptions of the parent-adolescent relationship and conflict behaviours. Teens' perceptions of the parent-adolescent relationship and parental responsiveness toward the teen, however, assessed via the Relationship Questionnaire, were strongly related to conflict levels and the family environment. A negative Relationship was indicative of high levels of conflict behaviours, low *cohesion* and an *organised* environment, where family members' *expression* of feelings and assertive *independence* was not valued.

Scores on the Domains and Development Questionnaire, which was used to ascertain whether adolescent development and parental authority was differentiated according to social-cognitive domain categories, were significantly related to high family *cohesion* and *expressiveness*, positive relationships between parents and teens, and low conflict levels. In contrast, problem-solving skills were associated with *expression* of feelings, but not with negative communication and conflict behaviours reported by parents or teens. Nor were problem-solving skills

associated with the teens' perception of the parent-adolescent relationship, although there was an association between these variables for parents.

It appeared that parents who rated themselves as *authoritarian* reported high levels of conflict and were less amenable to the Domain and Development intervention approach. On the other hand, *authoritative* parenting behaviours as rated by teens was strongly associated with lower conflict, a more positive perception of the parent-adolescent relationship, and greater responsiveness to the Domain approach. Problem solving was not related to parenting style, nor was psychological well-being before treatment related to conflict levels or the parent-adolescent relationship after treatment. Teens who reported having a negative relationship with their parent also reported experiencing high levels of conflict, and vice versa. Low conflict behaviours and positive parent-adolescent relationships were strongly related to parent and teen responsiveness to the Domain and Development approach, but not to the Problem Solving approach.

Impact of Treatment

Analyses used in the previous section to evaluate response to treatment showed a general trend of positive change after intervention irrespective of group condition, with some post-treatment improvements being statistically significant. There has been growing recognition, however, that traditional statistical significance tests do not provide information regarding individual variability of response to treatment or indicate the proportion of individuals who have benefited from treatment. Thus, statistical comparisons between treatment group means provides confidence that differences in performance of treatment are not chance findings, but may not bear on the clinical significance of the effect, or the impact derived by individual clients.

With regard to clinical significance, two questions arise: was the magnitude of change for individual clients statistically reliable, and how much change has occurred during the course of therapy? To examine whether individual change exhibited by participants was large enough to be considered reliable and clinically significant, the Conflict Behavior Questionnaire was selected for analyses, as this measure was believed to best represent the type of change sought from therapy. The Reliable Change index (Jacobson & Truax, 1991) was calculated to determine whether the degree of change in each case was of sufficient magnitude to exceed the margin of measurement error. This was computed for each client by subtracting the post-treatment score from the pre-treatment score and dividing this difference by the standard error of the difference. The standard error of difference was computed from the standard error of measurement, which was calculated using test-retest reliabilities for distressed dyads from waitlist control groups, and standard deviations from pre-assessment data of parents and adolescents referred to treatment for family relationship problems (Robin & Foster, 1989). All Reliable Change indexes that exceed 1.96 are considered statistically reliable and to reflect real change (Jacobson & Truax, 1991). The difference between pre- and post-intervention scores for individual clients on the Conflict Behavior Questionnaire and Reliable Change index are presented in Table 4.17.

As previously stated, the Reliable Change index score provides information about whether the degree of change is large enough to exceed the margin of measurement error. The Reliable Change index alone therefore does not necessarily reflect change that is clinically significant or meaningful the individual clients (Jacobson, Roberts, Berns, & McGlinchey, 1999), which is

Table 4.17
Difference Between Individual's Pre- and Post-Intervention Scores and Reliable Change Index for the Conflict Behavior Questionnaire

Dyad[a]	Parent Appraisal				Teen Appraisal			
	Other		Dyad		Other		Dyad	
	Diff[b]	RCI	Diff	RCI	Diff	RCI	Diff	RCI
PS-1	9	1.09	5	1.26	+5	+0.39	+9	+2.30
PS-2	24	2.91*	15	3.78*	22	1.70	9	2.30*
PS-3	24	2.91*	14	3.53*	20	1.55	5	1.28
PS-4	63	7.64*	57	14.36*	+2	+0.15	17	4.34*
PS-5	2	0.24	10	2.52*	2	0.15	5	1.28
PS-6	11	1.33	5	1.26	+14	+1.08	+17	+4.34
PS-7	16	1.94	10	2.52*	0	0.00	0	0.00
PS-8	+3	+0.36	+14	+3.53	0	0.00	+8	+2.04
PS-9	28	3.39*	19	4.79*	15	1.16	19	4.85*
PS-10	+5	+0.96	28	7.55*	11	1.77	4	1.56
PS-11	+2	+0.38	0	0.00	0	0.00	8	3.11*
PS-12	6	1.15	0	0.00	4	0.64	4	1.56
PS-13	31	5.94*	17	4.58*	31	4.98*	46	17.90*
DD-1	35	4.24*	38	9.57*	+4	+0.31	4	1.02
DD-2	0	0.00	43	10.83*	+25	+1.94	+13	+3.32
DD-3	11	1.33	5	1.26	+19	+1.47	+18	+4.59
DD-4	+21	+2.55	43	10.83*	+9	+0.70	26	6.63*
DD-5	19	2.30*	24	6.05*	22	1.70	26	6.63*
DD-6	25	3.03*	38	9.57*	16	1.24	35	8.93*
DD-7	12	1.45*	5	1.26	29	2.25*	35	8.93*
DD-8	+16	+1.94	+15	+3.78	13	1.01	0	0.00
DD-9	10	1.21	+10	+2.52	15	1.16	39	9.95*
DD-10	10	1.92	33	8.89*	13	2.09*	13	5.06*
DD-11	3	0.57	+17	+4.58	10	1.61	21	8.17*
DD-12	21	4.02	23	6.20*	21	3.38	12	4.67*
DD-13	0	0.00	0	0.00	9	1.45*	8	3.11*

Notes. [a] PS = Problem Solving group, DD = Domain and Development group; [b]Diff = Difference; + indicates increased (more negative) appraisal score from pre- to post-intervention. * Reliable Change = > 1.96.

relevant to the individuals who participated in this treatment programme. As the variability of participant scores is accounted for in the statistical calculation for Reliable Change, and greater variability signifies greater margin of error, this in turn means that a larger degree of change has to be attained for an individual's score to be statistically reliable. In this regard, standard deviations for distressed families on the Conflict Behavior Questionnaire (Robin & Foster, 1989) are greater for *appraisal of other* compared to *appraisal of dyad*, which means that the amount of change for some individuals who attended therapy may not have been large enough to be statistically reliable, but was meaningful within their family context. Changed scores from pre- to post-treatment have therefore been identified across a range of levels and a summary of the degree of change for each group is presented in Table 4.18. Five levels were identified to show the percentage of participants whose scores were: (a) *significantly better* (Reliable Change); (b) *better* (post-treatment improvement not sufficient to be categorised as significant according to the Reliable Change index statistic); (c) revealed *no change*; (c) were *worse*; or (d) were *significantly worse*.

The general trend, as indicated earlier in this section, was that most clients from both treatment groups exhibited positive change. Overall, a comparison of improved scores shows that more teens in the Domain and Development group (*appraisal of other* = 69%, *appraisal of dyad* = 77%) obtained improved post-treatment scores than teens in the Problem solving group (*appraisal of other* = 54%, *appraisal of dyad* = 69%). On the other hand, more parents from the Problem Solving group reported improvement (*appraisal of other* = 76%, *appraisal of dyad* = 77%), than did parents from the Domain group (*appraisal of other* = 69%, *appraisal of dyad* = 64%).

Table 4.18
Change Status Between Pre- and Post Intervention According to Reliable Change Index on the Conflict Behavior Questionnaire for Each Intervention Group

Degree of Change From Pre- to Post-Treatment	Problem Solving				Domain and Development			
	% Parents		% Teens		% Parents		% Teens	
	Other	Dyad	Other	Dyad	Other	Dyad	Other	Dyad
Improved								
Significantly better	38	62	8	38	31	54	23	69
Better	38	15	46	31	38	15	46	8
Total: Improved	76	77	54	69	69	64	69	77
No Change or Worse								
No Change	0	15	23	8	15	8	0	8
Worse	23	0	23	0	8	0	31	0
Significantly worse	0	8	0	23	8	23	0	15
Total: No Change or Worse	23	23	46	31	31	31	31	23

More specifically, as evident from information presented in Table 4.18, a considerably larger proportion of teens from the Domain group reported significantly Reliable Change on both of the subscales, when compared to the Problem Solving group, particularly for *appraisal of dyad.* Conversely, more parents from the Problem Solving group reported a significantly Reliable Change for both *appraisal of other* and *appraisal of dyad* than did parents from the Domain and Development group. As also seen from Table 4.18, many parents and teens reported experiencing less conflict at post-treatment, which is reflected by the percentage of clients with the next level of positive change, that is, *better* scores, particularly for *appraisal of other.* Some participants considered negative communication and conflict behaviour had not changed from pre- to post-treatment, and some reported increased conflict at post-intervention. Parents from

the Problem Solving group and teens from the Domain group reported the largest percentage of *worse* scores for *appraisal of other*. Some parents and teens from each treatment group were *significantly worse* at post-treatment, and information about these clients will be provided in the following section detailing clinical impressions. Overall, Problem Solving group teens reported least improvement.

Clinical impressions. Although there was a general finding that participants in both groups had positive outcomes, it is clear that there was considerable variation between participants irrespective of intervention group. While outcomes were positive for some individuals, others in the same intervention group did not realise the goal of reduced conflict and improved parent-adolescent relationship. Additional to individual family characteristics mentioned in the method section, during the course of therapy I became aware of a number of individual and family circumstances that appeared to have an important influence on this variation. Because of the confidential nature of this information it is not possible to provide details, but I will give a brief profile of circumstances for some families from each treatment group who did not report improvements.

One mother was involved with ongoing acrimonious access disputes with her ex-partner about her younger son and was preparing for a family court hearing. She acknowledged her distress and said she had limited time available to attend to the emotional and physical needs of her teenage daughter. The teens' wish that her mother could be happy, and her longing to spend more time with her mother did not change. Another mother was emotionally and physically unavailable for her teenage son because of her extensive work demands. One teenager became suicidal while attending therapy. Essentially she and her mother

had a good relationship, and the reasons for her distress were related to other issues. Another teenager was physically assaulted during the course of therapy by a male parent who had a history of violence, and more negative post-treatment scores were reported by this dyad. Of particular note in this case was the improvements reported by the mother and son after treatment, and the teenager recommended a friend of his attend therapy. For the mother in one family and the male teenager in another, mental health concerns were more salient than parent-adolescent relationship issues. Interestingly, the mother of the male teen with mental health concerns was also attending separate sessions with her daughter and the mother-daughter dyad reported significantly reliable improvements.

Summary of impact of treatment. A high percentage of clients reported experiencing less conflict and improved communication subsequent to therapy. More teens from the Domain and Development group obtained improved scores at post-treatment that were statistically reliable than did teens from the Problem Solving group. Conversely, more parents from the Problem Solving group than the Domain group reported statistically reliable improvement, although the difference was not as distinct as for the teens from each group. A greater proportion of both parents and teens reported improvements that were *significantly better* for *appraisal of dyad* compared to *appraisal of other.* The reverse was the case for the next level of positive change, with more individuals reporting improved *appraisal of other* compared to *appraisal of dyad.* As mentioned above, the greater variability of distressed family scores in the calculation of reliable change means the magnitude of change required was greater for improved scores on *appraisal of dyad* to be considered reliably changed. With this consideration in mind, it seems reasonable to assume that both

levels of improvement made a difference in people's lives. Overall, the teens from the Problem Solving group reported the smallest proportion of improved scores, and the largest proportion of scores indicating no change or worse communication and increased conflict behaviours at the completion of treatment.

The treatment programme was not comprehensive enough to meet the diverse needs of all families. However, they all continued to attend sessions, and improved scores were reported on at least one subscale of the Conflict Behavior Questionnaire by either one or both individuals from 25 of the 26 dyads who completed treatment.

At the end of therapy I discussed any mental health and safety concerns that were still evident, and initiated referrals to school counsellors or other health providers as appropriate to ensure the ongoing support and care was provided for these families.

Evaluations of Treatment

Participant evaluations. Parents and teens completed evaluation inventories that included two 9-item subscales to assess *acceptability* of treatment and *progress* in therapy. With a range of 9 to 45, an average rating across the nine items would be 27 (a score of 3 for each item) with higher scores reflecting more positive reactions. Histograms showing distribution of evaluation scores can be seen in Appendix N.

Of initial interest was client evaluation about treatment *acceptability*. As illustrated in Figure 4.23, treatment *acceptability* was rated favourably by parents with scores ranging from 26 to 45 ($M = 39.0$, $SD = 4.60$) and by teens with scores ranging from 24 to 43 ($M = 32.58$, $SD = 4.93$). In general, these ratings indicate

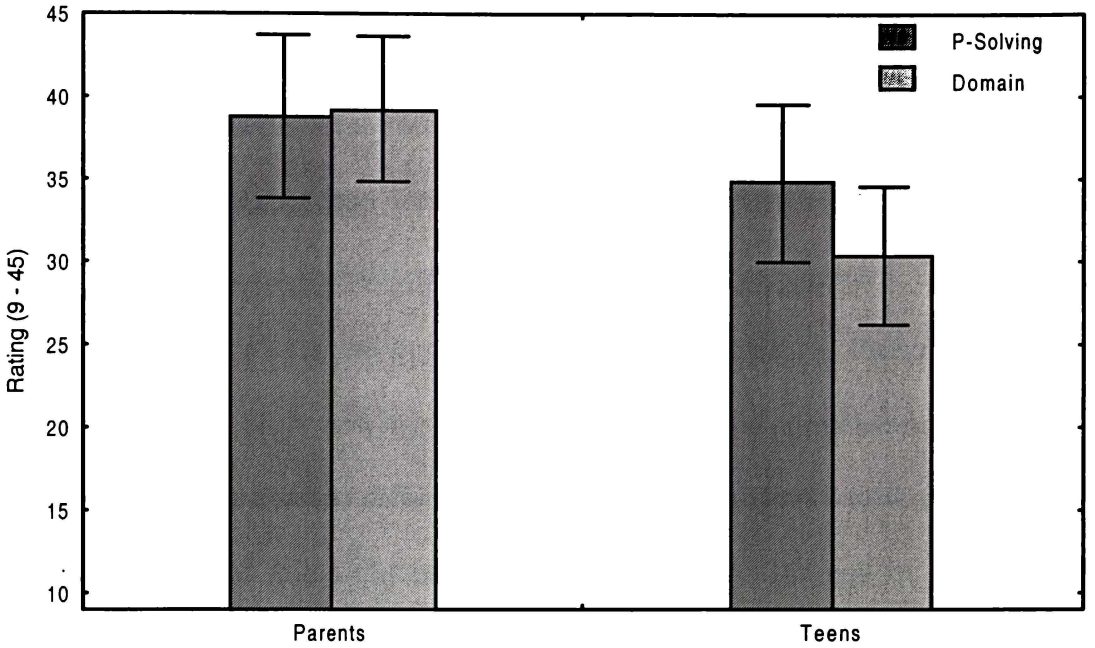

Figure 4.23. Participant evaluation of acceptability of treatment for each treatment group: Parents and teens.

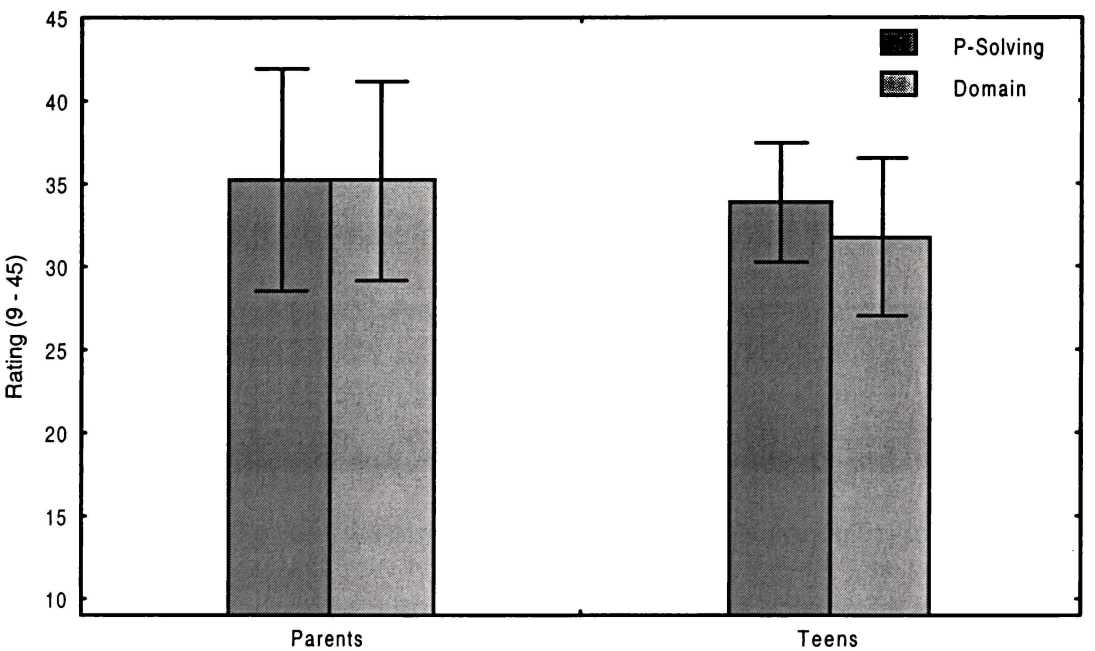

Figure 4.24. Participant evaluation of progress in therapy for each treatment group: Parents and teens.

that treatment was viewed positively, but statistical comparison showed that *acceptability* ratings for parents were higher than for teens, $t(50) = 4.85$, $p < .001$.

The *acceptability* rating for parents from the Domain group ($M = 39.23$, $SD = 4.40$) was higher than for parents from the Problem Solving group ($M = 38.76$, $SD = 4.95$), but this difference was not statistically significant. Conversely, ratings of treatment *acceptability* were higher for teens from the Problem Solving group ($M = 34.77$, $SD = 4.78$) than the Domain and Development group ($M = 30.38$, $SD = 4.17$), and this difference was significant, $F(1,24) = 6.20$, $p < .05$.

The second sub-scale included parent and teen ratings of their own *progress* in treatment. Both parents and teens tended perceive themselves as having made progress as scores ranged from 20 to 45 for parents ($M = 35.19$, $SD = 6.24$) and from 24 to 43 for teens ($M = 32.58$, $SD = 4.93$). As displayed in Figure 4.24, parent ratings of *progress* were higher than teen ratings ($M_{parent} = 35.19$, $SD = 6.24$; $M_{teen} = 32.81$, $SD = 4.26$) but this difference did not attain statistical significance.

The mean *progress* scores for parents from the Problem Solving group and Domain group were 35.23 ($SD = 6.71$) and 35.15 ($SD = 6.01$) respectively, while the mean scores for teens were lower at 33.84 ($SD = 4.26$) and 31.76 ($SD = 4.75$) respectively. Neither parent nor teen ratings of *progress* in treatment differed significantly between treatment groups.

Participants comments about treatment. While parents and teens had to complete pre- and post-assessment instruments, and follow specific treatment protocols, most expressed positive feelings about attending treatment irrespective of the intervention they received, but some differences in the content of feedback emerged. Frequently, comments from Problem Solving group participants referred

to confirming what they already knew. Comments made by parents and teens in the Domain group more often referred to improved understanding of their relationships. Following are representative examples of comments written at the bottom of the formal evaluation instrument. The first five are comments from clients in the Problem Solving group, the second five are written by clients in the Domain group.

> *The sessions have been invaluable – especially enabling us to rescue our relationship. Thank you.*
>
> *Found the programme and time spent to be encouraging. Confirmed what we knew, put us back on track.*
>
> *The confirmation was helpful.*
>
> *Our personal communication has improved and we have and discussed agreements together more positively.*
>
> *Most worthwhile.*
>
> *We have appreciated the opportunity to participate. Our son has told his friends about the programme and his enthusiasm speaks volumes about how he felt about the programme. Well done and thank you.*
>
> *It has become easy to discuss/resolve issues with an umpire. Now we must fly solo, but I think that the tools we have been given have helped us learn how to do that better. Thanks.*
>
> *Giving us tools with which we can develop better understanding has had short-term benefits to date. We will continue to develop the skills and use the tools we have been given to become a 'family' again.*
>
> *I think it was a very interesting and well laid-out programme. It has helped me and my relationship with my parents heaps. Thank you very much.*
>
> *I did enjoy the sessions. They have helped me communicate with my parents more easily and for them to understand me better, which has helped me a lot. I am really grateful for your help and encouragement.*

Therapist evaluations. I rated client's *responsiveness* during sessions and *improvement* as a result of treatment. Scores on the *responsiveness* scale ranged from a minimum of 6 to a maximum of 30, so 18 would be an average rating across the six items. With the range of *improvement* scores extending from 15 to 45 across nine items, an average rating would be 27. Higher scores reflect more positive evaluations. Therapist evaluations of these two sub-scales for both parents and teens were highly correlated (r = .84 and .75 respectively) but separate scales were maintained to permit a comparison of parent and teen *progress* ratings and therapist *improvement* ratings.

Therapist ratings of participant *responsiveness* ranged from 13 to 29 for parents (M = 24.96, SD = 3.48), and 17 to 29 for teens (M = 23.12, SD = 2.82). The rating of parent and teen *responsiveness* by the therapist was not statistically different. The mean *responsiveness* scores for parents were 24.00 (SD = 4.45) and 25.92 (SD = 1.84) for the Problem Solving and Domain groups respectively. Teen scores were lower, with means calculated as 23.54 (SD = 2.54) and 22.69 (SD = 3.12) for the Problem Solving and Domain groups respectively. As depicted in Figure 4.25, *responsiveness* during treatment did not differ statistically for parents or teens from each treatment group.

Scores for therapist rating of *improvement* after treatment for parents ranged from 12 to 42 and produced a mean score of 33.19 (SD = 7.04), and ranged from 11 to 42 for teens with a mean score of 31.92 (SD = 6.81). Therapist ratings of parent and teen *improvement* after treatment were not significantly different. As shown in Figure 4.26, *improvement* after treatment scores were higher for parents from the Domain and Development group (M = 34.69, SD = 3.95) than the Problem Solving group (M = 31.69, SD = 9.10). Conversely, ratings

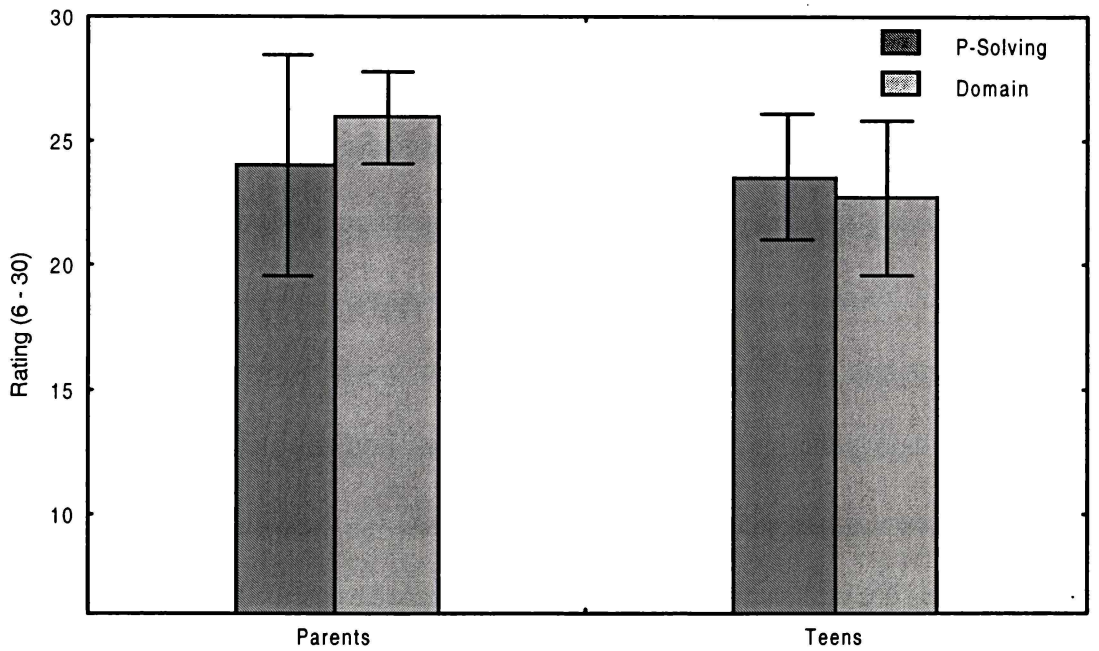

Figure 4.25. Therapist evaluation of responsiveness during sessions for each treatment group: Parents and teens.

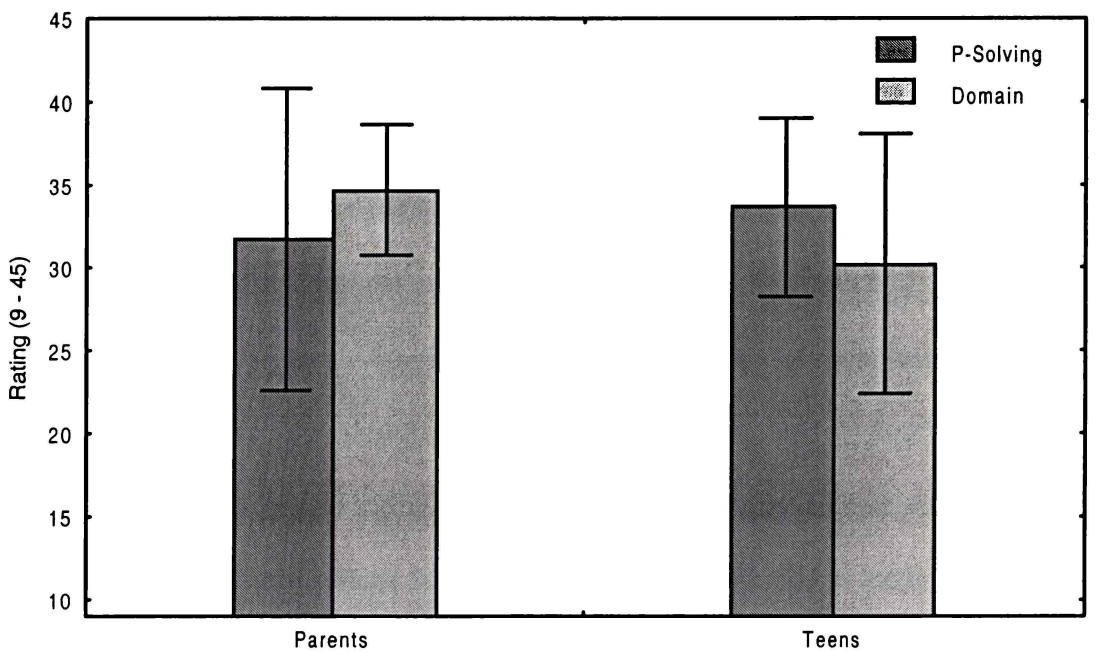

Figure 4.26. Therapist evaluation of improvement as a result of therapy for each treatment group: Parents and teens.

of *improvement* after treatment were higher for teens from the Problem Solving group (M = 33.62, SD = 5.39) than the Domain and Development group (M = 30.23, SD = 7.83). Statistical comparisons showed that parent and teen *improvement* scores for each treatment group were not significantly different.

Correlations between participant and therapist evaluations. Correlations of participant *acceptability* of treatment and *progress* ratings and the therapist ratings of *responsiveness* and *improvement* indicated significant relations among these perspectives at $p < .05$. Ratings of treatment *acceptability* were positively related to therapist ratings of *responsiveness* both for parents (r = .58) and teens (r = .46). Parent and teen ratings of *progress* were significantly related to therapist evaluation of *improvement* (r = .40 and .46 respectively).

Demographic influences. Ratings for *acceptability* of treatment were more favourable for middle adolescents (M = 35.09, SD = 4.87) than early adolescents (M = 30.73, SD = 4.23). This was a significant main effect of adolescent age, $F(1,24) = 5.93$, $p < .05$. The therapist ratings of *responsiveness* during sessions were also more favourable for middle adolescents (M = 24.55, SD = 2.42) than early adolescents (M = 22.07, SD = 2.69). Statistical analysis confirmed that *responsiveness* ratings were significantly different by adolescent age, $F(1,24) = 5.86$, $p < .05$. Further analysis of these effects using planned comparisons showed that middle adolescents from the Domain group (M = 33.50, SD = 3.45) rated *acceptability* of treatment significantly higher than middle adolescents from the Problem Solving group (M = 27.71, SD = 2.63), $F(1,22) = 5.86$, $p < .05$. This was consistent with therapist evaluation of *responsiveness* during sessions being rated higher for middle adolescents from the Domain group (M = 24.67, SD = 3.08) than for middle adolescents from the Problem Solving

group (M = 21.00, SD = 2.08), $F(1,22) = 6.61$, $p < .05$. There were no statistically significant differences revealed regarding evaluations by early adolescents for each treatment group, and no differences on evaluation ratings with respect to other demographic characteristics.

Personal evaluation of interventions. Irrespective of the group families were allocated to, many parents and teens responded well to therapy, both in terms of reporting improved changes on the pre- and post-intervention assessment instruments, and by favourable evaluations of treatment. The results already presented demonstrate the general trend of improvement, but do not reflect my clinical impressions or experience as the therapist. Although the communication skills component overlapped the two treatments, consistent differences were evident for each treatment protocol.

First and foremost, I would like to say that I enjoyed working with these families – even though solving topics of dispute was the agenda and it was never necessary to work with hypothetical examples. It is evident from previous comments that some families were experiencing particularly difficult circumstances, so many demanding and challenging issues arose. Irrespective of different family backgrounds and circumstances, all families attended treatment to address conflict that was being experienced between the parent and the teenager. I therefore did not directly address issues that arose that were not related to the parent-adolescent relationship, but in some cases it was imperative that concerns were addressed immediately, which meant I maintained communication with relevant counsellors and health care providers. Although some discussions certainly did involve high levels of emotional distress for parents and teens, most interactions were amicable and many were fun. Generally, goodwill existed

among family members and most were keen to improve their relationships. I believe that emphasising positive communication and the use of drawings, cartoons and humour to illustrate points contributed to building an enjoyable and non-critical atmosphere during sessions, which generalised to the home environment for many families.

The use of problem-solving strategies to identify specific problems, generate and evaluate alternative solutions, and implement the most appropriate solution was a constructive approach to resolving issues of dispute, particularly when all individuals involved were prepared to compromise. Parents and teens typically displayed good knowledge of problem-focused strategies, but had not been utilising them to resolve family conflicts. Parents were therefore readily able to discuss specific issues within the problem-solving framework. Some teens were not aware of the problem solving steps, and had not previously considered the immediate and longer-term consequences of potential options. All were able to understand the strategies, although some utilised them to greater advantage than others when discussing issues. During the course of therapy, the most salient issues of dispute were raised, discussed, and compromise solutions were often agreed upon. It is not surprising therefore that many families in the Problem Solving group reported improvements at the end of therapy. Whether the improvements will be sustained in the long term, however, cannot be determined. Most parents and many teens were already aware of problem-solving skills, but they were not using them. Some made firm commitments to continue using the strategies to resolve future issues. Others, however, described the problem-solving steps as time consuming and tedious, and some made comments such as they just "didn't have time" to go through the whole process every time an issue arose.

Comments of this nature suggest that when new issues arise in these families, conflict is likely to re-emerge.

Parents and teens in the Domain and Development group were able to develop definitions for each of the domain categories, and generally agreed upon who should have legitimate authority of each conceptual domain. Responses were fairly consistent across families. For the moral, conventional, and safety domains most parents considered teens should contribute to decisions, although they typically thought their input should be greater than that of their teen. Most teens said their parents should have at least equal say about issues in these domain categories. All agreed that the personal issues should be decided by the teen alone. By this stage, within the context of adolescent developmental tasks, a shared understanding of adolescence was often formed: (a) changes in decision making responsibility were going to occur during adolescence, and (b) joint decision making was considered appropriate and reasonable, but the degree of independent decision making would be differentiated according domain categories.

Different aspects of the model were emphasised depending on the individual family, the direction of their communication, or the issue being discussed. Interestingly, the model worked well for both everyday issues and more complex issues. Sometimes reasons were clearly identified and articulated, and agreements were easily reached. At times resolution was more difficult, but once reasons for a particular stance were justified using the domain framework, an agreement about who had authority to make the decision was usually reached. For example, a common issue of dispute was teens wanting to go to parties and parents not allowing them to do so. Parents generally categorised going to parties as an issue belonging to the safety domain, and when specific and often

reasonable safety concerns were identified, discussion typically led to mutual understanding or compromise.

The notion of where on the journey from being a child to adult that issues shift from one domain to another was also helpful. For example, one mother was insisting that her daughter's bedroom was a conventional issue, which meant she was entitled to input, and she wanted the bedroom to be tidy. Her daughter was adamant that her bedroom was a personal issue. When the mother realised that she believed her own bedroom to be personal, and considered at what stage of development her daughter's bedroom might become personal, she reconsidered her stance, and a satisfactory compromise was reached.

In another situation, a father who typically exhibited rigid authoritarian perspectives and expected his teenager daughter to be obedient, used the domain framework effectively to differentiate between issues he considered most important, and insisted he maintain authority over those issues, and issues that he could comfortably categorise as personal immediately. He was also able to indicate to his daughter at what age he believed legitimate authority should shift toward the personal domain for different issues. His decisions were acceptable to the teenager who previously perceived she had no personal jurisdiction.

Information provided by one family at the beginning of treatment indicated that conflict escalated when disagreements were emerging between the mother and son and the stepfather became involved in an attempt to support his partner. The Domain framework enabled this family to clearly articulate domains of authority, which they decided were different for the mother and stepfather, and both dyads reported significant improvements after treatment.

As indicated by the formal evaluations of treatment, parents and teens from both treatment groups generally found the treatment acceptable and considered they made good progress. Similarly, I perceived most individuals to be responsive to treatment, and observed marked improvements among family relationships. Additional to the different outcomes reported in terms of family circumstances that have already been referred to, some notable differences were apparent regarding responsiveness to the Domain intervention in particular.

It was evident, that if teens did not have adequate problem-solving abilities, they were less able to negotiate issues using the Domain framework than teens who did have a grasp of problem-solving abilities. The developmental level of teens also influenced outcomes, evidenced by younger teens who displayed cognitive processes that were more concrete rather than conceptual not being as responsive to the Domain approach as older teens were. These differences were quite distinct, which led to my mean scores for evaluations of *responsiveness* and *improvement* (Figures 4.25 and 4.26) for teens in the Domain group being lower than for teens the Problem Solving group. The lower group mean, therefore, does not in fact reflect my overall clinical impressions of how responsive teenagers in the Domain group actually were, or how much improvement was generally displayed.

In summary, my impression was that families in the Problem Solving group used the skills and strategies to reach agreements about specific issues of dispute, and many of them accomplished this goal very well. In comparison, families in the Domain and group developed a shared conception of adolescence, and changes in legitimate domains of authority during adolescence, which provided an understanding of what underlies specific issues of disagreement,

rather than addressing the topic of conflict only. The Domain approach, however, was more appropriate for teens who had moderate problem-solving abilities and were able to think conceptually.

On a final note, many families acknowledged satisfaction with their improved relationships in a tangible manner. I received numerous thankyou cards expressing appreciation, bottles of wine, pharmacy vouchers, and flowers. One teen baked a chocolate cake for me.

Overall Summary

Pre-treatment analysis showed that most families who attended treatment were experiencing very high levels of negative interaction and conflict with each other. Perceptions of the family environment were generally negative, and many individuals reported poor psychological well-being. Both parents and teens, however, reported having adequate problems solving skills.

Overall, teens viewed the family environment more negatively than parents did both before and after treatment, with post-treatment perceptions of cohesion and expressiveness being significantly lower than was reported by parents. Teens also rated their parents as being significantly less authoritative than parents did themselves, and perceived the parent-adolescent relationship to be significantly less positive than parents at pre- and post-treatment. Before treatment, parents and teens obtained similar scores on the Domains and Development Questionnaire, but after intervention, parents reported giving greater consideration to teen development and domain categories than teens did. Parents reported having significantly higher levels of problem-solving skills than teens both before and after treatment.

Discrepant perspectives between parents and teens at pre-intervention regarding authoritative parenting and the parent-adolescent relationship were related to higher conflict being reported by teens. At post-intervention, divergent perceptions about open expression of feelings was associated with teens reporting greater levels of conflict. Also, divergent reports regarding parental responsiveness towards teens were related to higher teen and parental conflict after treatment.

The relationship among measures remained relatively consistent between pre- and post-treatment. High conflict was associated with an organised, structured family environment characterised by set rules and procedures, low cohesion, and low authoritative parenting behaviours, where expression of feelings and independence was generally not encouraged. Teens' who reported having a negative relationship with their parent also reported experiencing high levels of conflict, but parents' perception of the parent-adolescent relationship was not related to conflict levels. Neither parent nor teen psychological well-being was related to conflict levels or the parent-adolescent relationship. Awareness of adolescent developmental tasks and parental authority based on the social-cognitive domain categories was related to expression of feelings, higher family cohesion, lower conflict, authoritative parenting behaviours, and positive parent-adolescent relationships by parents and teens. Parents who rated themselves as higher on authoritarian parenting style appeared to respond to the domain intervention approach less favourably than did authoritative parents. Problem-solving skills were associated with family members being encouraged to openly express their feelings, but not to the perceptions of the parent-adolescent relationship or to conflict levels.

Analysis showed a general trend of improvement for parents and teens in both treatment groups, with a greater commitment and support, and less expressed anger and conflict among family members. Parental responsiveness towards teens was also improved after treatment, and statistical analyses demonstrated that general perceptions of communication and dyadic interactions were significantly and reliably more positive for a large proportion of parents and teens. Increased awareness of problem-solving strategies and greater consideration of adolescent development and social-cognitive domain categories were apparent after treatment. Additionally, formal and informal evaluations of treatment were favourable.

While outcomes were positive for many families in both treatment groups, all individuals did not make progress. Information provided regarding family circumstances illustrates that variable response to treatment appeared to be more attributable to specific difficult family circumstances rather than to each intervention.

Statistical comparison of each group treatment did not reveal any differences according to teen age or gender, parent gender, religious affiliation, family composition, or dyad. However, teens' evaluations regarding acceptability of treatment and my evaluations of responsiveness during therapy differed according to adolescent age. Older teens in the Domain group rated treatment as more acceptable than younger teens did, which was consistent with my clinical observations and rating of older teens as being more responsive to the Domain intervention than younger teens were. Evaluations of treatment by adolescents in the Problem Solving group were not differentiated by age.

In summary, statistical procedures carried out demonstrated that the intervention approach designed to assist families increase their understanding of adolescent developmental tasks, and provide a framework for parental authority based on the social-cognitive development model was comparable with the more traditional problem-solving skills training approach. Furthermore, shared conceptions of adolescence and changing parental authority according to the social-cognitive domain categories were strongly associated with lower conflict and positive parent-adolescent relationships.

CHAPTER 5:
DISCUSSION AND CONCLUSIONS

This research project began with questions about an experience that is recognised as common in popular accounts of living together with teenagers in Western societies – namely conflict between teenagers and their parents. Because of physical proximity, shared tasks, and long-term commitments, most people would agree that conflict exists to some degree in many family relationships. But as outlined in the introduction, the actual severity and nature of conflict between parents and teens is not as universal as popular accounts would have us believe.

Adolescence is a period of growth and transition, however, characterised by a complex set of developmental tasks or demands through which individuals must pass in order to become competent, healthy young adults. Adolescents are confronted with adjusting to the physical changes of puberty and increased cognitive capacity, achieving increased independence from parents and family, developing appropriate social relationships with same and opposite-sex peers, completing academic requirements, preparing for an occupation, and developing a sense of identity and a set of values to guide their behaviour. This complex constellation of changes in the adolescent sets in motion a series of changes in the family and while some families experience disruption and minor disagreements during this process, others encounter more severe distress.

I reviewed evidence indicating that serious conflicts have negative sequelae for mental health that go beyond the specific areas of disagreement and can affect every aspect of family life. Although connections are generally correlational, severe parent-adolescent conflict appears to be destructive to

effective adjustment and negotiation of the developmental tasks, and jeopardises family relationships.

To date, research on parent-adolescent conflict has been conducted primarily with European-American middle-class families, and the generalisability of results to the New Zealand population has not been explored. The initial phase of this project therefore sought information from New Zealand families regarding their levels of conflict about specific topics. Relationships between conflict levels and demographic and family characteristics frequently associated with parent-adolescent conflict were examined. As parent-adolescent conflict appears to be symptomatic of a variety of serious adolescent problems, and has been linked with parental psychopathology, self-reports of psychological distress were also obtained. Another area that has received attention is the discrepancies in perceptions of decision making. Available data suggest that parents and their teens do not have similar views regarding decision making, so the perspectives of parents and adolescents were assessed to identify whether similarities and discrepancies that may exist influenced conflict levels.

Given the interest in adolescent adjustment and autonomy, and transformations in family relations during adolescence, surprisingly little attention has been given to how changes in adolescents' reasoning capabilities and developing social understanding affects family relationships and conceptions of parental authority. The development of social understanding was initially studied in large social systems (e.g., school). Research based on a domain model of social-cognitive development (Smetana, 1983, Turiel, 1983) showed children's social judgements develop in conceptually distinct domains: morality, or prescriptive understanding, structured by justice, welfare and rights of people;

social conventions, or behavioural uniformities that structure social interactions within social systems; and psychological concepts, or understanding of self and others. Smetana (1988b) asserts that changes in parent-adolescent relationships can be meaningfully understood within a social-cognitive framework that takes into consideration the ways in which teens and parents interpret their social worlds, because the family is a social system entailing hierarchical structures, patterns of authority, rules and conventions. Thus, conflicts between parents and teens can be characterised in terms of conflicts between domains of social judgements.

Research based on the domain model of social-cognitive development (Smetana, 1988b, 1989, Smetana et al., 1991a) has shown that teens and parents typically agree on the issues which cause conflict, but they interpret family rules and expectations in conceptually different ways. In particular, concepts of convention have been empirically distinguished from personal issues, which is one aspect of the psychological domain, and moral issues. Conceptual distinctions have been made regarding prudential issues, a further aspect of the psychological domain. Prudential issues pertain to acts that include safety, harm to the self, comfort and health. Parents and adolescents up to 18 years agree that parents should retain authority regarding moral and conventional domains, but they judge issues as belonging to different domains; this reflects the multidimensional nature of many events and the complexity of the social world. Findings obtained from hypothetical vignettes, and interviews with teens and their parents who described actual family conflicts and justified their position on the dispute, showed that perceptions of parental authority differed according to the type of act under consideration, and that teen personal reasoning increased with age, which suggests

discrepant perceptions of parental authority provided an explanation for increased conflict. For this reason, I examined adolescents and parents' thinking within the social-cognitive development framework.

To explore whether adolescents and parents in New Zealand families conceptualised issues according to social-cognitive domains, I developed a questionnaire that asked them to justify their position on specific issues along the lines proposed in the developmental research by Smetana. For the purposes of this research, four domain categories were used: moral, conventional, personal and safety (prudential). Each issue was rated according to the degree to which participants considered the issues belonged to the domain categories. The match or mismatch in parent and teen perspectives was then examined in relation to reported conflict.

The initial phase of the project established the utility of the four conceptual domains in terms of responsibility for decision making. Issues were categorised by parents and teens as belonging to different domain categories. More specifically, overall, parents rated issues as belonging more to the safety and moral domains than to the conventional and personal domains, while teens categorised issues more often as belonging to the personal and safety domains than to the moral or conventional domains. Categorisation of issues by New Zealand parents differed from previous research that showed parents were more likely to reason about conflicts and regulating their teen's behaviour as conventional, whereas adolescents in previous research and in this study generally treated issues as belonging to their personal jurisdiction (Smetana, 1988a, Smetana & Asquith, 1994, Smetana et al., 1991a). Further, from early- to mid-adolescence, teens became increasingly likely to reason about issues in terms of

personal choice, but parents did not demonstrate similar changes, which is a pattern that has also been evident in Smetana's series of studies. The main finding was that, in these New Zealand families, the social-cognitive domain model provided a better framework for understanding parent-adolescent conflict than did decision-making patterns as discrepant perspectives on who does, and who should, make decisions about the issues addressed in this aspect of the research did not provide an explanation about conflict levels reported. Discrepant categorisation of issues to domain categories was, however, related to higher frequency and anger-intensity of discussions.

Findings also showed that conceptualisation of issues and levels of conflict differed according to parenting style. Authoritarian parents reported higher levels of conflict and rated fewer issues as belonging to adolescent jurisdiction than did authoritative or permissive parents, which was anticipated according to an earlier study that examined the relationship between parenting styles and conceptions of parental authority (Smetana, 1995). Perceptions of the quality of the parent-adolescent relationship were also related to parenting style and conflict levels in the expected direction (Hall & Bracken, 1996; Noller & Callan, 1991). That is, authoritative parenting was associated with more positive perceptions of relationships and lower levels of conflict compared to authoritarian parenting.

The survey questionnaire study also revealed some other important findings regarding conflict in New Zealand families. For instance, results were consistent with previous research indicating that parent-adolescent conflict generally occurs over everyday details of family life, such as doing chores, keeping one's bedroom tidy, regulating activities, and doing homework (Barber, 1994; Smetana, 1989; Smetana, et al., 1991c). Female parents reported discussing

more issues than male parents did, which has been found elsewhere probably because mothers are more involved in regulating everyday details of family life (Montemayor, 1982; Smetana, 1989). To some extent this replicated studies carried out in the United States, and it is interesting that despite differences between American and New Zealand cultures, the nature of adolescence in modern industrial societies, and the sharing around the globe of teenage values, ideas, and icons, etc, results in a high level of commonality regarding topics of conflict. The strong relationship revealed between conflict and psychological well-being in adolescents, however, indicates that conflict about everyday issues is not trivial, and highlights the importance of developing effective treatment strategies to address conflict in families when adolescents are referred to mental health clinics.

Taken together, results from the survey study support the relationship between developmental changes in adolescents' social understanding and construction of expectations and responsibilities, which provides a method for analysing judgements in multifaceted situations and for understanding family conflict. In turn, this means the domain model of social-cognitive development has implications for clinical practice.

Contemporary best practice in cognitive behaviour therapy for treatment of parent-adolescent conflict derives from the empirical work carried out in a series of studies by Foster and Robin (Foster & Robin 1988; Robin & Foster, 1989). Their model relies heavily on a focus on the topic central to the conflict, which is in contrast to the global and content free authoritative parenting style described in terms of responsiveness and demandingness (Baumrind, 1971, 1989). It is recognised that treatment approaches for parent-adolescent conflict are not

complete, which points to the need to design more sophisticated intervention programmes. Additional information derived from the social-cognitive developmental psychology perspective suggests that gains in understanding family relations could be made by going beyond the specific issue causing conflict to recognising different domain considerations. It appears that conflicts occur when adolescents' attempts to assert their autonomy compete with parents' standards and goals of regulating the household and maintaining authority. Such findings indicate that the specific topic is somewhat less important than the fact that conflicts occur over what issues teenagers consider fall into what categories, and shifts in legitimate parental authority taking place in some domains but not in others. Discussion of specific topics of conflict, therefore, rather than considering parental versus teen jurisdiction in terms of domain categorisation of issues, may explain why many family conflicts are unresolved and repetitive.

To assess whether these constructs could be used in treatment, an exploratory treatment study was designed and conducted as the final stage of the research project. One could argue that neither one approach nor the other is mutually exclusive, and therefore in actual practice likely to be done together. Since the Domain oriented intervention is novel, however, it seemed prudent to initiate research at the level of asking whether providing a strategy to assist teens and parents in articulating their reasoning in the context of social-cognitive domains was at least as good as the standard cognitive-behavioural approach. While this leads to an uncomfortable research design in that two approaches are being compared which are both likely to be successful, there was not an obvious alternative available to establish the suggested utility of the Domain approach. Two therapeutic protocols were therefore designed, one representing the

traditional cognitive-behavioural therapy approach of focusing on problem-solving skills, and the other focusing more on insight regarding the interplay between social-cognitive development, parental authority and adolescent autonomy.

Families were recruited to the study by informing schools and community agencies about the research project being undertaken and that treatment was available for parents and teens experiencing conflict. Twenty-six families participated in treatment, thirteen in each intervention approach. It was somewhat surprising that more families did not self-refer for therapy, but this may be a reflection of parent-adolescent conflict being viewed as inevitable and something families just have to deal with. Many interesting observations were made, however, during the course of working with the participating families.

First, teens tended to perceive the family environment and family relationships more negatively than did parents. Similar to other studies (Barnes & Olson, 1985; Kashani, et al., 1995; Moos & Moos, 1986; Prange et al., 1992) high levels of conflict were associated with negative family environments characterised by low levels of cohesion where family life was run by rules and procedures, and open expression of feelings and independent decision making were not encouraged. Greater conflict was also associated with a lower frequency authoritative parenting behaviours, and teens perceiving parents as not being responsive toward them, which has been previously alluded to in terms of mutual respect, with teens disobeying their parents and being rude when parents are controlling, critical, and fail to acknowledge their teens (Youniss & Smollar, 1985).

Second, negative communication and deficient problem-solving skills have been reported by, and observed in, parents and teens referred for treatment of relationship issues (Robin & Weiss, 1980, Vincent-Roehling & Robin, 1986). Yet among the parents and teens who attended this treatment programme, high conflict levels were associated with negative communication and interactions, but not with self-reported knowledge and utilisation of problem-solving skills.

Third, the study was designed primarily to elicit what one might call a subclinical population, but the reality was that some family problems emerged that were comparable to those seen in general clinical practice, which corresponds with literature that clearly indicates many clinically referred families experience high levels of conflict (Barkley et al., 1992a, 1992b; Hanson et al., 1984; Mann et al., 1990; Sanders et al., 1992). In addition, the families varied greatly in the structure and dynamics of the family unit, and these differences had to be accommodated when implementing the treatment. Thus, I often had to make strategic decisions during therapy that had not been anticipated in the original design of the protocols, some of which have been described in the clinical impressions section in Chapter 4. This circumstance is often raised in psychotherapy outcome literature that critically analyses treatment outcome research and current efforts to manualise clinical practice. For example, Eifert, Evans and McKendrick (1990) assert that random assignment of clients to treatment groups has led to neglect of individual differences between persons, and treatment packages are no substitute for treatment individualisation. Drozd and Goldfried (1996) have also proffered the argument that empirically validated manualised treatments may not match the dynamics in any particular case in clinical practice, and do not capture the complexity of clinical phenomenon. Due

to the necessity of following treatment protocols in order to evaluate the utility of each intervention approach, however, the therapeutic techniques independent to each protocol were adhered to, even when attention was given to meeting the additional needs of some individual clients.

With the above proviso in mind, there was a critical ingredient that had to be in place before any change plan could be implemented. Robin and Foster (1989) have documented that they learned from their clinical experiences that parents and teenagers referred for relationship problems did not behave in a reasonable logical manner, and negative communication behaviours interfered with verbal problem-solving discussions. For this reason all families, regardless of group, received an initial session in communication skills. Because of the high levels of conflict and serious problems being experienced among the families, intense negative interactions were frequently displayed during initial sessions, and the communication skills had to be rehearsed and re-emphasised on many occasions throughout treatment.

Now I come to the central issue of this part of the research – did either or both the interventions appear to reduce conflict levels and improve family relationships? I addressed this question by using both standard, formal approaches used in prior treatment outcome research, as well as a less formal, and subjective impressions based on my experience as the primary and indeed only clinician for the two groups.

On the formal analysis, the findings were, in general, both treatments led to changes and similar improvements, and a high percentage of parents and teens reporting improvements after treatment at an individual level. I did not make predictions regarding the differential effectiveness of Problem Solving training

and Domain and Development training. Yet the few statistically significant differences between these two treatment groups that emerged for improved communication and lower conflict tended to favour the parents in the Problem Solving group and teens in the Domain and Development group. More detailed comparisons of change between pre- and post-intervention for individuals from each group showed that a similar proportion of parents and teens from the Domain group reported improvements, whereas in the Problem Solving group fewer teens reported improvements compared to the parents. Following treatment, the largest proportion of those who described outcomes that had not improved was teens from the Problem Solving group. Of particular note was that, overall, lower conflict was associated with greater consideration being given to adolescent developmental level and differentiated parental authority according to social-cognitive-domain categories, whereas problem-solving skills were not associated with conflict levels.

It could have been reasonably anticipated, based on previous research findings, that outcomes would be differentiated according to demographic characteristics. This, however, was not generally the case. No differences regarding response to treatment emerged according to family composition. This was inconsistent with research that has indicated family functioning differs in two-parent, one-parent, and blended families, with one-parent families being less hierarchical, more permissive and less controlling and that their adolescents have more independence and responsibility in decision making than do adolescents from married families (Hetherington, 1989; Smetana, et al., 1991c).

More mothers than fathers did attend treatment, which may either correspond with research that has shown parent-adolescent conflict is more

frequent between mothers than fathers (Smetana, 1989, Youniss & Smollar, 1985), or alternatively reflect greater willingness by mothers to actually attend treatment. However, change between pre- and post-treatment did not differ according to either parent or teen gender.

While statistical analysis indicated that adolescent age did not influence response to treatment for each group, participant evaluations revealed that middle adolescents found the Domain intervention more acceptable than early adolescents, which was consistent with therapist evaluations of older teens being more responsive to the Domain treatment. Different responsiveness to the Domain approach is in accord with literature that describes characteristic social cognitive development in terms of emerging mutual perspective taking and the ability to approach problems more flexibly (Atwater, 1996).

Inevitably there are some limitations in the formal measures used, but on the more subjective front, my impressions generally matched those found by the formal results. All the families were aware that two different treatment approaches were being evaluated, but none expressed dissatisfaction during the course of therapy and asked for information or skills from the alternative approach to be provided to them. Few families took the opportunity to meet with me and get information and materials about the other group after post-treatment assessment was completed, which generally reflected satisfaction with the treatment approach received and with improvements made during therapy. My observations did indicate, however, that variation between individual participants in both treatment groups appeared to be influenced more by extremely difficult family circumstances than by each intervention approach in most cases. The exception to this was that younger teens with less advanced cognitive processes, and limited

problem solving awareness, were somewhat less responsive to the Domain approach.

Social conventions, which play an important role in understanding parent-adolescent conflict, may vary from one family to another or from one culture to another and this research did not provide evidence that there is cross-cultural applicability of domain distinctions. Social conventions, however, are defined as arbitrary and agreed-on behavioural uniformities that coordinate the interactions of individuals within different social systems (Smetana, 1991c). As such, the domain model of social-cognitive development provided for individual family variations, and may therefore assist families in other cultures by providing a framework for understanding variations in perspectives, irrespective of whether the authority patterns within a family encourage independence and autonomy or conformity.

Recent models of treatment outcome suggest that client (or client families) might be placed on some kind of trajectory by formal psychological intervention, so that the results seen at the end of treatment may only anticipate continued developments and improvements. I was not able to conduct a long term follow up, but in terms of the informally reported progress, it is clear that some families continued to make positive changes and maintained relationship improvements, sometimes with interesting variations. For example, I met with one of the male teenagers approximately six months after therapy who talked enthusiastically about the *great friendship* he and his mother had. They were no longer living in the same house, but he believed that they had reached that decision amicably as a direct result of what they had learned when attending treatment, and that they both now valued and enjoyed their relationship in a way they were not able to

previously. On the other hand, others who exhibited more serious mental health concerns have sought further assistance.

From these general findings I conclude that the Domain and Development approach was at least as good as an empirically validated standard approach in terms of helping families deal with persistent conflict. Furthermore, I have argued that the Domain approach has additional benefits in terms of giving the families some principals of wide generality that they can use in the future as new and unforseen difficulties emerge. While there is suggestions that these will be used this way, the current data do not unequivocally support such a claim and this might be an area for useful future research.

Since both protocols have value, the recommendation to clinicians working in this area is to implement both and not to separate them in the artificial way required by the present research design. Combining the two approaches would ensure individuals have the fundamental building blocks necessary for effective management of disagreements, and they would also have a means of understanding the underlying cause of conflict and ongoing changes that occur in parent-adolescent relationships regarding legitimate boundaries of parental authority.

In turn, this raises some interesting questions regarding what it is exactly that is being validated in treatment research. Evans (1996, 1999) argues that empirical studies validate theory, not technique, and specific tactics used are less important than the principles that are used to guide intervention. I would argue that what is being validated in this research is a rather broad or abstract principle, based on processes considered to be involved in the development of the problem, providing strategies for allowing teens and their parents to understand and

negotiate their conflict. Within these broad strategies, there may be more specific skills that are required, such as communication, and problem solving, since without this type of infrastructure, insight alone regarding shared conceptions of adolescence and the true nature of what underlies conflict cannot lead to resolution of difficulties. The lesson for therapists in the future, therefore, might be, as others have recently been arguing, that a validated treatment is not so much the uncritical application of a manualised protocol, but the implementation of a set of strategic principals whereby change can be negotiated in families. Families need the skills and the ability to listen and to communicate, to express needs and feelings, and they also need greater insight regarding the complex issues of family values, autonomy and control, and who decides what represents the essence of this particular family.

Given that broad conclusion, it seems that the overall ideas of the Domain approach, linking developmental principles with practical applications are of considerable value to clinicians and in my own recent work I find myself using these ideas quite routinely as I approach family difficulties. It is hoped that other clinicians reading and using these principles will find similar positive results.

I conclude with the saying that I gave to all families at the end of treatment.

There ain't no good guys

There ain't no bad guys,

There's only you and me,

And sometimes we just disagree.

Dave Mason

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Appendix A

Advertisement Placed on Psychology Department Research Noticeboard to Recruit Participants for Focus Group Discussions

DISCUSSION GROUPS

- FOR TEENAGE STUDENTS
- FOR PARENTS WITH TEENAGE CHILDREN

We are running some pilot research to investigate how teenagers report having handled conflict with their parents, and how parents report their teenage children handle conflict with them. In particular we will be exploring whether communication / conflict resolution skills known by teenagers are used and, if not, reasons why this may be the case.

To take part all you need to do is come along and participate in a two hour discussion (which will give you a 2% course credit for either 18.102 or 18.103).

- **there are no right answers**
- **the purpose of the group is to talk**
- **we are interested in your experiences, opinions, and ideas**

Format

- Participants will be asked to think back to two recent conflict situations
  - one that was resolved satisfactorily
  - one that was not resolved satisfactorily

- Participants will then be invited to share their experiences with the group, looking at the differences between these two situations

Everyone will have the right NOT to talk about or discuss anything that they don't feel comfortable with.

If you are a teenager, or the parent of teenage children, and wish to take part, please put your name on the list below at a time that is suitable to you.
We anticipate having 6-8 people in each group.

ALL INFORMATION PROVIDED DURING GROUP DISCUSSIONS WILL BE TREATED AS CONFIDENTIAL

Information Provided to Participants Regarding Procedure for Focus Group Discussions

INFORMATION TO PARTICIPANTS

(discussion groups for teenagers)

Adolescence is a period in which many parent-child conflicts arise. As parent-adolescent conflict can be viewed as the result of skill deficits, the teaching of problem solving and appropriate communication skills is often seen as a viable form of intervention. This approach assumes that teens with family problems lack positive coping abilities. However, the degree of coping skill knowledge has not previously been investigated in a rigorous way, and the relationship between use of effective and appropriate coping skills and undesirable behaviours during conflict is not well understood.

A doctoral research project is currently being undertaken by myself in the Clinical Psychology Research Laboratory at the University of Waikato to investigate the relationship between knowledge of coping skills and conditions that might interfere with access to those skills (e.g. emotional conditions or family barriers).

Purpose of Discussion Groups

We are conducting these pilot discussion groups to investigate how teenagers report having handled conflict with their parents. In particular we will be exploring whether communication / conflict resolution skills known by teenagers are used, and if not, reasons why this may be the case.

Format

The group will be run by Marie Connelly, and Ian Evans or a Masters Level Clinical Psychology student. Our job will be to explain the purpose of the discussion to the group and facilitate the discussion.
PARTICIPANTS WILL BE INVITED TO ASK US QUESTIONS

- Confidentiality issues will be discussed and agreed to by participants, and consent forms will be signed.

- Each participant will be asked to think back to two recent conflict situation that occurred with one or both of their parents
  - one that was resolved satisfactorily
  - one that was not resolved satisfactorily.

- Participants will then be invited to share their experiences with the group, looking at the differences between these two situations.

General

- The group will be made up of 6-8 first year psychology students who are teenagers.

- Everyone will have the right NOT to talk about or discuss anything that they don't feel comfortable with

- Participants have the right to withdraw from the discussion at any time

- Information gathered in the discussion group will be treated as confidential. What is said in the discussion group may be summarised in a report, but individual names will never be used.

- The researchers, supervisors and assistants involved in the research have been asked not to disclose the names of participants involved

Your participation and cooperation in conducting this pilot research is greatly appreciated. If you have any queries, or require any further information, please do not hesitate to contact me.

Marie Connelly
Room: K1.04
Phone Extension: 8040

Consent Form Used for Participants in Focus Group Discussions

PARTICIPATION CONSENT FORM: Participant's Copy

Name of Research Project: Pilot discussions to investigate how adolescents report handling conflict with their parents

Name of Researcher: Marie Connelly

I have received an information sheet about this study or the researcher has explained the study to me. I have had a chance to ask any questions and discuss my participation with other people. Any questions have been answered to my satisfaction.

I agree to participate in this research project and I understand that I may withdraw at any time.

Signature:

Printed name:

Date:

---------- CUT HERE

PARTICIPATION CONSENT FORM: Researcher's Copy

Name of Research Project: Pilot discussions to investigate how adolescents report handling conflict with their parents

Name of Researcher: Marie Connelly

I have received an information sheet about this study or the researcher has explained the study to me. I have had a chance to ask any questions and discuss my participation with other people. Any questions have been answered to my satisfaction.

I agree to participate in this research project and I understand that I may withdraw at any time.

Signature:

Printed name:

Date:

Appendix B

Letter to Classroom Teachers

School of Social Sciences
Psychology Department
The University of Waikato
Private Bag 3105
Hamilton, New Zealand

Marie L. Connelly
Clinical Research Laboratory
Telephone 64-7-856 2889 Ex.8040
Facsimile 64-7-856 2158
Email mlc2@waikato.ac.nz

The University of Waikato
Te Whare Wānanga o Waikato

[date]

The Form Teachers of Students in Forms 3, 4, and 5
[School name and address]

Dear Teachers

Your school principal, ... has given us permission to ask you if you are willing to invite students in your classroom to be involved in our research project.

The research is about what leads to, or increases, conflict between teenagers and their parents or caregivers, and in particular what factors may prevent teenagers from using coping skills they are aware of. For the current aspect of the research, we are specifically interested in decision making, the influence that parenting style has on reasoning during disagreements, adolescent's reasoning, and the relationship between the parents and the teenagers, and how these themes relate to levels of conflict actually experienced and outcomes for adolescents. The purpose of the research and an outline of the procedure are presented in the invitation to participate.

We would like your help in the following ways:

a) Distribute an invitation to participate to all the students in your class and ask them to take it home and inform parents or caregivers.

b) Encourage students to give serious consideration to participating - please emphasise that it is an opportunity for them to have their say.

c) Point out to students that both sections of the consent form need to be completed for them to be eligible for the draw, that is, one teenager and one parent or caregiver must complete the consent form.

d) Inform the students that we would prefer one teenager and one parent or caregiver from each family to complete the questionnaires. However, if only one family member is willing to participate, we would still appreciate the questionnaires being completed by that person.

e) Remind students a couple of days after receiving the invitation to return the consent form to the box at the school office if they haven't already done so - whether they are willing to participate or not - so they will be in the draw for a music voucher or movie passes.

We would greatly appreciate your assistance, and hope that this will not take up very much of your time. If you would like a copy of the research findings please fill out form below. If you have any questions or require further information about the research, please contact us at the above phone number or address.

Thanks your help.

Yours sincerely,

Marie L. Connelly
Clinical Psychology Trainee, PhD Candidate

Ian M. Evans
Professor of Psychology

✂----------

When the project is over I would like to receive information about the research findings.

Name: [please print].....Signed:.....

Address: [please print].....

Letter to School Board of Trustees

School of Social Sciences
Psychology Department
The University of Waikato
Private Bag 3105
Hamilton, New Zealand

Marie L. Connelly
Clinical Research Laboratory
Telephone 64-7-856 2889 Ex.8040
Facsimile 64-7-856 2158
Email mlc2@waikato.ac.nz

The University of Waikato
Te Whare Wānanga o Waikato

[date]

The Board of Trustees
[School name and address]

Dear Board Members

Last week I met with your school principal, to talk about my doctoral research project. He asked me to present an outline of this research to the Board as he gave permission for the teachers in your school to be asked if they are willing to distribute a brochure inviting students in their classrooms to be participants. Participation in the research will not take place during school time. Students will not be sent questionnaires unless a consent form signed by both the teenager and their parent or caregiver is received.

My research is investigating the relationship between positive coping skills and negative behaviours within the framework of parent-adolescent conflict. Adolescence is a period in which parent-child conflict is widely reported. Not only is conflict unpleasant for all family members, but it may place adolescents at risk for emotional and behavioural problems. As parent-adolescent conflict is often viewed as the result of skill deficits, the teaching of problem solving and appropriate communication skills is seen as a viable form of intervention. Although the value of teaching skills has been demonstrated, there are serious limits to the success of this approach. This may be because teenagers not so much lack positive skills, but lack the ability to access known skills. During the course of the research, factors that will be investigated are the relationship between the level of knowledge of coping skills an individual has, their negative conflict behaviours, emotional conditions that might interfere with the utilisation of coping skills, and family patterns that might prevent their use.

For the current aspect of the research, we are seeking information from the general New Zealand community concerning family patterns regarding decision making (actual and ideal), adolescent's reasoning about issues that frequently lead to disagreements, the influence that parenting style has on reasoning during disagreements, the relationship between teenagers and their parent or caregiver,

and how these themes relate to levels of conflict actually experienced and outcomes for adolescents. Disagreements in families are not uncommon. Sometimes outcomes are harmless, sometimes they are serious. We believe information gained from these questionnaires will be helpful in identifying what factors make the difference which will be valuable when assisting families who are experiencing high levels of conflict with serious outcomes for teenagers.

For your information I have enclosed the brochure inviting students and their parent or caregiver to participate which outlines the purpose of the research and the procedure, and a letter to teachers. I have also enclosed a set of questionnaires that will be sent to those who agree to be participants in this research project.

If you have any queries, or would like further information, please do not hesitate to contact me at the above address. A summary of findings will be sent to you for your information when the project is over.

Yours sincerely,

Marie L. Connelly
Clinical Psychology Trainee, PhD Candidate

Ian M. Evans
Professor of Psychology

Consent Form

I have read and understood the description of the research project. I have had a chance to ask any questions and discuss my participation. Any questions have been answered to my satisfaction. I understand I may withdraw at any time.

ADOLESCENT - please tick appropriate box

☐ female ☐ male

I agree / do not agree to participate in this research project.

Signature:.....

Printed name:.....

ADULT - please tick appropriate boxes

☐ female ☐ male ☐ parent ☐ caregiver

I agree / do not agree to participate in this research project.

Signature:.....

Printed name:.....

Address:.....

.....

Date:.....Phone:.....

Both adolescent and adult sections must be completed to be eligible for the draw

When the project is over we would like a summary of the research findings sent to the above address.

☐ Yes ☐ No

Cut Here

Your participation in this research will be greatly appreciated

This research is being conducted by Marie Connelly, a doctoral student in the Clinical Psychology Research Laboratory at the University of Waikato, supervised by Professor Ian Evans.

The ethical review committee at the University of Waikato has approved the research.

If you have any queries, or require any further information, please do not hesitate to contact me.

Marie Connelly
phone: (07)838-4466 Ext. 8040
[with 24 hour voice mail]
e-mail: mlc2@waikato.ac.nz

Invitation to Participate

Research about teenagers in New Zealand families

Disagreements in families are not uncommon

- ❖ sometimes disagreements are harmless
- ❖ sometimes outcomes are serious

WHAT MAKES THE DIFFERENCE?

You can help answer this question

- We would like one teenager and one parent or caregiver from your family to assist in this research by completing some questionnaires.
- The questionnaires explore what issues lead to disagreements, decision making, reasoning about these issues, parenting style, and how these themes may relate to levels of conflict and outcomes for adolescents.

Why is this important?

- ♦ Adolescence is a time of change which sets the stage for increased conflict.
- ♦ Conflict may place teenagers at risk.
- ♦ High levels of conflict are unpleasant and may impact all family members.
- ♦ More information about what contributes to different outcomes will help with assisting families who are experiencing high levels of conflict with serious outcomes.

What do you do to participate?

- Fill out the attached consent form and return it to school.
- Two sets of questionnaires will be posted to you - one for the teenager, one for the parent or caregiver.
- The questionnaires will take less than one hour to complete.
- They can be completed in your own home to ensure confidentiality and convenience.
- The researcher will be available to answer any questions, or meet with you if you want assistance with completing the questionnaires.
- Two freepost envelopes will be provided to return questionnaires separately.
- You will have the right to withdraw from the study at any time.

What will happen to the information?

- All information will be confidential.
- Names will not be recorded.
- No information will be reported that could identify any individual person or family.
- A summary of findings will be available for your information.

Be in to win !!!!

Every consent form returned

goes in a draw

(whether you agree to participate or not)

One draw per two classrooms

If your consent form gets drawn you can choose **one** of the following prizes

- ➢ **$30 music voucher (value of 1 CD)**
- ➢ **or two tickets to the movies**

Please note that if you do not want to participate, it will not effect your relationship with the school or the University of Waikato in any way.

Research about teenagers
in New Zealand families

RETURN CONSENT FORMS HERE

Remember:
Both adolescent and adult sections of the consent form
must be completed to be eligible for the draw.

Appendix C

Self-Report Measures Developed or Adapted for Survey Study

Thank you for agreeing to complete these questionnaires

This set of questionnaires is for the teen

Please read these notes

- To make sure your responses remain confidential, we do not want your name on these questionnaires.
- The questionnaires are numbered so teenager and parent or caregiver responses can be matched for data analysis.
- You do not need to compare your responses with your parent - questionnaires can be completed individually.
- Two envelopes have been provided for you and your parent to return your questionnaires separately.
- The first section seeks some demographic information. Later pages ask about decision making, reasoning, disagreements, parenting style, relationship and general health.
- If you have any questions or concerns, or would like assistance with completing the questionnaires, please contact me at 838-4466 ext. 8040 or Mobile 0800-277-003 (with 24 hour voice mail).
- We emphasise that there are no right or wrong answers, and disagreements within families are not unusual. However, if the items raise any concerns for you, please feel free to contact me or your school counsellor.
- When you have completed the questionnaires, place them in the freepost envelope provided and return them to the researcher.

To acknowledge our appreciation of your time - all completed questionnaires will go in a draw to win $100.

Two draws will be made - one for teenage participants, one for the parents and caregivers.

Demographics

1. **You indicated on your consent form that you are a female adolescent, and questionnaires will be completed by you and your mother.**
   Is this correct? ☐ **Yes** ☐ **No**

   If no, please detail correct information.....

   If no, the wording of some questionnaire items will not match your gender and/or relationship, but the meaning of each item is the same. You may either continue or contact me and I will send you another set of questionnaires.

2. **How old are you?** (*in years and months, e.g., 14 yrs 3 mths)*.....

3. **What cultural / ethnic group do you belong to?** (*tick one)*
   - ☐ New Zealand Maori
   - ☐ New Zealand European / Pakeha
   - ☐ Pacific Islander *(please detail)*.....
   - ☐ Other (*please detail)*.....

4. **What is your current religion?** (*tick one)*
   - ☐ Anglican
   - ☐ Catholic
   - ☐ Baptist
   - ☐ Hindu
   - ☐ No religion
   - ☐ Other *[please detail]*.....
   - ☐ Presbyterian
   - ☐ Methodist
   - ☐ Buddhist
   - ☐ Muslim

5. **Please list the people who live in your house - and give their relationship to you.**

Relationship to You (names are not needed)	**Their Age** (say "about" if you are not sure)
e.g. mother	*38*
step-father	*39*
brother	*12*

(Please continue on the back of this page if you need more space)

Decision Making

- This questionnaire includes a number of issues that often get talked about at home. We would like to know who in your family makes a decision about these issues.
- Please circle each of the following statements the way it applies to you best most of the time.
- There are no right or wrong answers.
- Please answer every item.

EXAMPLE:

a	I decide myself whether I smoke.	YES	NO

- If you think the statement applies to you, or applies to you best in most cases, put a circle around the yes
- If you don't smoke because you don't want to - still put a circle round the yes because you have made that decision yourself.
- If you want to smoke, but don't because your mother has made the decision about your smoking, put a circle round the no

b	My mother feels I should **not** smoke.	YES	NO

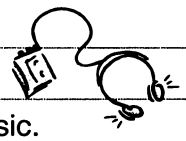
- If your mother feels you should not smoke, put a circle round the yes
- If your mother does not mind whether you smoke or not, put a circle round the no

c	I think teenagers my age should be able to decide for themselves about smoking.	YES	NO

- If you think teenagers your age should be able to decide for themselves about smoking, put a circle round the yes
- If you think your mother should make the decision about smoking for teenagers your age, put a circle round the no

c	I think teenagers my age should be able to decide for themselves about smoking.	YES	NO

- If you want to correct an answer, cross out the circle you want to correct and put a circle round the other answer.



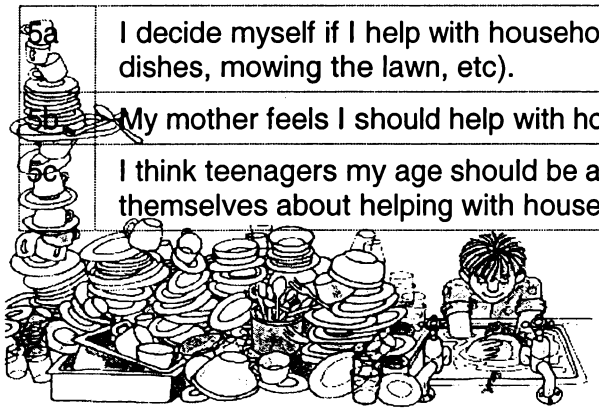
1a	I decide myself what music I listen to.	YES	NO
1b	My mother feels I should **not** listen to certain music.	YES	NO
1c	I think teenagers my age should be able to decide for themselves about what music to listen to.	YES	NO

2a	I decide myself whether to get involved in things like stealing or vandalism.	YES	NO
2b	My mother feels I should **not** get involved in things like stealing or vandalism.	YES	NO
2c	I think teenagers my age should be able to decide for themselves about getting involved in things like stealing or vandalism.	YES	NO

3a	I decide myself how much time I spend talking on the phone (when no one else wants to use it).	YES	NO
3b	My mother feels I should spend only a certain amount of time on the phone.	YES	NO
3c	I think teenagers my age should be able to decide for themselves about how much time to spend talking on the phone.	YES	NO

4a	I decide myself what clothes I wear.	YES	NO
4b	My mother feels I should **not** wear certain clothes.	YES	NO
4c	I think teenagers my age should be able to decide for themselves about what clothes to wear.	YES	NO

5a	I decide myself if I help with household chores (e.g. doing the dishes, mowing the lawn, etc).	YES	NO
5b	My mother feels I should help with household chores.	YES	NO
5c	I think teenagers my age should be able to decide for themselves about helping with household chores.	YES	NO



6a	I decide myself if I wear a bike helmet.	YES	NO
6b	My mother feels I should wear a bike helmet.	YES	NO
6c	I think teenagers my age should be able to decide for themselves about wearing a bike helmet.	YES	NO

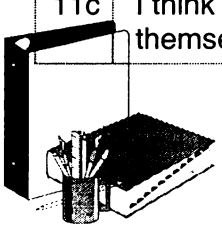
7a	I decide myself how I look regarding my hairstyle.	YES	NO
7b	My mother feels I should **not** have certain hairstyles.	YES	NO
7c	I think teenagers my age should be able to decide for themselves about the way their hair looks.	YES	NO

8a	I decide myself what table manners I use at meal times.	YES	NO
8b	My mother feels I should observe certain table manners.	YES	NO
8c	I think teenagers my age should be able to decide for themselves about how to behave at meal times.	YES	NO

9a	I decide myself about how I talk (including use of swear words).	YES	NO
9b	My mother feels I should **not** swear.	YES	NO
9c	I think teenagers my age should be able to decide for themselves about how to talk.	YES	NO

10a	I decide myself whether to hit other people.	YES	NO
10b	My mother feels I should **not** hit other people.	YES	NO
10c	I think teenagers my age should be able to decide for themselves about whether to hit other people.	YES	NO

11a	I decide myself how much time I spend on my homework.	YES	NO
11b	My mother feels I should spend more time on my homework.	YES	NO
11c	I think teenagers my age should be able to decide for themselves about how much time to spend on homework.	YES	NO



12a	I decide myself whether I have a space to keep private things, which will **not** be looked at by anyone else.	YES	NO
12b	My mother feels I should **not** have a space to keep private things.	YES	NO
12c	I think teenagers my age should be able to decide for themselves about whether to have a space to keep private things.	YES	NO

13a	I decide myself where I am going when I go out.	YES	NO
13b	My mother feels I should **not** go to certain places.	YES	NO
13c	I think teenagers my age should be able to decide for themselves about where to go when going out.	YES	NO

14a	I decide myself whether I smoke.	YES	NO
14b	My mother feels I should **not** smoke.	YES	NO
14c	I think teenagers my age should be able to decide for themselves about smoking.	YES	NO

15a	I decide myself who my friends will be.	YES	NO
15b	My mother feels I should **not** go around with certain friends.	YES	NO
15c	I think teenagers my age should be able to decide for themselves who to have as friends.	YES	NO

16a	I decide myself on the amount of lollies or chocolate I eat.	YES	NO
16b	My mother feels I should **not** eat a large amount of lollies or chocolate.	YES	NO
16c	I think teenagers my age should be able to decide for themselves about the amount of lollies or chocolate they eat.	YES	NO

17a	I decide myself what I do and don't do concerning boy friends.	YES	NO
17b	My mother feels I should **not** be too involved with boy friends.	YES	NO
17c	I think teenagers my age should be able to decide for themselves about boy friends.	YES	NO

18a	I decide myself what sports or hobbies I take part in.	YES	NO
18b	My mother feels I should **not** take part in certain sports or hobbies.	YES	NO
18c	I think teenagers my age should be able to decide for themselves about what sports or hobbies to take part in.	YES	NO

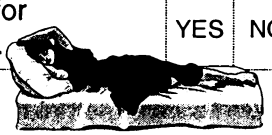
19a	I decide myself what time I come home at night.	YES	NO
19b	My mother feels I should come home at a certain time at night.	YES	NO
19c	I think teenagers my age should be able to decide for themselves about what time to come home at night.	YES	NO

20a	I decide myself whether I call adults by their first names.	YES	NO
20b	My mother feels I should **not** call adults by their first names.	YES	NO
20c	I think teenagers my age should be able to decide for themselves about calling adults by their first names.	YES	NO

21a	I decide myself how much alcohol I drink.	YES	NO
21b	My mother feels I should **not** drink too much alcohol.	YES	NO
21c	I think teenagers my age should be able to decide for themselves about drinking alcohol.	YES	NO

22a	I decide myself whether to keep promises.	YES	NO
22b	My mother feels I should keep promises.	YES	NO
22c	I think teenagers my age should be able to decide for themselves about keeping promises.	YES	NO

23a	I decide myself what time I get up at weekends.	YES	NO
22b	My mother feels I should **not** sleep late at weekends.	YES	NO
23c	I think teenagers my age should be able to decide for themselves about what time to get up at weekends.	YES	NO



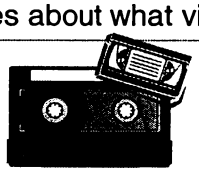
24a	I decide myself how tidy my bedroom will be.	YES	NO
24b	My mother feels I should keep my bedroom tidy.	YES	NO
24c	I think teenagers my age should be able to decide for themselves about how tidy their bedroom is.	YES	NO

25a	I decide myself whether to have my ears, nose, eyebrow, or lip pierced.	YES	NO
25b	My mother feels I should **not** have certain parts of my body pierced.	YES	NO
25c	I think teenagers my age should be able to decide for themselves about what parts of their body to have pierced.	YES	NO

26a	I decide myself whether I use drugs.	YES	NO
26b	My mother feels I should **not** use drugs.	YES	NO
26c	I think teenagers my age should be able to decide for themselves about using drugs.	YES	NO

27a	I decide myself whether to be honest with my mother.	YES	NO
27b	My mother feels I should be honest with her.	YES	NO
27c	I think teenagers my age should be able to decide for themselves about being honest with their mother.	YES	NO

28a	I decide myself what videos I watch.	YES	NO
28b	My mother feels I should **not** watch certain videos.	YES	NO
28c	I think teenagers my age should be able to decide for themselves about what videos to watch.	YES	NO



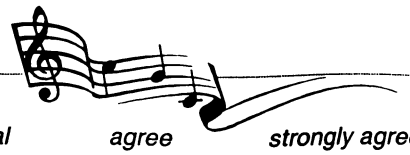
Reasoning

- Below are a number of issues often discussed in families, with four reasons that may be given when making a decision about that issue.
- Circle the comment that shows how strongly you agree or disagree with each reason ***when making a decision with regard to yourself.***
- There are no right or wrong answers, so don't spend a lot of time on any one reason. We are looking for your overall impression.
- Be sure to answer each item.
- Choose only one comment for each reason.

EXAMPLE:

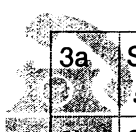
a	Smoking is always **wrong.**				
	strongly disagree	*disagree*	*neutral*	*agree* (circled)	*strongly agree*
b	Smoking is **wrong** only if my parent says so.				
	strongly disagree	*disagree*	*neutral* (circled)	*agree*	*strongly agree*
c	Smoking is **wrong** because it affects my safety or health.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree* (circled)
d	Smoking is not an issue of **right** or **wrong** - it is up to the individual.				
	strongly disagree	*disagree* (circled)	*neutral*	*agree*	*strongly agree*

Remember: All information from these questionnaires is confidential. It is important that your responses are as honest as possible.



1a	Listening to certain music is always **wrong.**				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
1b	Listening to certain music is **wrong** only if my parent says so.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
1c	Listening to certain music is **wrong** because it affects my safety, comfort, or health.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
1d	Listening to certain music is not an issue of **right** or **wrong** - it is up to the individual.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*

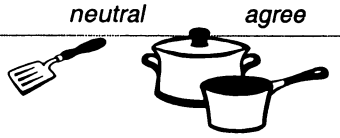
2a	Stealing or vandalism is always **wrong.**				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
2b	Stealing or vandalism is **wrong** only if my parent says so.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
2c	Stealing or vandalism is **wrong** because it affects my safety or health.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
2d	Stealing or vandalism is not an issue of **right** or **wrong** - it is up to the individual.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*



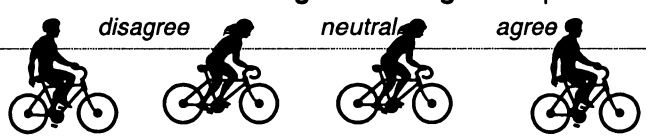
3a	Spending more than a certain amount of time talking on the phone is always **wrong.**				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
3b	Spending more than a certain amount of time talking on the phone is **wrong** only if my parent says so.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
3c	Spending more than a certain amount of time talking on the phone is **wrong** because it affects my safety or health.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
3d	Spending more than a certain amount of time on the phone is not an issue of **right** or **wrong** - it is up to the individual.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*

4a	Wearing certain clothes is always **wrong.**				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
4b	Wearing certain clothes is **wrong** only if my parent says so.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
4c	Wearing certain clothes is **wrong** because it affects my safety or health.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
4d	Wearing certain clothes is not an issue of **right** or **wrong** - it is up to the individual.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*

5a	Helping with household chores is always **right.**				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
5b	Helping with household chores is **right** only if my parent says so.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
5c	Helping with household chores is **right** because it affects my safety or health.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
5d	Helping with household chores is not an issue of **right** or **wrong** - it is up to the individual.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*



6a	Wearing a bike helmet is always **right.**				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
6b	Wearing a bike helmet is **right** only if my parent says so.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
6c	Wearing a bike helmet is **right** because it affects my safety or health.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
6d	Wearing a bike helmet is not an issue of **right** or **wrong** - it is up to the individual.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*

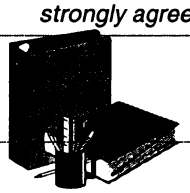


7a	Having certain hairstyles is always **wrong.**				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
7b	Having certain hairstyles is **wrong** only if my parent says so.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
7c	Having certain hairstyles is **wrong** because it affects my safety or health.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
7d	Having certain hairstyles is not an issue of **right** or **wrong** - it is up to the individual.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*

8a	Observing certain table manners at meal times is always **right.**				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
8b	Observing certain table manners at meal times is **right** only if my parent says so.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
8c	Observing certain table manners at meal times is **right** because it affects my safety or health.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
8d	Observing certain table manners at meal times is not an issue of **right** or **wrong** - it is up to the individual.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*

9a	Using swear words is always **wrong.**				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
9b	Using swear words is **wrong** only if my parent says so.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
9c	Using swear words is **wrong** because it affects my safety or health.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
9d	Using swear words is not an issue of **right** or **wrong** - it is up to the individual.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*

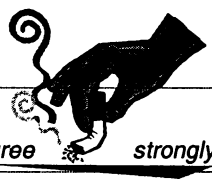
10a	Hitting other people is always **wrong.**				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
10b	Hitting other people is **wrong** only if my parent says so.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
10c	Hitting other people is **wrong** because it affects my safety or health.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
10d	Hitting other people is not an issue of **right** or **wrong** - it is up to the individual.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*



11a	Spending a certain amount of time on my homework is always **right.**				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
11b	Spending a certain amount of time on homework is **right** only if my parent says so.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
11c	Spending a certain amount of time on my homework is **right** because it affects my safety or health.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
11d	Spending a certain amount of time on my homework is not an issue of **right** or **wrong** - it is up to the individual.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*

12a	Having a space to keep private things is always **wrong.**				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
12b	Having a space to keep private things is **wrong** only if my parent says so.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
12c	Having a space to keep private things is **wrong** because it affects my safety or health.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
12d	Having a space to keep private things is not an issue of **right** or **wrong** - it is up to the individual.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*

13a	Going out to certain places is always **wrong.**				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
13b	Going out to certain places is **wrong** only if my parent says so.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
13c	Going out to certain places is **wrong** because it affects my safety or health.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
13d	Going out to certain places is not an issue of **right** or **wrong** - it is up to the individual.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*



14a	Smoking is always **wrong.**				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
14b	Smoking is **wrong** only if my parent says so.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
14c	Smoking is **wrong** because it affects my safety or health.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
14d	Smoking is not an issue of **right** or **wrong** - it is up to the individual.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*

15a	Going around with certain friends is always **wrong.**				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
15b	Going around with certain friends is **wrong** only if my parent says so.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
15c	Going around with certain friends is **wrong** because it affects my safety or health.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
15d	Going around with certain friends is not an issue of **right** or **wrong** - it is up to the individual.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*

16a	Eating a large amount of lollies or chocolate is always **wrong.**				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
16b	Eating a large amount of lollies or chocolate is **wrong** only if my parent says so.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
16c	Eating a large amount of lollies or chocolate is **wrong** because it affects my safety or health.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
16d	Eating a large amount of lollies or chocolate is not an issue of **right** or **wrong** - it is up to the individual.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*

17a	Being too involved with a boy friend is always **wrong.**				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
17b	Being too involved with a boy friend is **wrong** only if my parent says so.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
17c	Being too involved with a boy friend is **wrong** because it affects my safety or health.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
17d	Being too involved with a boy friend is not an issue of **right** or **wrong** - it is up to the individual.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*

18a	Taking part in certain sports and hobbies is always **wrong.**				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
18b	Taking part in certain sports and hobbies is **wrong** only if my parent says so.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
18c	Taking part in certain sports and hobbies is **wrong** because it affects my safety or health.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
18d	Taking part in certain sports and hobbies is not an issue of **right** or **wrong** - it is up to the individual.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*

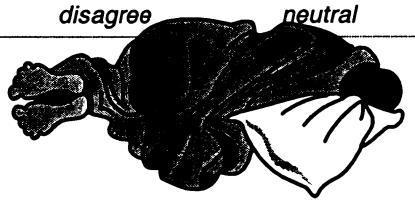
19a	Coming home at a certain time is always **right.**				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
19b	Coming home at a certain time is **right** only if my parent says so.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
19c	Coming home at a certain time is **right** because it affects my safety or health.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
19d	Coming home at a certain time at night is not an issue of **right** or **wrong** - it is up to the individual.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*

20a	Calling adults by their first names is always **right.**				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
20b	Calling adults by their first names is **right** only if they say so.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
20c	Calling adults by their first names is **right** because it affects my safety or health.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
20d	Calling adults by their first names is not an issue of **right** or **wrong** - it is up to the individual.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*

21a	Drinking too much alcohol is always **wrong.**				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
21b	Drinking too much alcohol is **wrong** only if my parent says so.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
21c	Drinking too much alcohol is **wrong** because it affects my safety or health.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
21d	Drinking too much alcohol is not an issue of **right** or **wrong** - it is up to the individual.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*

22a	Keeping promises is always **right.**				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
22b	Keeping promises is **right** only if my parent says so.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
22c	Keeping promises is **right** because it affects my safety or health.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
22d	Keeping promises is not an issue of **right** or **wrong** - it is up to the individual.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*

23a	Sleeping late at weekends is always **wrong**.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
23b	Sleeping late at weekends is **wrong** only if my parent says so.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
23c	Sleeping late at weekends is **wrong** because it affects my safety or health.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
23d	Sleeping late at weekends is not an issue of **right** or **wrong** - it is up to the individual.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*

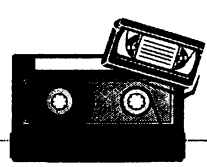


24a	Having a tidy bedroom is always **right.**				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
24b	Having a tidy bedroom is **right** only if my parent says so.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
24c	Having a tidy bedroom is **right** because it affects my safety or health.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
24d	Having a tidy bedroom is not an issue of **right** or **wrong** - it is up to the individual.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*

25a	Certain body piercing is always **wrong.**				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
25b	Certain body piercing is **wrong** only if my parent says so.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
25c	Certain body piercing is **wrong** because it affects my safety or health.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
25d	Certain body piercing is not an issue of **right** or **wrong** - it is up to the individual.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*

26a	Using drugs is always **wrong.**				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
26b	Using drugs is **wrong** only if my parent says so.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
26c	Using drugs is **wrong** because it affects my safety or health.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
26d	Using drugs is not an issue of **right** or **wrong** - it is up to the individual.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*

27a	Being honest with parents is always **right.**				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
27b	Being honest with parents is **right** only if they say so.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
27c	Being honest with parents is **right** because it affects my safety or health.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
27d	Being honest with parents is not an issue of **right** or **wrong** - it is up to the individual.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*



28a	Watching certain videos is always **wrong.**				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
28b	Watching certain videos is **wrong** only if my parent says so.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
28c	Watching certain videos is **wrong** because it affects my safety or health.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*
28d	Watching certain videos is not an issue of **right** or **wrong** - it is up to the individual.				
	strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*

Conflict Checklist

- Below is a list of things that sometimes get talked about at home. We would like to know how often you discuss these topics with your mother, and whether they are discussed calmly or angrily.
- There are no right or wrong answers, so don't spend a lot of time on any one item. We are looking for your overall impression regarding each item.
- Be sure to answer each item.

1st

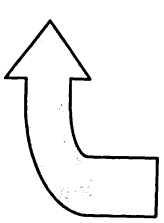
Circle the number that shows how often you discuss each topic with your mother

2nd

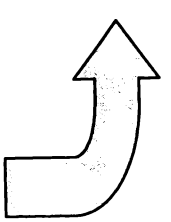
Circle the number that applies to how calm or how angry discussions about this topic usually are

HOW OFTEN?			TOPIC		HOW ANGRY?		
NEVER	SOME TIMES	OFTEN			CALM	A LITTLE ANGRY	ANGRY
1	2	3	(1)	Listening to certain music	1	2	3
1	2	3	(2)	Stealing or vandalism	1	2	3
1	2	3	(3)	Talking on the phone	1	2	3
1	2	3	(4)	Wearing certain clothes	1	2	3
1	2	3	(5)	Doing household chores	1	2	3
1	2	3	(6)	Wearing a bike helmet	1	2	3
1	2	3	(7)	Hairstyle	1	2	3
1	2	3	(8)	Table manners	1	2	3
1	2	3	(9)	Swear words	1	2	3
1	2	3	(10)	Hitting other people	1	2	3

HOW OFTEN?			TOPIC		HOW ANGRY?		
NEVER	SOME TIMES	OFTEN			CALM	A LITTLE ANGRY	ANGRY
1	2	3	(11)	Homework	1	2	3
1	2	3	(12)	Having a space to keep private things	1	2	3
1	2	3	(13)	Going out certain places	1	2	3
1	2	3	(14)	Smoking	1	2	3
1	2	3	(15)	Going round with certain friends	1	2	3
1	2	3	(16)	Eating lollies or chocolate	1	2	3
1	2	3	(17)	Boy friends	1	2	3
1	2	3	(18)	Sports or hobbies	1	2	3
1	2	3	(19)	Coming home at a certain time	1	2	3
1	2	3	(20)	Calling adults by their first name	1	2	3
1	2	3	(21)	Drinking alcohol	1	2	3
1	2	3	(22)	Keeping promises	1	2	3
1	2	3	(23)	Sleeping late at weekends	1	2	3
1	2	3	(24)	Having a tidy bedroom	1	2	3
1	2	3	(25)	Body piercing	1	2	3
1	2	3	(26)	Using drugs	1	2	3
1	2	3	(27)	Being honest with your parent or caregiver	1	2	3
1	2	3	(28)	Watching certain videos	1	2	3



Have you completed both columns?



Parenting Style

- For each of the following statements, circle the number of the 5-point scale that best describes how that statement applies to you and your mother.
- There are no right or wrong answers, so don't spend a lot of time on any one item. We are looking for your overall impression regarding each statement.
- Be sure to answer each item.
- Choose only one number for each statement.

1	2	3	4	5
STRONGLY DISAGREE	DISAGREE	NEITHER DISAGREE NOR AGREE	AGREE	STRONGLY AGREE

Example:						
	My mother considers my opinions when making family decisions, but she does ***not*** decide something just because it is what I want.	1	2	3	(4)	5

		STRONGLY DISAGREE ◄ ► STRONGLY AGREE				
1	My mother feels that I should have my way in the family home as often as she does.	1	2	3	4	5
2	Even if I do ***not*** agree with her, my mother feels that it is for my own good if I am forced to conform to what she thinks is right.	1	2	3	4	5
3	When my mother tells me to do something, I am expected to do it immediately without asking any questions.	1	2	3	4	5
4	When a family rule is made, my mother discusses the reason for that rule with me.	1	2	3	4	5
5	My mother encourages me to talk about family rules and restrictions that I think are unreasonable.	1	2	3	4	5
6	My mother feels that I should be free to make up my own mind and to do what I want to do, even if it is different to what she might want.	1	2	3	4	5

1	2	3	4	5
STRONGLY DISAGREE	DISAGREE	NEITHER DISAGREE NOR AGREE	AGREE	STRONGLY AGREE

		STRONGLY DISAGREE ◄			► STRONGLY AGREE	
7	My mother does ***not*** allow me to question any decisions she makes.	1	2	3	4	5
8	My mother directs my activities and decisions with reasoning and discipline.	1	2	3	4	5
9	My mother feels that adults should use more force to get children to behave the way they are supposed to.	1	2	3	4	5
10	My mother supports me if I get in trouble because she does ***not*** feel that I need to obey rules just because someone in authority has made the rule.	1	2	3	4	5
11	I know what my mother expects of me, but she will discuss those expectations with me if I feel that they are unreasonable.	1	2	3	4	5
12	My mother feels that it is wise to teach children early just who is boss in the family.	1	2	3	4	5
13	My mother seldom sets expectations and guidelines for my behaviour but she helps me meet the goals I set for myself.	1	2	3	4	5
14	When making family decisions, my mother usually does what the children in the family want.	1	2	3	4	5
15	My mother guides and directs me using consistent and fair reasons.	1	2	3	4	5
16	My mother gets very upset if I try to disagree with her.	1	2	3	4	5
17	My mother feels that most problems in society would be solved if adults did ***not*** restrict children's activities and decisions as they are growing up.	1	2	3	4	5
18	My mother lets me know what behaviour is expected of me, and I am punished if I do ***not*** meet those expectations.	1	2	3	4	5
19	My mother lets me decide most things for myself without much direction from her, but she always knows what I have decided.	1	2	3	4	5

1	2	3	4	5
STRONGLY DISAGREE	DISAGREE	NEITHER DISAGREE NOR AGREE	AGREE	STRONGLY AGREE

		STRONGLY DISAGREE ◄ ► STRONGLY AGREE				
20	My mother considers my opinions when making family decisions, but she does ***not*** decide something just because it is what I want.	1	2	3	4	5
21	My mother does ***not*** feel she is responsible for directing and guiding my behaviour as I grow up, but does care about what I do.	1	2	3	4	5
22	My mother sets clear standards of behaviour for the children in our home, but will adjust those standards to meet the needs of each child in the family.	1	2	3	4	5
23	My mother expects me to follow her guidance and direction, but she will listen to me and talk about that direction when I disagree with her.	1	2	3	4	5
24	My mother allows me to form my own point of view on family matters and she generally allows me to decide for myself what I am going to do.	1	2	3	4	5
25	My mother feels that most problems in society would be solved if adults were strict and forced children to do what they are supposed to as they are growing up.	1	2	3	4	5
26	My mother often tells me exactly what she wants me to do, and how she expects me to do it.	1	2	3	4	5
27	My mother gives me clear direction for my behaviours and activities, but is understanding when I disagree with her.	1	2	3	4	5
28	My mother does ***not*** direct or guide my behaviours and activities, but is interested in what I do.	1	2	3	4	5
29	I know what my mother expects of me and she insists that I meet those expectations simply out of respect for her authority.	1	2	3	4	5
30	If my mother makes a decision that hurts me, she is willing to talk about it with me and admit it if she has made a mistake.	1	2	3	4	5

Relationship

- This group of questions has to do with your relationship with your mother.
- For the following statements please circle the number of the 4-point scale that best describes how you generally feel about your relationship with your mother.
- There are no right or wrong answers, so do not spend much time on any one item.
- Be sure to answer each statement.

1 NEVER TRUE	2 SOMETIMES TRUE	3 USUALLY TRUE	4 ALWAYS TRUE

Example:					
0.	My mother listens to my point of view	1	2	(3)	4

		NEVER TRUE ◄·····► ALWAYS TRUE			
1	My mother praises me and gives me compliments	1	2	3	4
2	My mother accepts and understands me as a person	1	2	3	4
3	My mother spends the right amount of time with me	1	2	3	4
4	My mother acknowledges what is important to me	1	2	3	4
5	When something is bothering me, I am able to talk it over with my mother	1	2	3	4
6	My mother listens to my point of view	1	2	3	4
7	My mother is reliable and does not let me down	1	2	3	4
8	My mother takes an interest in my activities	1	2	3	4
9	My mother discusses her ideas and opinions with me	1	2	3	4
10	My mother behaves in the same as way I am expected to behave	1	2	3	4

Appendix D

Descriptive Statistics for Self-Report Measures Used in Survey Study

Table D.1
Ranges, Means and Standard Deviations from Survey Study Self-Report Measures

Measure	Parents				Teens			
	Range		*M*	*SD*	Range		*M*	*SD*
	Min	Max			Min	Max		
Conflict Checklist								
Quantity Discussed	6	28	21.06	5.20	5	28	17.36	5.08
Anger Intensity	1	1.93	1.30	0.22	1	2.74	1.53	0.36
Reasoning Questionnaire: Categorisation of Issues to Domains								
Moral Issues:								
Moral Domain	2.75	5.00	4.38	0.50	1.75	5.00	3.89	0.62
Conventional Domain	1.00	4.25	1.89	0.59	1.00	4.50	2.44	0.74
Safety Domain	1.00	5.00	3.71	0.80	2.00	5.00	3.43	0.68
Personal Domain	1.00	4.50	2.17	0.77	1.25	5.00	2.89	0.79
Conventional Issues:								
Moral Domain	2.00	4.75	3.53	0.51	1.50	4.50	3.27	0.54
Conventional Domain	1.00	4.75	2.60	0.61	1.00	5.00	2.91	0.62
Safety Domain	1.00	4.50	2.86	0.65	1.25	4.75	2.74	0.68
Personal Domain	1.50	4.50	2.78	0.68	1.00	5.00	3.16	0.71
Safety Issues:								
Moral Domain	2.50	5.00	4.20	0.49	1.75	4.75	3.62	0.72
Conventional Domain	1.00	4.00	2.00	0.58	1.00	4.50	2.43	0.74
Safety Domain	3.25	5.00	4.57	0.36	2.00	5.00	4.21	0.56
Personal Domain	1.00	4.25	2.30	0.75	1.25	5.00	3.11	0.82
Personal Issues:								
Moral Domain	1.00	3.25	2.00	0.46	1.00	3.00	1.58	0.48
Conventional Domain	1.00	4.00	2.19	0.64	1.00	4.25	2.06	0.78
Safety Domain	1.00	4.00	2.59	0.57	1.00	4.50	2.31	0.74
Personal Domain	2.00	5.00	3.79	0.53	2.50	5.00	4.27	0.61
Multi-dimensional Issues:								
Moral Domain	1.83	4.42	3.04	0.51	1.00	4.17	2.50	0.62
Conventional Domain	1.00	3.83	2.46	0.60	1.00	4.00	2.49	0.71
Safety Domain	2.00	4.42	3.42	0.49	1.00	4.67	3.01	0.67
Personal Domain	1.67	4.75	3.02	0.59	2.08	5.00	3.77	0.63
Reasoning Questionnaire: Categorisation of Response Trends								
Moral	2.25	4.21	3.32	0.38	1.36	4.07	2.84	0.50
Conventional	1.07	3.54	2.29	0.49	1.04	4.00	2.47	0.60
Safety	2.18	4.29	3.43	0.42	1.39	4.64	3.10	0.55
Personal	1.64	4.21	2.87	0.51	2.36	4.86	3.53	0.57

(table continues)

Table D.1 *(continued)*

Measure	Parents				Teens			
	Range		*M*	*SD*	Range		*M*	*SD*
	Min	Max			Min	Max		
Parental Authority Questionnaire								
Authoritarian	13	39	27.13	5.53	14	44	29.77	6.08
Authoritative	28	50	40.94	3.87	13	50	34.90	6.61
Permissive	13	42	25.02	5.33	13	39	27.81	5.05
Relationship Questionnaire								
Total Score	22	40	31.99	4.03	15	40	30.35	5.95
Symptom Checklist-90-Revised								
Global Severity Index	30	81	53.03	10.09	19	81	50.02	12.93

Table D.2
Ranges, Means and Standard Deviations of Frequency of Discrepant Responses Between Parents and Teens on Survey Study Self-Report Measures

Measure	Range		*M*	*SD*
	Min	Max		
Decision-Making Questionnaire: Discrepant Responses				
Actual Decision Making	0	19	4.98	3.87
Ideal Decision Making	0	25	7.65	4.92
Reasoning Questionnaire: Discrepant Categorisation				
Moral	4	62	25.45	9.89
Conventional	5	58	26.57	11.32
Safety	12	62	26.70	9.36
Personal	10	79	32.43	12.85

DISAGREEMENTS THAT OCCUR OVER EVERYDAY DETAILS OF FAMILY LIFE ARE IMPORTANT

They are always unpleasant

They can harm your relationship

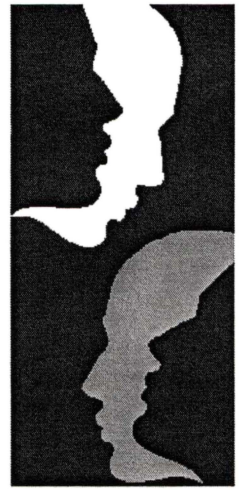
PARTICIPATION IN THIS PROGRAMME WILL HELP YOU TO IMPROVE YOUR FAMILY RELATIONSHIP

- *The programme will be administered by Marie Connelly, who is a parent of four teenage children, with clinical psychology training. Supervision will be provided by Dr Ian Evans, Director of the Clinical Psychology Diploma Programme at the University of Waikato and Trish Young, Maori Researcher.*
- *The programme will be evaluated to provide important information about what contributes to the most satisfactory outcomes for teens and parents in New Zealand.*
- *The ethical review committee at the University of Waikato has approved this programme.*

Marie Connelly
Phone: 838-4466 Ext.8040
or 025-274-0837
(with 24-hour voice mail)
E-mail: mlc2@waikato.ac.n.z

SUPPORT FOR FAMILIES WITH TEENAGERS

A programme
to reduce family conflict
and improve your relationship



DISAGREEMENTS IN FAMILIES ARE NOT UNCOMMON

Most families generally get along well. There are times for all of us when we don't. Parents and teenagers often struggle with mild bickering, disagreements and conflicts. These may be about major issues or decisions, or they may be about everyday responsibilities that seem to come up over and over again (e.g. doing the dishes, tidy bedrooms).

- ❖ Is there a teen in your family between 13 and 16 years old?
- ❖ Would you like to learn new ways of talking to each other?
- ❖ Would you like to improve your relationship?

PROGRAMMES THAT HAVE HELPED OTHER PARENTS AND TEENS ARE AVAILABLE

In connection with the University of Waikato, this special programme is being offered as part of a larger project about teenagers in New Zealand families.

IF YOU TO PARTICIPATE.....

- ⇨ You can improve your relationship.
- ⇨ You can reduce family conflict.
- ⇨ You will learn and practise skills and strategies to deal with current difficulties.
- ⇨ You will learn ways of reaching agreements that are OK to the teen and the adult.
- ⇨ You will finish the programme with skills and strategies that you can use to deal with new problems that arise.
- ⇨ Families will be seen individually so your personal issues and goals can be addressed.
- ⇨ Discussions with families, and the fact that they are attending the programme will be treated as confidential.

Where: **At a central Hamilton city location**

When: **Starting in June and again in August this year**

Time: **1 hour per week for 6 weeks**

Evening appointments available

Cost: **No charge**

If you would like any further information, please do not hesitate to contact me. Either complete and return the form below, or give me a phone call. I would be pleased to answer any questions.

I am interested in the support programme for families with teenagers. Could you please contact me to provide further information.

Name: .....

Phone No:.....

Address:.....

.....

SEND TO:
Freepost No. 502
Attention: Marie Connelly
Department of Psychology
University of Waikato
Private Bag 3105
HAMILTON

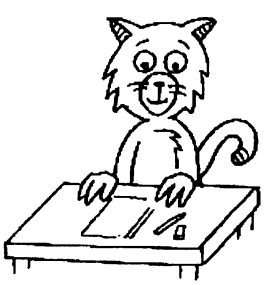
Marie Connelly
Phone: 838-4466 Ext.8040
or 025-274-0837
(with 24-hour voice mail)

Appendix F

Self-Report Measures Developed or Adapted for Treatment Study

Domains and Development

- These are some ways that you might behave, think, or feel about how parents and teenagers get along and ways they reach decisions.
- Please read each statement carefully and choose one of the numbers below that best shows how much the statement is true of you.
- See yourself as you would **usually** think, feel, and respond.
- Circle only one number for each item.
- Please **do not** skip any items.



THERE ARE FIVE POSSIBLE RESPONSES FOR EACH STATEMENT

0	1	2	3	4
NOT AT ALL TRUE OF ME	SLIGHTLY TRUE OF ME	MODERATELY TRUE OF ME	VERY TRUE OF ME	EXTREMELY TRUE OF ME

EXAMPLES:

		NOT AT ALL TRUE OF ME ◄·····► EXTREMELY TRUE OF ME				
0	I am unsure about the developmental changes that take place during the teenage years.	0	1	2	(3)	4
0	We discuss the roles and responsibilities of teenagers when making decisions.	0	1	(2)	3	4

0	1	2	3	4
NOT AT ALL TRUE OF ME	SLIGHTLY TRUE OF ME	MODERATELY TRUE OF ME	VERY TRUE OF ME	EXTREMELY TRUE OF ME

		NOT AT ALL TRUE OF ME ◄·····► EXTREMELY TRUE OF ME				
1	I think parents and teenagers cannot understand each other's point of view no matter how hard they try.	0	1	2	3	4
2	We discuss the roles and responsibilities of parents when making decisions.	0	1	2	3	4
3	When we talk about safety or health concerns, we try to find out whether we think the parent or the teenager is responsible for that decision.	0	1	2	3	4
4	I am unsure about the developmental changes that take place during the teenage years.	0	1	2	3	4
5	When making decisions, we consider whether the issue will affect the rights or welfare of others.	0	1	2	3	4
6	I believe teenagers should follow their parent's beliefs and standards to guide their behaviour.	0	1	2	3	4
7	I am aware of the developmental tasks of teenagers (i.e., their roles and responsibilities).	0	1	2	3	4
8	When discussing an issue, I think about whose responsibility the decision might be (i.e., the parent, the teenager, or both of us).	0	1	2	3	4
9	Understanding teenage development helps me discuss issues without arguing.	0	1	2	3	4
10	I see teenagers as being difficult to get along with, which threatens family relationships.	0	1	2	3	4
11	When we have a different point of view about family rules or organisation, we talk about who should make the decision.	0	1	2	3	4
12	Having a teenager in the family changes how we think about who is responsible for making decisions regarding some issues.	0	1	2	3	4
13	I believe families can adjust to changes during the teenage years without serious conflict.	0	1	2	3	4
14	During our discussions, we identify whether or not we think the issue is a personal one that should be decided by the teenager alone.	0	1	2	3	4
15	I believe teenagers should develop their own set of beliefs and standards to guide their behaviour.	0	1	2	3	4
16	When making decisions, I go out of my way to keep teenage development in mind.	0	1	2	3	4
17	When we disagree, we try to find out if we have different reasons for our point of view.	0	1	2	3	4
18	We discuss the roles and responsibilities of teenagers when making decisions.	0	1	2	3	4
19	I believe understanding teenage development will help us resolve differences we may have.	0	1	2	3	4
20	When discussing differences, we use a system to explain and understand each other's reasons.	0	1	2	3	4

Participant Evaluation

- The purpose of this scale is to obtain your overall evaluation of the programme.
- For each of the following statements, please circle the number that that best describes your overall impression.
- Choose only one number for each statement.
- Please be sure to answer every item.

1. How useful did you find the written handout materials?

1	*2*	*3*	*4*	*5*
not at all	*a little*	*somewhat useful*	*quite useful*	*really useful*

2. Please rate how much you think you learned from sessions.

1	*2*	*3*	*4*	*5*
nothing	*a little*	*some*	*quite a lot*	*a great deal*

3. How much did you learn about talking and listening to each other when discussing concerns or differences?

1	*2*	*3*	*4*	*5*
nothing	*a little*	*some*	*quite a lot*	*a great deal*

4. How much did you learn about getting along with each other?

1	*2*	*3*	*4*	*5*
nothing	*a little*	*some*	*quite a lot*	*a great deal*

5. Please rate how much new information you now have about reaching agreements.

1	*2*	*3*	*4*	*5*
none	*a little*	*some*	*quite a lot*	*a great deal*

6. How much did you enjoy the sessions?

1	*2*	*3*	*4*	*5*
not at all	*sort of enjoyed them*	*enjoyed them about half the time*	*enjoyed them quite a lot*	*enjoyed them very much*

7. How much did you look forward to attending sessions?

1	*2*	*3*	*4*	*5*
didn't want to go at all	*kind of didn't want to go*	*didn't look forward to it but didn't mind going*	*looked forward to sessions*	*really liked being there*

8. When you were in the sessions, did you want it to be over as soon as possible?

1	*2*	*3*	*4*	*5*
all the time	*often*	*some times*	*fairly glad*	*really liked being there*

9. Are you glad you participated in the programme?

1	*2*	*3*	*4*	*5*
not at all	*a bit*	*not glad or unhappy*	*fairly glad*	*very glad that I participated*

10. How interesting were the sessions?

1	*2*	*3*	*4*	*5*
very boring	*somewhat boring*	*neither interesting nor boring*	*usually pretty interesting*	*very interesting*

11. Please rate how you felt about your relationship with the programme administrator.

1	*2*	*3*	*4*	*5*
very poor	*poor*	*O.K.*	*good*	*very good*

12. Please rate how well the programme administrator understood your feelings and concerns.

1	*2*	*3*	*4*	*5*
not at all	*somewhat understanding*	*moderately understanding*	*quite understanding*	*very understanding*

13. Please rate how much you feel you can use what you have learned.

1	*2*	*3*	*4*	*5*
can almost never use	*can use a bit*	*use about half the time*	*can use quite a lot*	*can use a great deal*

14. Has what you learned changed the way you react toward each other?

1	*2*	*3*	*4*	*5*
not at all	*a little*	*some change*	*quite a lot*	*changed a great deal*

15. Do you react differently to problem situations now compared to when you first started the programme?

1	*2*	*3*	*4*	*5*
no	*a little*	*somewhat*	*quite differently*	*very differently*

16. Are you now able to discuss concerns or differences more appropriately?

1	*2*	*3*	*4*	*5*
no	*a little*	*somewhat*	*quite a lot*	*very much more able*

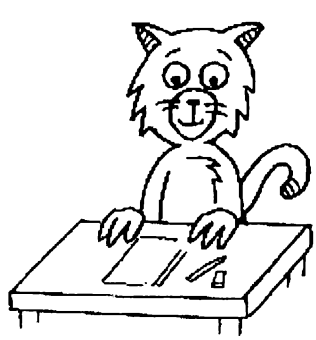
17. Have your discussions improved as a result of attending the programme?

1	*2*	*3*	*4*	*5*
no change	*a little*	*some improvement*	*quite a lot of improvement*	*very much improved*

18. Please give an overall rating of the programme.

1	*2*	*3*	*4*	*5*
very poor	*poor*	*O.K.*	*good*	*very good*

Please add any comments that you would like to make.



Participant Evaluation

Scoring Sheet

Participant No. _____

Date of Scoring: _____

Acceptability	
Item No.	Score
1	
6	
7	
8	
9	
10	
11	
12	
18	
Total	

Progress	
Item No.	Score
2	
3	
4	
5	
13	
14	
15	
16	
17	
Total	

Therapist Evaluation of Treatment: Teen

To be completed after the final treatment session

1. How receptive was this teenager to treatment?

1	2	3	4	5
not at all	*a little receptive*	*moderately*	*quite receptive*	*very receptive*

2. How cooperative was this teenager?

1	2	3	4	5
very uncooperative	*fairly uncooperative*	*OK*	*fairly cooperative*	*very cooperative*

3. Was this teenager able to learn the strategies and concepts presented?

1	2	3	4	5
no	*not very able*	*OK*	*fairly capable*	*very capable*

4. Did this teenager want to change the way they interacted with their parent?

1	2	3	4	5
no, very resistant	*somewhat resistant*	*neutral*	*some desire to change*	*strong desire to change*

5. How much did the teenager learn about appropriate communication during therapy?

1	2	3	4	5
nothing	*only a little*	*learned some*	*quite a bit*	*a great deal*

6. How much new information did the teenager acquire from the therapy about reaching agreements?

1	2	3	4	5
none	*a little*	*some*	*quite a bit*	*a lot*

7. **How much has this teenager's communication improved as a result of attending therapy?**

1	2	3	4	5
no improvement	*a little*	*some*	*quite a bit*	*a great deal*

8. **How much has this teenager's approach to reaching agreements improved as a result of therapy?**

1	2	3	4	5
no improvement	*a little*	*some*	*quite a bit*	*a great deal*

9. **How consistently did this teenager use appropriate communication when talking to their parent/caregiver?**

1	2	3	4	5
very inconsistent	*fairly inconsistent*	*somewhat consistent*	*fairly consistent*	*very consistent*

10. **Was there a change in how much this teenager was prepared to compromise when discussing concerns and differences?**

1	2	3	4	5
none	*a little*	*some*	*quite a bit*	*a great deal*

11. **Was this teen able to use the model presented to more appropriately discuss concerns and differences, and reach agreements?**

1	2	3	4	5
no	*a little*	*somewhat*	*fairly able*	*very able*

12. **Does this teenager react differently toward their parent than they did at the beginning of therapy?**

1	2	3	4	5
no	*a little*	*some*	*quite differently*	*very differently*

13. **Does this teenager react differently to problem situations now compared to when they first started the programme?**

1	2	3	4	5
none	*a little*	*somewhat*	*quite differently*	*very differently*

14. **How much have this teen's discussions improved compared to when they first started the programme?**

1	2	3	4	5
not at all	*a little*	*some*	*quite a bit*	*a lot*

15. **How well is this family likely to do in the future?**

1	2	3	4	5
very poorly	*not real well*	*OK*	*pretty well*	*very well*

Therapist Evaluation: Teen

Scoring Sheet

Participant No. _____

Date of Scoring: _____

Responsiveness	
Item No.	Score
1	_____
2	_____
3	_____
4	_____
5	_____
6	_____
Total	_____

Progress	
Item No.	Score
7	_____
8	_____
9	_____
10	_____
11	_____
12	_____
13	_____
14	_____
15	_____
Total	_____

Appendix G

Treatment Session Checklist

Name: Participant No: Date:

Treatment Group: Session No:

COMMUNICATION SKILLS	YES	NO	EXAMPLE
Interaction, Builds, Circular = BOTH RESPONSIBLE			
Irreversible			
Context / Noise			
Non-verbal			
Listening			
- Paraphrasing / Summarising			
- Asking Questions			
- Validating			
Talking			
- Expressing Positive			
- Expressing Negative			
- one problem			
- say something positive			
- brief			
- specific - clear description of behaviour			
- I-statement - reaction / response			
- suggest a solution			
- No threats, put-downs, exaggerations,			
- Admit your role in the situation			
- No inferences			
Other Communication Targets			

PROBLEM-SOLVING SKILLS	YES	NO	EXAMPLE
Problem definition			
Generation of solutions			
Evaluation of solutions			
Solution selection			
Plan implementation of solution			
Evaluation of plan			

DOMAINS AND DEVELOPMENT	YES	NO	EXAMPLE
Teen developmental changes			
Teen roles / responsibilities			
- adjust to developmental changes			
- develop independence/remain connected			
- develop guidelines/standards for decisions			
- accept responsibility/consequences for outcomes of independent decisions			
Parent roles / responsibilities			
Change in one effects others			
Domains: Categorise Issue / Whose Decision?			
Moral			
Conventional			
Safety			
Personal			

COMMENTS	EXAMPLE

Appendix H

Materials Used For Initial Session of Treatment Study

Information to Participants

Most parents and teenagers struggle with conflict at some stage. Treatments shown to help teens and their parents with distressing arguments have not been verified with New Zealand families. This programme will provide information about what contributes to satisfactory outcomes when assisting teens and parents in New Zealand. Two treatment approaches aimed at reducing distressing conflict and improving family relationships will be evaluated. Personal family goals will be addressed within this framework. It is expected that families will develop skills and strategies to resolve current concerns and to deal with new problems that arise.

Participation guidelines

- Families will be seen individually.
- Individual family issues and goals will be addressed.
- Treatment sessions will be offered over 5 weeks, 1 hour per session.
- At least one parent or caregiver and a teenager from each family agree to attend the treatment sessions.
- You will have the right to withdraw from the programme at any time.
- Family members who continue with the programme agree to complete questionnaires before sessions begin, when sessions have been completed, and again three months after session completion.
- Teenagers and their parents or caregivers will work together during treatment sessions, but may be seen individually at the end of each session.
- Generally, any topic can be raised if it can be discussed within the treatment framework.
- Everyone will have the right NOT to talk about or discus anything that they do not feel comfortable with.

Reporting outcomes

- All programmes need to be evaluated to find out how well they work. As this programme is designed to evaluate treatment outcomes, you will be asked to provide important information regarding your progress.

- A summary of the value of the programme, and its usefulness for families will be available to you, schools, and community organisations. It will be presented at conferences, published in psychological journals, and may be reported via radio interviews or newspaper articles, or be used for future research.
- At no time will information be reported in a way that could identify any individual person or family. Nor will information be reported in a way that could have a negative impact on any group of people.

Confidentiality

- Information obtained during sessions will be treated as confidential, and will not be disclosed to any other person without your permission.
- Information obtained from questionnaires or during individual discussions will be treated as confidential and will not be disclosed to other family members without your permission.
- No identifying information will be kept on your records. Questionnaires will be identified with a code number.
- Confidentiality Limitation: If information is disclosed that indicates either you or another person may be harmed or is not safe, and permission to disclose is denied, consultation with the supervisor will be sought, and professional judgement will be exercised in deciding whether to breech confidentiality.

Your participation and co-operation in conducting this programme evaluation is greatly appreciated. If you have any queries, or require any further information, please do not hesitate to contact me.

Marie L. Connelly
Phone 025-274-0837 or 0800-277-003 (both with 24-hour voice mail)

Consent Form Used in the Treatment Study

University of Waikato, Psychology Department
CONSENT FORM

Participant's Copy

Project:	Treatment of Parent-Adolescent Conflict
Administrator:	Marie Connelly, BSocSci(Hons), PhD Candidate, Clinical Psychology Trainee
Supervisors:	Dr Ian Evans, Director, Clinical Psychology Diploma Programme, Anne Phipps, Senior Tutor, Clinical Psychology Diploma Programme Trish Young, Maori Researcher

I have received an information sheet about this treatment research programme and the therapist has explained the study to me. I have had the chance to ask any questions and discuss my participation with relevant family members. Any questions have been answered to my satisfaction.

I agree to participate in this programme and I understand that I may withdraw at any time. However, if I continue in the programme, I agree to complete the requested evaluations before and after the programme, and at a three-month follow up. If I have any concerns, I may contact one of the supervisors named above.

Participant's
Name:________________________Signature:___________________Date:_________

✂ ==================================

University of Waikato, Psychology Department
CONSENT FORM

Researcher's Copy

Project:	Treatment of Parent-Adolescent Conflict
Administrator:	Marie Connelly, BSocSci(Hons), PhD Candidate, Clinical Psychology Trainee
Supervisors:	Dr Ian Evans, Director, Clinical Psychology Diploma Programme, Anne Phipps, Senior Tutor, Clinical Psychology Diploma Programme Trish Young, Maori Researcher

I have received an information sheet about this treatment research programme and the therapist has explained the study to me. I have had the chance to ask any questions and discuss my participation with relevant family members. Any questions have been answered to my satisfaction.

I agree to participate in this programme and I understand that I may withdraw at any time. However, if I continue in the programme, I agree to complete the requested evaluations before and after the programme, and at a three-month follow up. If I have any concerns, I may contact one of the supervisors named above.

Participant's
Name:________________________Signature:___________________Date:_________

Initial Interview Outline

1. **Introductions**

2. **Rationale**
   Many families have experience disagreements and have difficulty coping at some stage. You are not alone with this situation. The treatment being offered has been shown to help others improve relationships and decrease conflict. Supported by research/literature. You have taken the most important step of all. By coming here you have acknowledged that things could be better and you are looking for that to happen.

3. **Treatment goals**
   To reduce level of distressing conflict and improve family relationship by (a) working through some current concerns to reach satisfactory solutions, and (b) learning skills and strategies that can be used when new situations arise in the future. Personal family goals will be addressed within this framework. Will discuss that further after I have provided you a more information about what attending the treatment programme involves.

4. **Purpose of the research**
   Treatments shown to help teens and their parents with distressing arguments have not been verified within New Zealand families. Evaluation of individual change from pre- to post-intervention will provide information regarding effective treatment of family conflict within New Zealand families.

5. **What will happen to the research results?**
   A summary of results will be available to participants, schools, and community organisations. Results will be presented at conferences, published in psychological journals, and may be reported via radio interviews or newspaper articles. The results may also be used for future research. Results will be reported in a way that will not identify any individual person or family, and will not have a negative impact on any group of people.

6. **Treatment format**
   Because this is part of a research programme, some of what we do will be structured so the outcomes can be evaluated accurately. Two slightly different treatment approaches will be used. Some content will be the same for both approaches and some will be different. It is expected that families from both treatment groups will have decreased conflict and improved relationships at the end of the programme.

   a) A skills training approach will be followed:
      - New material will be presented and modelled
      - Skills will be role-played and practised during sessions
      - Experiments will be conducted to check out use of the skills at home
   b) After the initial session today, there will be five more one-hour sessions, one per week.

c) During Sessions 2 and 3, new material will be presented. Skills will be discussed, modelled, role-played, and practiced.
d) During the next three sessions you will the have the opportunity to "use the skills" when talking about issues and reaching solutions that are important to your family. During those discussions, I will monitor the use of skills to reinforce appropriate communication and to interrupt when inappropriate communication has been used.

7. Assessment

Questionnaires will be completed pre- and post-intervention to evaluate what has changed and how much it has changed, and what has not changed.

8. Scope of the treatment

Generally, any topic can be raised if it can be discussed using the skills being learned and relates to the interaction between family members. Personal problems that do not fit within this framework will not be addressed. If personal problems arise that are outside the scope of this treatment, information about options for assistance and/or alternative referral sources will be provided.

Limits of skills training: The skills or strategies being taught will not work for everything all of the time. We are not claiming that this is the only way to handle differences. However, we are confident that what you learn will be very useful a lot of the time.

9. Therapist role

a) To provide information and skills that can be used when solving your differences, and to support you in using those skills so you can reach solutions that are satisfactory to you.
b) To give you each of the opportunity to talk and be listened to.
c) Not to take sides with anyone.
d) To work with you to help you achieve your goals - it is not my role to provide you with solutions, or impose solutions on you.

10. Participant role

a) Agree to attend all of the sessions.
b) One parent or caregiver and their teenager must be consistently involved in all sessions. Two parents or caregivers will not be required to attend sessions. However, if two parents or caregivers begin the programme it is requested that they both continue to attend until its completion.
c) Agree to complete the assessment questionnaires before and after treatment.
d) Actively participate in the sessions and become involved with home experiments. This is not a "quick fix". The skills training will only work if you do! Information without practice will not lead to change.
THIS WILL NOT BE LIKE TAKING A PANADOL FOR A HEADACHE.
e) Adopt an "experimenting set" toward the programme (i.e., try it out). After you have completed the programme, and given the approach a try, take what works best for your family and use it in your everyday life.

f) Provide feedback about what you have done, what progress is being made and what is not going well.
g) You will have the right to complain if you feel that your trust has been abused. You may do this by talking with one of the supervisors identified on the consent form.

11. Confidentiality

a) Information provided by participants, and the fact that they are attending treatment, will be treated as confidential. No information disclosed will be repeated outside the research programme setting without permission. No identifying information will be kept on your records. Questionnaires will be identified with a code number.

b) Confidentiality Limitation: If information is disclosed that indicates any person may be harmed or is not safe, and permission to disclose is denied, consultation with the supervisor will be sought, and professional judgement will be exercised in deciding whether to breech confidentiality.

c) Generally, information provided during individual discussions will not be shared with other family members without your permission. Limitations to that confidentiality assurance *within* the family are (a) the same as above regarding harm or safety of any person, and (b) information disclosed regarding harmful or high risk behaviour, for example, teen drug use.

d) I will attend regular meetings with my supervisor who is bound by the same ethical guidelines as I am. Supervision is ensure that the programme is delivered in a way that meets research protocols and best suits individual family needs. Families will not be identified during supervision without permission.

12. Exclusion criteria

a) Currently attending other treatment regarding family conflict.
b) Impairment that would interfere with participation (e.g., speech or hearing impairment, intellectual disability) or inability to understand English.
c) Does family know of any reason why it would not be appropriate to attend the sessions?

13. Questions from participants

Check that family members understand key points.
Provide opportunity for participants to ask questions.

14. Consent forms

a) Review consent form.
b) Leave the room to allow family to decide whether or not to proceed.

- If family decides not to continue:
  - Ask if they are willing to share the reason for their decision.
  - Thank them for their time and interest.
  - Provide referral information if appropriate.
- If family decides to continue with therapy, continue with session.

15. Family discussion to identify goals

Have talked about general goals – now to your specific family goals:

a) What is the reason you made an appointment to see me?
b) What happens when you argue? (behaviour, thoughts, and feelings)
c) What do you argue about most of all?
d) Example of recent conflict incident. Typical?
e) Antecedents, behaviour, consequences. Functional analysis.
f) What would you like to see changed? Expectations/goals. How would things be if they were as you wanted them to be?
g) Match expectations/goals with therapy being provided.

History of problem:

h) Events leading to now
i) Time line, changes

General Family and Social Background:

j) Household members / family members
k) School information
l) Peers
m) Activities and interests
n) Strengths

Observations of interactions during discussion (including behaviour, affect, cognitions, and responses to different interactions)

16. Adult participants leave room to complete questionnaires

17. Individual discussion with teen

Goal: To develop rapport

a) Feelings/concerns about attending sessions. (Be prepared for negative response) Address concerns raised.
b) Reframe: Identify advantages of attending and/or change for the teen. For example, chance to tell their story, to be heard, to use their voice in a way that will be heard by adults.
c) Acknowledge the importance of the problem to them.
d) Discussions will follow a no-blame approach. Goals will be achieved through participation, that is, parents and teens will be asked to work together – it is not likely that either the teen or the parent will be asked to make all the changes.
e) Typical day.
f) Any information that might make a difference to attending or participating in sessions (e.g., medical, current therapy, current legal proceedings).
g) Relationship:
   - How would you describe your relationship with your parent(s)?
   - How do you think they would describe the relationship?
   - Different with other family members?
h) What do you think would make the biggest difference regarding arguments with your parents?

18. Teen participant leaves room to complete questionnaires

19. Individual discussion with parent(s)

a) follow same format as individual discussion with teen

20. Summary - Parent(s) and teen together

a) Any additional relevant information that has not been discussed.
b) Summarise session, goals.
c) Encouragement / reassurance.

21. Session close

Practical arrangements for subsequent sessions:

a) Arrange appointment time.
b) Agree to come on time - session will finish on time even if you arrive late (due to other appointments).
c) Do not come to sessions under influence of drugs or alcohol.
d) Phone if going to be late or are not able to attend a session.
e) Explain access to premises / door locked, waiting room.
f) Tea/coffee facilities available.
g) Toilet.
h) Any other considerations relevant to the family.
i) Acknowledge and express appreciation that family has attended.

Appendix I

Communication Skills Handout Provided to all Participants

Interpersonal Communication

This programme is intended to teach you skills that will begin a process of learning. This is similar to learning to ride a bike. Most of us are not really too good at it when we first start. With practise, we do get better. With continued practise, we usually become competent. It is the same with new ways of talking. It may seem awkward at first. So we ask that you practise the skills - they will not necessarily solve all of your problems, but when learned they will help you get through problem situations.

Communication skills can be learned, developed, and improved

LISTENING

paraphrase - summarise
check for understanding
rephrase in your own words
do not add judgements

"So what you're saying is..."
"In other words..."
"What I understand is that....."
"What you have said so far is ...."

validation
Acknowledge what has been said
- even if you don't agree
State your reaction - use an I-statement
Suggest a solution

communication is circular

Each communication affects all others

communication is irreversible

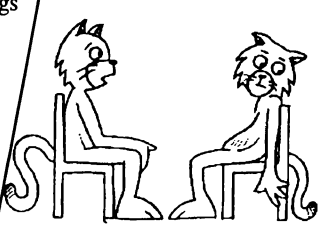
NONVERBAL

delivery of a message

communicates emotions and feelings

voice face eyes posture gestures

CAN HAVE MORE IMPACT THAN THE WORDS USED



Context

who, what, when, where, how, mood

previous conversations

perceptions beliefs

THE CAT

TALKING

Express praise, approval and affection
Look for positive behaviour
Tell the other person you have noticed
Praise doesn't take much time and it will be appreciated

Expression of negative feelings or thoughts
describe the problem as you see it
use I-statements to express your reactions
make a constructive request
say how you would like things to be

Remember
describe the behaviour
no personal attacks

INTERACTION
those talking are mutually responsible for what occurs

Guidelines For Expressing Negative Reactions

❖ **Discuss only one problem at a time**
Discussing more than one problem at a time will result in side-tracking.

❖ **Always start by saying something positive**
It is always difficult to accept criticism. Most of us feel attacked and want to defend ourselves when we are criticised. To minimise feelings of discomfort, and encourage collaboration, always start with a positive remark, such as an expression of appreciation, or mention something you like about the other person. Ideally, the positive remark should be related to the problem. If this is not possible, express appreciation in a general way.

❖ **Be specific**
- Clearly describe exactly what behaviour is bothering you.
- Identify when and where the problem occurs.
- Describe the consequences of the problem for you. Use I-statements to make your feelings known.
- If appropriate, suggest a solution. Say how you would like things to be.
- No threats, put-downs, insults, or labels - stick to describing the behaviour. Do not say things that would unnecessarily hurt each other.
- Avoid exaggerations (e.g. words like "always' and "never")
- Be considerate and polite.

❖ **Be brief**
Stick to the topic under discussion. Avoid listing endless examples of the problem behaviour, or dredging up past conflicts.

❖ **Admit to your role in the situation**
This applies to everyone involved. Look to accept responsibility rather than blaming each other. Accepting responsibility does not mean you are agreeing to change your behaviour. Nor is it an admission of guilt. It does mean you agree there is a problem and you are making a commitment to discuss and negotiate a solution because it is upsetting the other person.

❖ **Don't make inferences**
Stick to behaviour you can observe. Do not assume bad intentions. You do not know what a person is thinking or feeling, or why they did something, unless they tell you. Claiming good intentions for your own behaviour does not change that the other person is finding your behaviour a problem - and the behaviour needs to be discussed.

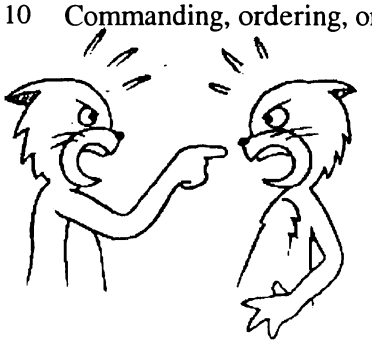
❖ **Listener paraphrases what the speaker has said**

Ask Yourself the Following Questions

- Am I just in a rotten mood or do I really have a legitimate bone to pick?
- Is this an important issue?
- Why do I think this issue is important?
- Am I overreacting to a trivial situation?
- What would I like to see change about this specific problem?
- Do I just want to tell them how I feel - or do I really want to solve this?
- Is this the right time?
- How will the other person react - what are the likely consequences?
- If I had a magic wand, what outcome would I wish for?
- Is a trade possible?
- Can the physical environment be rearranged?
- What can the other person do?
- What can I do?
- What can be done together?
- Can something be done to help remind family members to act differently?
- What is preventing us from reaching an agreement?

Common Problem Communication And the Alternative

	Problem Communication	Possible Alternative
1	Talking through a third person.	Talk directly to another person.
2	Accusing and blaming remarks - and defensive responses. Often a "you" statement.	Use I-statements. (e.g. I feel ..... when .....happens) Validatation.
3	Putting down, zapping, shaming, criticising, insults.	Distinguish between the person and the behaviour of the person. Talk about the person's behaviour. Be specific. Accept responsibility. Use I-statements.
4	Interrupting (interruption for clarification is positive)	Practice active listening. Gesture when you want to talk. Speaker to use brief statements. Interrupt with an "excuse me" if there is an urgent need to interrupt.
5	Overgeneralising, catastrophising, Making extreme, absolute, or rigid statements.	Make straightforward and tentative statements. Use terms like "sometimes" and "maybe" instead of "always" and "never".
6	Lecturing, preaching, or moralising.	Make brief, specific statements about the problem.
7	Talking in a sarcastic tone of voice.	Talk in a neutral tone of voice.
8	Mind reading. Assuming what the other person is thinking or feeling. Guesses are often not accurate.	We cannot "read the other person's mind". Ask. Paraphrase. Check out how the other person feels or what they mean.
9	Getting off the topic.	Stop. Return to the problem as defined.
10	Commanding, ordering, or threatening.	Suggest alternative solutions.



	Problem Communication	Possible Alternative
11	Dwelling on the past.	Sticking to the present and future - suggest changes to correct past problems.
12	Monopolising the conversation.	Take turns, make brief statements.
13	Intellectualising	Speak in simple, clear language that can be easily understood.
14	Humouring or discounting.	Validate what the other person has said.
15	Mismatch between verbal and nonverbal behaviour.	Match language with tone of voice, posture and gestures.
16	Failing to make eye contact.	Look at the person you are talking to.
17	Fidgeting or moving while someone is speaking to you.	Sit in a relaxed way.
18	Remaining silent, not responding.	Validation. Express any negative feelings you have. Say why you are finding it difficult to respond.
19	The other person is not listening.	Speaker asks listener to paraphrase.
20	Kitchen sinking. Not sticking to one Topic and dragging in everything but the "kitchen sink".	Stop. Take a note of the new issue and agree to discuss it later. Go back to the original point.
21	Cross-complaining. When one person brings up an issue, the response is a counter-complaint.	Stop. Focus on one issue at a time.
22	A standoff. Each person stands firm in their position.	Validation. Try to see things from the other person's perspective.
23	"Yes - but ..."	Paraphrase. Validate.

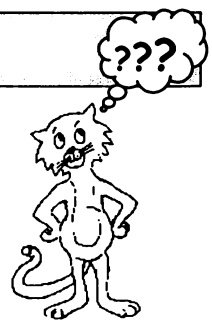
Adapted from Robin and Foster (1989) and Gottman, et al. (1976).

Appendix J

Materials Provided to Problem-Solving Skills Training Group Participants

Problem Solving

What Is A Problem?



What is a problem?

A problem is a situation that demands a response

- It may be something that has to be accomplished or answered
- It may be something difficult to understand or difficult to deal with

And there is no immediate response apparent or available

What is a solution?

A solution is a coping response

- It may be a an action aimed at altering the problem situation
- It may be an altered emotional response so the situation is no longer perceived as a problem

The solution is how you deal with a situation that demands a response

The problem is not usually the issue or circumstance

It is more likely that the problem is about how the situation is handled or resolved

EXAMPLE 1

You all sit down to watch TV - then argue about what programme you will watch

- the problem isn't that there are different programmes on (that happens!)
- the problem is that you argued, i.e. you did not find a solution for the situation

EXAMPLE 2

You get a flat tyre - and have no jack in the car - or don't know how to use it

- the problem isn't the flat tyre (it happens!)
- the real problem is finding a solution - what are you going to do to get the tyre changed?

What is a Problem?

"A problem is not finding a response that works"

What Is Problem Solving?

Problem solving is a specific step-by-step activity used to find solutions

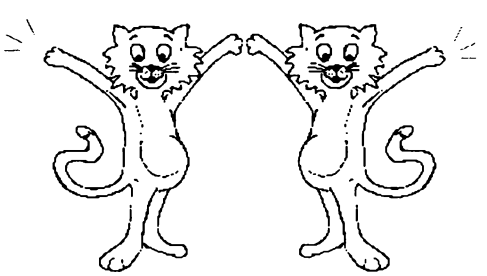
- It may not feel spontaneous or natural
- But when you become practised it can be fun!

Problem solving is not about winning and losing

Problem solving involves collaboration and compromise

Collaboration: Working together to the same end

Compromise: Giving a little, changing a little
We can't all have everything we want
Half a loaf is better than none!

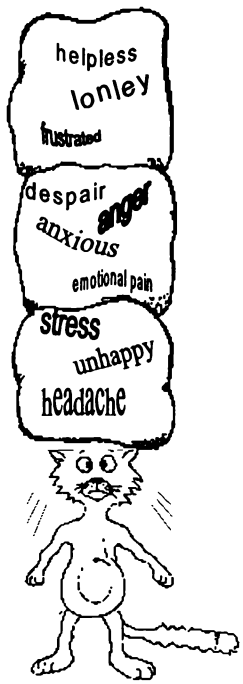


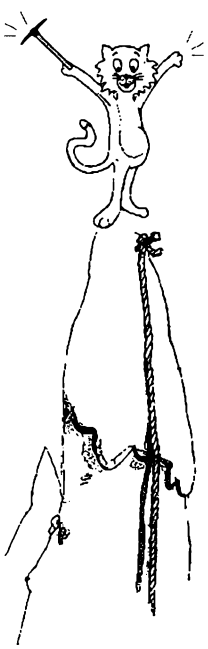
Problem-solving is about finding solutions that everyone can agree to

Why Do Problem Solving?

What happens when you don't have problem-solving skills?

- You may feel inadequate or incompetent
- You may become stressed and have reactions such as tension headaches
- You may keep thinking about the situation over and over again
- You may feel of helpless which makes the problem seem harder and more impossible to handle
- You may feel anxious, frustrated or angry
- You may feel hurt and those feelings won't go away
- You may be impatient and give up easily if an immediate solution is not available to you
- You may ignore the situation and do nothing - which means it probably won't get better and it may get worse
- You may do something impulsive that seems effective at the time but ends up a disaster.





What happens when you do have problem-solving skills?

- You will see problems as being normal and recognise them when they occur
- You will believe that problems can be solved
- You will have confidence in your ability to solve problems
- You will stay calm and have a greater sense of control
- You will know there is no harm in attempting to solve a problem and not succeed
- You will not feel threatened and may view problems as challenges or opportunities
- You will know that problem solving takes time and effort

Problems are normal - we all have them from to time
It is up to us to deal with them

Advantages of Problem Solving

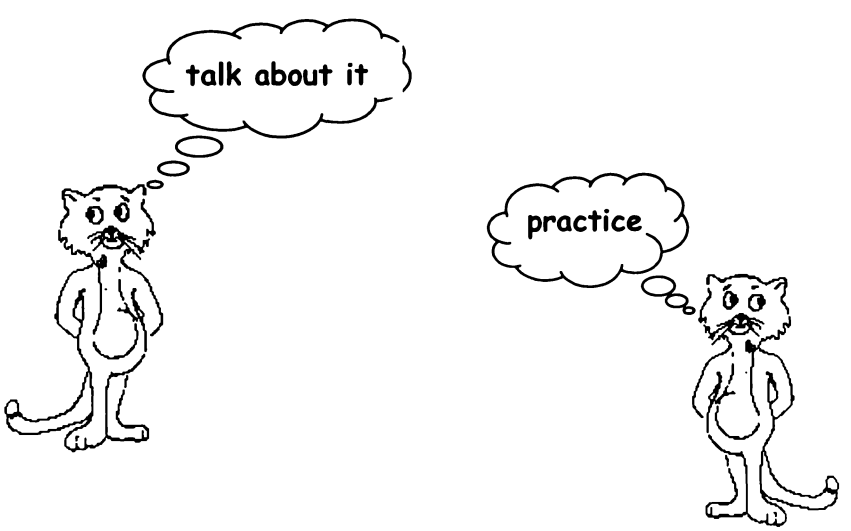
If there is a disagreement, there is a problem. The problem solving approach sets up a situation in which you can solve the problem together. It produces creative ideas and stronger relationships.

- ⇨ One person does not have total control over the discussion
- ⇨ It helps you listen to each other.
- ⇨ It provides guidelines to discuss difficult issues
- ⇨ Problem solving is present and future oriented - there is no need to discuss past events
- ⇨ Learning problem solving will help you to figure out the consequences to potential solutions and come up with other responses that will pay off in the long run.
- ⇨ It helps you to find solutions to problems or reach agreements

People learn to be good problem solvers

Think about this in the same way as learning to ride a bike

- Most people aren't too good at when they first start
- With practice - they do get better
- With further practice - they become quite skilled



The Five Stages of Problem Solving

Define the Problem

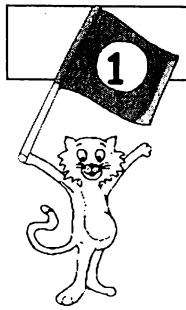
Generate Possible Solutions

What are the Choices - "Brainstorm"

Evaluate the Possible Solutions

Select the Best Solution

Put Your Plan into Action and Evaluate the Outcomes



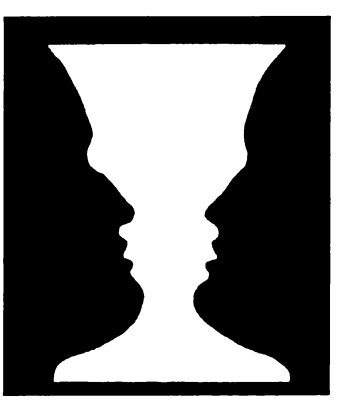
Define the Problem

The problem must be clearly defined and understood by everyone involved. Trying to solve a problem before having a clear definition is likely to be as successful as playing tennis when the strings in your racket are broken.

Questions to help define the problem

- Where does the problem occur?
- When does the problem occur?
- Who else is present when the problem occurs?
- What does the other person do when the problem occurs?
- What do I do when the problem occurs?

What do you see?



Defining a problem is a bit like looking at these pictures. You might see a problem in different ways when you look more closely.

Generate Possible Solutions "Brainstorm"

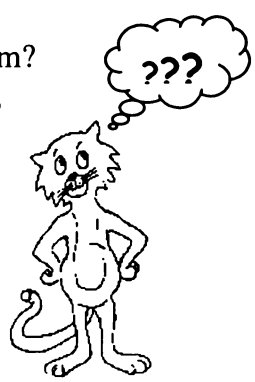
- List as many ideas as possible - all ideas are acceptable. Quantity is wanted. The greater the number of ideas, the greater the likelihood of useful ideas.

- No judgements, evaluations or criticisms. This stops new ideas being suggested.

- Be creative, imaginative, and outrageous - anything goes.

- Build on or improve ideas others have put forward. Suggest how other ideas can be turned into *better* ideas. Suggest how two or more ideas can be joined combined.

Questions you can ask yourself



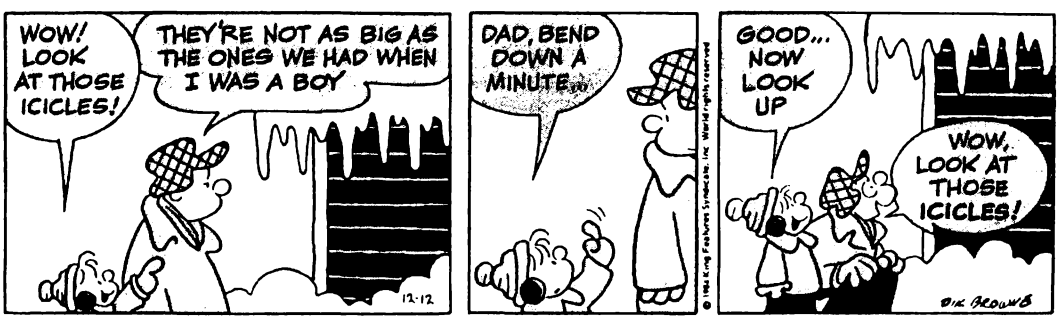
- What would you like to see change about this specific problem?
- If you had a magic wand, what outcome would you wish for?
- Is a trade possible?
- Can the physical environment be rearranged?
- What can the other person do?
- What can I do?
- What can be done together?
- Can something be done to help remind family members to act differently?
- What is preventing us from solving our problem?

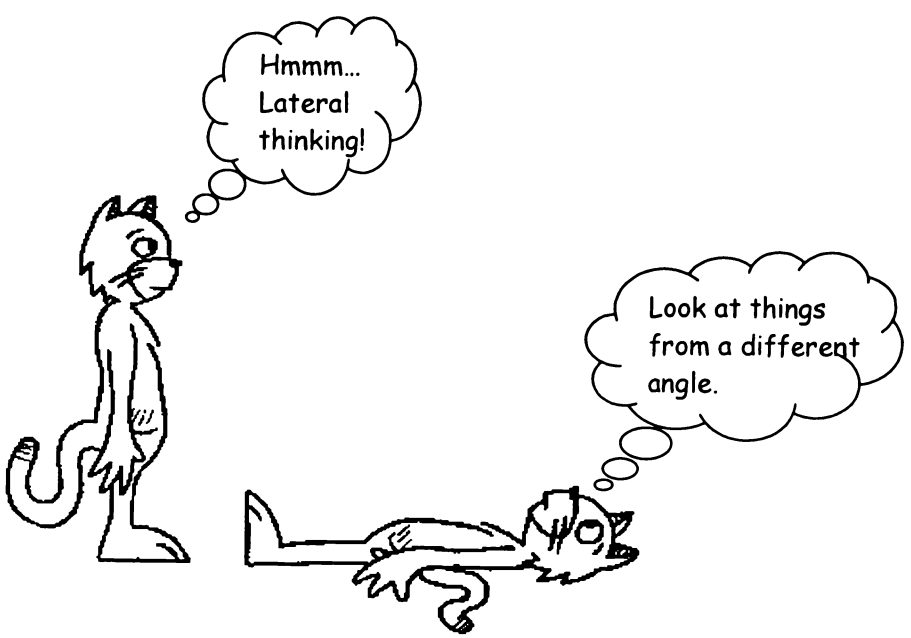
What you can do if you get stuck

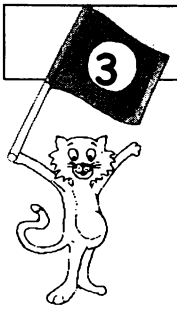
Picture it. Picture what the situation would look like if the problem were already solved. Imagine what you would be doing if it were solved. Imagine what others would be doing if it were solved. Think about how you might get to that point from where you are now.

Think silly. Come up with completely ridiculous solutions, the funnier the better. Once you have had a few laughs, you may have a surprisingly clearer perspective of the problem.

Change perspective. Reverse roles. Think about how the other person sees the situation.







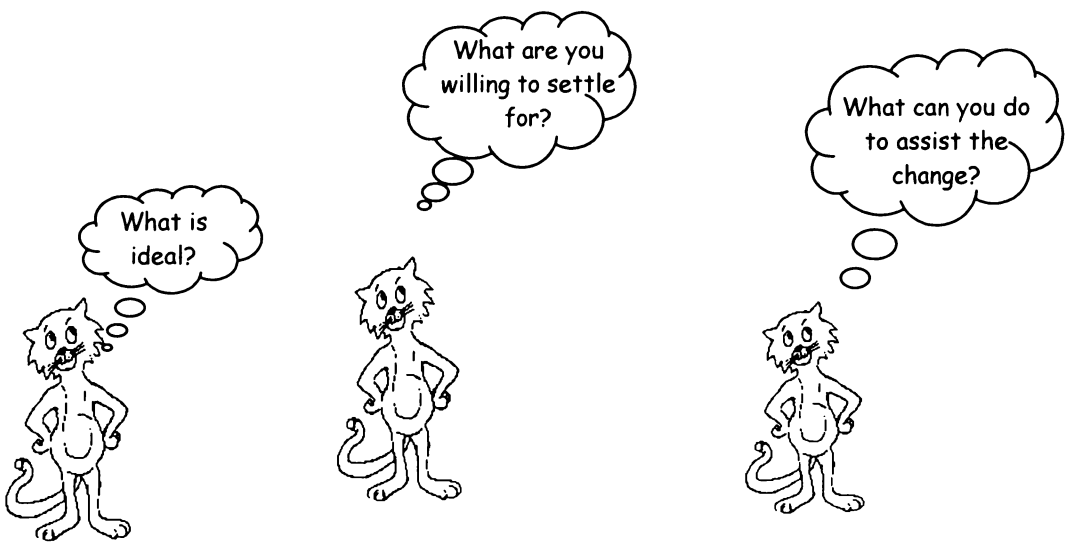
Evaluate the Options

The solutions for problems should involve change by all the people involved whenever possible

- Decide which options are realistic and unrealistic
  - eliminate unrealistic options - cross them off the list

- Consider the consequences of each option
  - what would happen if you tried that?
  - would it help to solve the problem?
  - how would you feel?
  - how would others feel?
  - is it safe?
  - would it change your reaction to other people?
  - would it change how other people react to you?
  - does it solve this problem but create other problems?

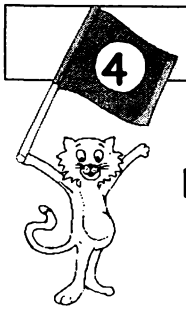
- Use the decision grid technique
  - what good and not so good things that will come from each option?
  - what will the effects be right now?
  - what will the effects be next week, next month, or next year?



You must be willing to compromise when asking others to change their behaviour

DECISION GRID

Suggested Solution	Positive Outcomes		Negative Outcomes	
	Short Term	Long Term	Short Term	Long Term



Select the Best Solution

Negotiate an agreement that is going to work the best for each family member

- Look at the advantages and disadvantages of each option.
- Which option will be most rewarding for the people involved?
- Which options are most realistic?
- Which suggestions are too hopeful or are likely to be difficult to carry out?
- Can options be combined?

Rate the best 2-3 ideas

Put Your Plan into Action and Evaluate the Outcomes

Now the option is chosen -
Plan how to achieve that goal

Final agreements should be written down

- State clearly what each family member is going to do differently
- (when, where, how often, etc).
- How you are going to monitor the outcomes?
- What will the reward be for keeping to the agreement?
- What will happen if the agreement is broken?

- ❖ **Put the agreement in a prominent place in your home**
- ❖ **Put your plan into action**
- ❖ **If the plan doesn't work out - just go back to step 2 or 3 and try again**

Appendix K

Materials Provided to Domain and Development Training Group Participants

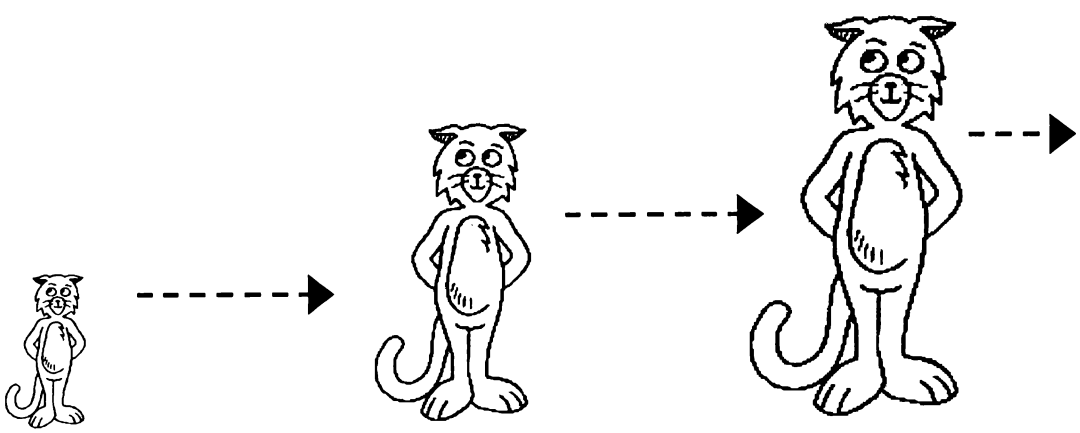
Understanding Changing Roles and Responsibilities in Our Family

Change

All people change as they travel on their journey from a child to being an adult

- Some changes are gradual
- Some changes are sudden

Many changes take place during teenage years - some quite rapidly



Our goal is to understand what changes take place that makes this time difficult for some teens and for some parents. The teenage years can be less difficult and less stressful if we are aware of our roles and discuss our responsibilities that come along with those changes.

What is Teenage Development?

Teen development refers to the changes that take place as we travel on our journey from being a child to becoming an adult.

- **Biological**
  Even though the timing differs - everyone becomes physically and sexually mature.

- **Social Status**
  Legal and political status changes during the teenage years. For example, teens reach an age where they can legally drive a car, drink alcohol, or vote. (It also means teenagers usually have to pay more to go places like the movies!)

- **Reasoning and Thinking**
  Teens become more aware. Understanding and knowledge develop. Teens think and reason differently from when they were children about new experiences and opportunities. They begin to think about what is possible and what might be, not only what is real.

- **Education**
  Schools can influence teen development. Many friendships are formed there. Emphasis is placed on achievement or training for employment.

- **Vocation**
  Choosing and preparing for a job or career is a developmental task of adolescence.

- **Autonomy / Independence**
  Teenagers may become more assertive and develop independent decision making abilities which leads to re-negotiation of the parent-teen relationship.

- **Changed Relationships with Peers**
  Teens spend more time with peers. They begin to share feelings, plans, hopes and experiences with their friends rather than just sharing activities or interests. Dating may take on increased importance. Feelings of self-worth may become dependent on acceptance from peers.

- **Sense of Identity**
  Teens begin to develop some idea of who they are, where they are going, and what the possibilities are of getting there.

Why Do We Need To Know About Teen Development?

What are the Roles and Responsibilities of Teenagers?

- To adjust to the changes and master the developmental tasks.
- To develop independent decision-making abilities, while remaining connected to your family. **Remember:** HEALTHY INDEPENDENCE IS FOSTERED BY CLOSE FAMILY RELATIONSHIPS.
- To develop a set of guiding beliefs and standards as a basis for independent decisions and actions.
- To accept responsibility for the consequences of your decisions.

What are the Roles and Responsibilities of Parents?

These roles and responsibilities are commonly identified by parents of teenagers.

- provide food and shelter
- provide supervision and guidance
- provide emotional support
- be supportive
- take an interest in their activities
- gradually increase the teen's areas of independence
- provide opportunities for friendships with peers
- discuss and negotiate rules
- set clear standards
- have interests outside the family to maintain their own sense of self-esteem

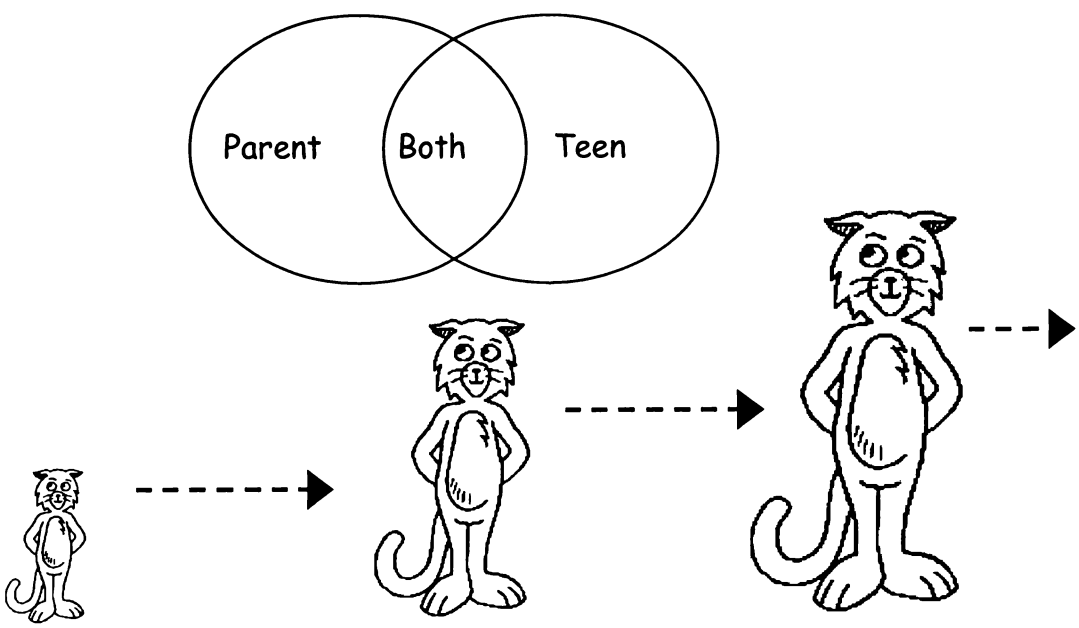
There may be other roles and responsibilities that are important in your family. Please add them to this list.

Who Makes the Decisions?

During this time of changing roles and responsibilities, we also have changing beliefs about who is responsible for the decisions that are made.

There are three main ways decisions can be made and responsibility for decisions is accepted.

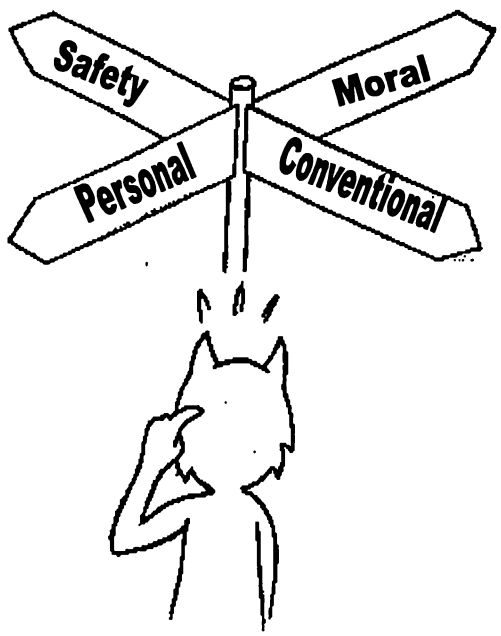
- by the parent alone
- by the teenager alone
- by the parent and teenager together



Parents and teenagers usually have the same long term goal, that is, for the teenager to become a responsible young adult you can make it on their own. To achieve this goal, parents support their teen in developing good decision making skills, and gradually increase the areas of independent teen decision-making.

Domains for Decisions Making

These four domains are a way of looking at understanding who is responsible for decisions made. It is also a way of understanding our reasoning about issues of conflict and why parents and teens may disagree.



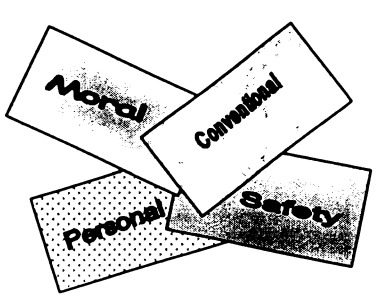
Moral
Behaviour that is wrong because it affects the rights and welfare of others.

Conventional
Agreed-upon rules, customs, and standards of social behaviour that structure our interactions and environments.

Safety
Issues that have negative consequences to you such as harm, comfort, and health.

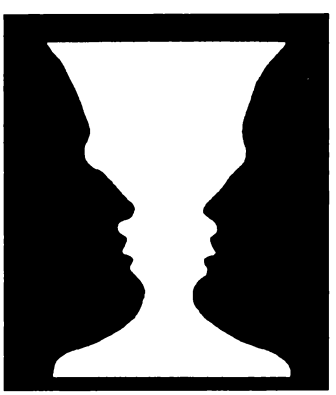
Personal
Issues that concern only the individual involved, and have consequences only to the individual involved. Personal issues are those that fall outside conventional social behaviour standards and moral concerns.

Remember: These domains are not always distinct. The boundaries may overlap. That is, you may see some issues as belonging to more than one domain.

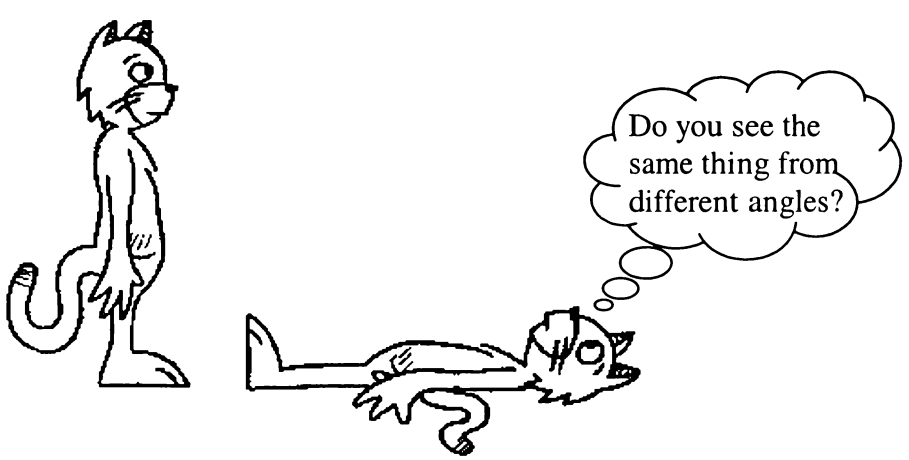


Questions for your Family to Consider

- **What domain do you put issues in?**
- **Who is responsible for making decisions in each of these domains?**
- **Does this change as the teenager becomes older?**



Do you the same thing differently?
Talk about it.



Appendix L

Comparisons of Participants' Pre-Treatment Data With Normative Samples

Table L.1
Means and Standard Deviations from the Family Environment Scale for Normative Family Sample and Treatment Study Participants at Pre-Treatment

Sub-scale	Treatment Group				Normal Family Sample	
	Parents		Teens			
	M	*SD*	*M*	*SD*	*M*	*SD*
Cohesion	4.54	2.61	3.15	2.44	6.61	1.36
Expressiveness	4.23	1.70	3.35	1.83	5.45	1.55
Conflict	4.85	2.48	5.65	2.08	3.31	1.85
Independence	5.73	1.28	4.92	1.72	6.61	1.19
Organisation	4.85	2.11	4.69	2.09	5.41	1.83
Control	5.23	2.05	6.38	2.38	4.34	1.81

Note: 10 is the maximum score

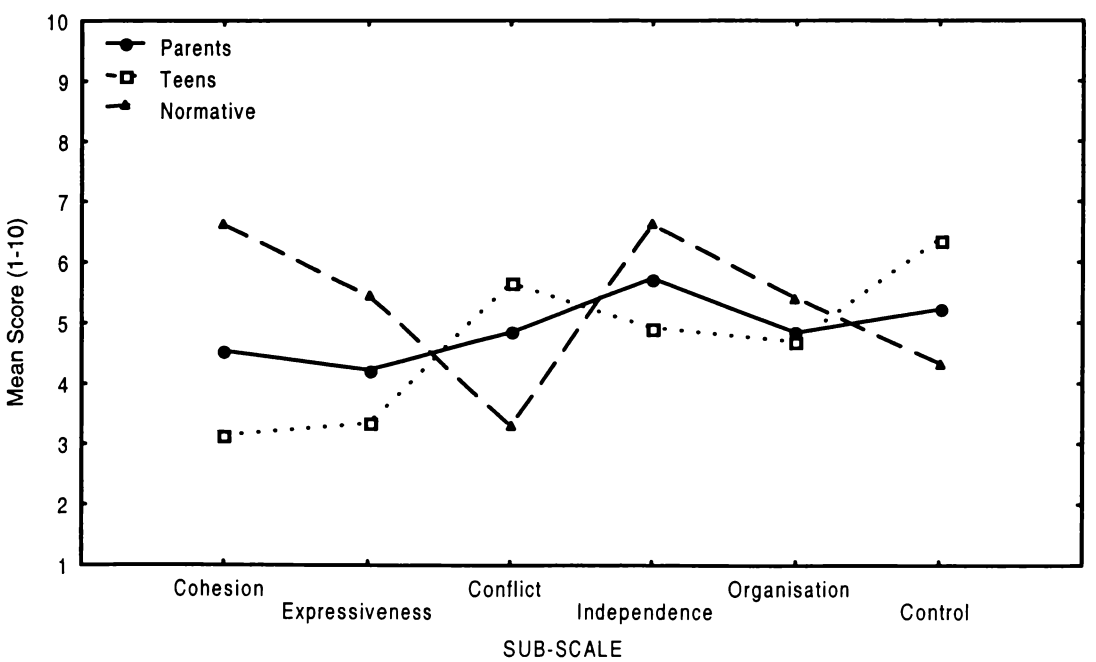


Figure L.1. Profile of mean scores from the Family Environment Scale for normative family sample and treatment group participants at pre-treatment.

Table L.2
Means and Standard Deviations from the Conflict Behavior Questionnaire for Non-distressed Normative Sample and Treatment Study Participants at Pre-treatment

Variable	Treatment Group Participants			Non-distressed Normative Sample		
	n	*M*	*SD*	*n*	*M*	*SD*
Female Parent						
Parent appraisal of teen	18	26.9	7.6	68	8.0	5.7
Parent appraisal of dyad	18	8.7	4.0	68	2.4	2.1
Teen appraisal of parent	18	23.1	11.9	68	6.8	7.3
Teen appraisal of dyad	18	9.7	5.1	68	4.0	2.3
Male Parent						
Parent appraisal of teen	8	25.0	8.9	14	11.1	7.1
Parent appraisal of dyad	8	8.4	5.6	14	2.9	1.8
Teen appraisal of parent	8	18.6	13.7	14	6.1	5.2
Teen appraisal of dyad	8	8.3	5.3	14	4.2	2.4

Note:
Maximum scores for *appraisal of other* are 53 for parents and 51 for teens.
Maximum scores for *appraisal of dyad* are 22 for both parents and teens.

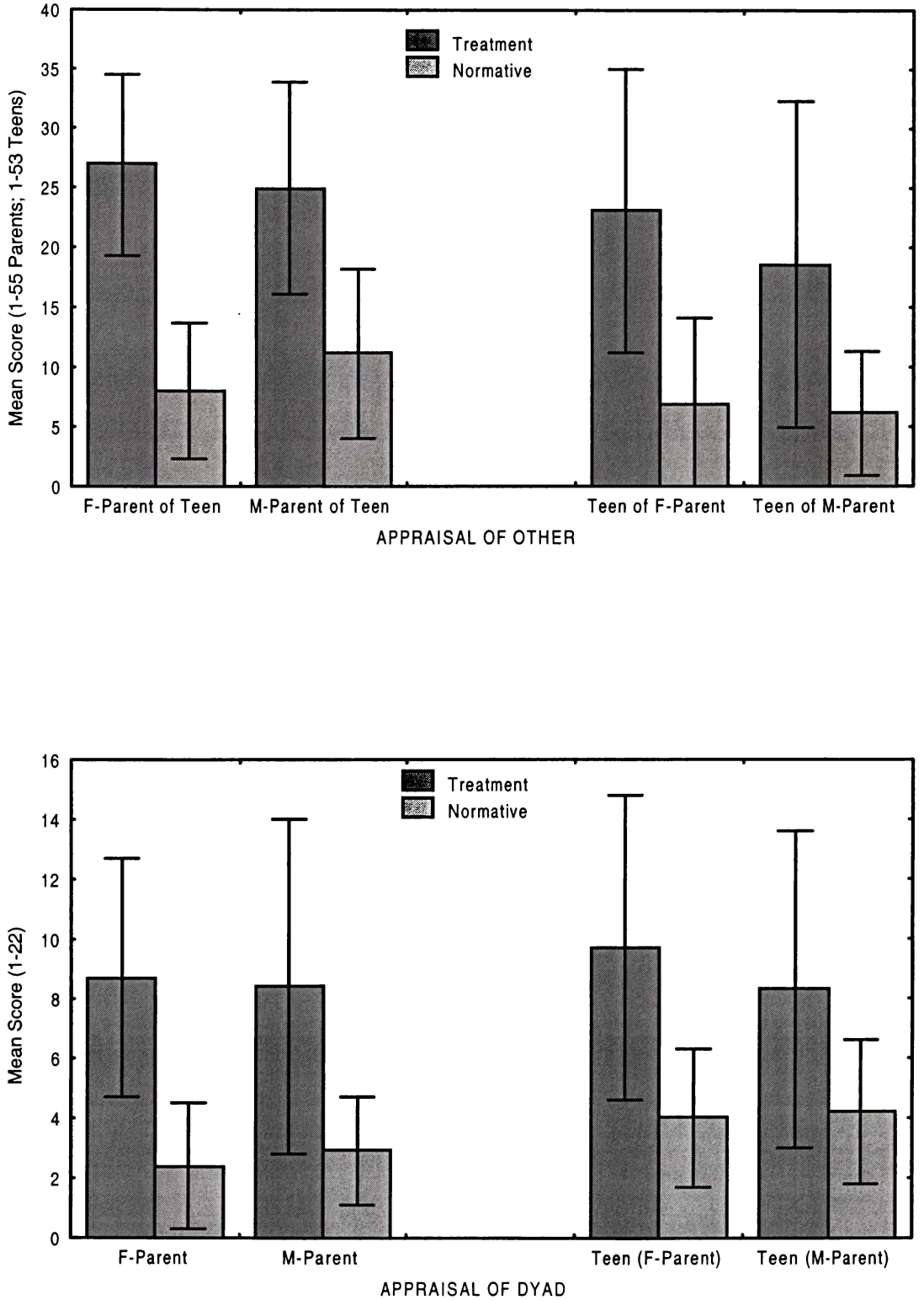


Figure L.2. Mean scores from the Conflict Behavior Questionnaire for normative family sample and treatment group participants at pretreatment; top = appraisal of other, bottom = appraisal of dyad.

Table L.3.
Means and Standard Deviations from the Parental Authority Questionnaire for Normative Samples and Treatment Study Participants at Pre-Treatment: Teens

	Treatment Group: Teens		Normative Samples			
			High School Students[a]		University Students[b]	
	M	*SD*	*M*	*SD*	*M*	*SD*
Mother						
Authoritarian	28.61	6.50	21.49	5.23	26.97	7.12
Authoritative	30.78	6.98	24.69	5.30	37.34	5.60
Permissive	26.94	5.95	17.92	4.87	25.43	5.73
Father						
Authoritarian	32.13	4.61	22.78	6.02	28.74	7.90
Authoritative	34.88	5.67	23.01	5.78	35.56	6.57
Permissive	25.63	5.21	16.64	4.46	25.12	5.39

Note: [a] Mean age = 17.4 years, [b] Mean age = 18.8 years

Table L.4
Means and Standard Deviations from the Parental Authority Questionnaire from the Survey Study and Treatment Group Participants at Pre-Treatment

Variable	Treatment Group				General Community Group			
	Parents		Teens		Parents		Teens	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Authoritarian	28.42	5.79	29.69	6.12	27.13	5.53	29.77	6.08
Authoritative	39.77	4.61	32.04	6.77	40.94	3.87	34.90	6.61
Permissive	25.62	4.10	26.54	5.66	25.02	5.33	27.81	5.05

Table L.5
Means and Standard Deviations from the Relationship Questionnaire from the Survey Study and Treatment Group Participants at Pre-Treatment

Variable	Treatment Group				General Community Group			
	Parents		Teens		Parents		Teens	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Total Score	30.00	3.79	25.65	5.56	31.99	4.03	30.35	5.95

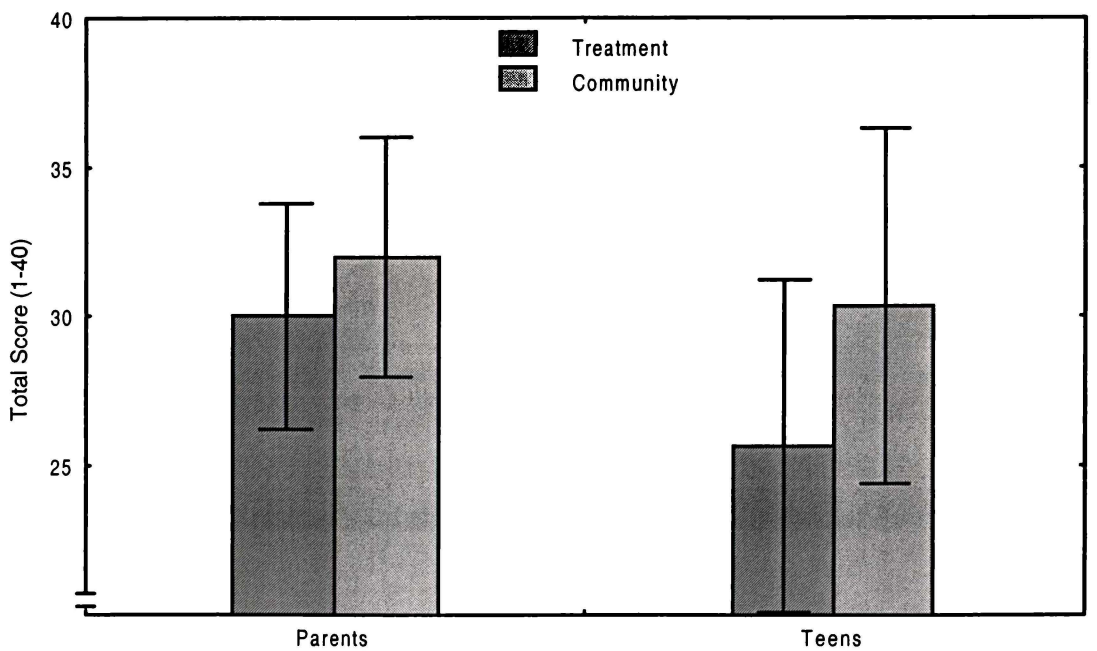
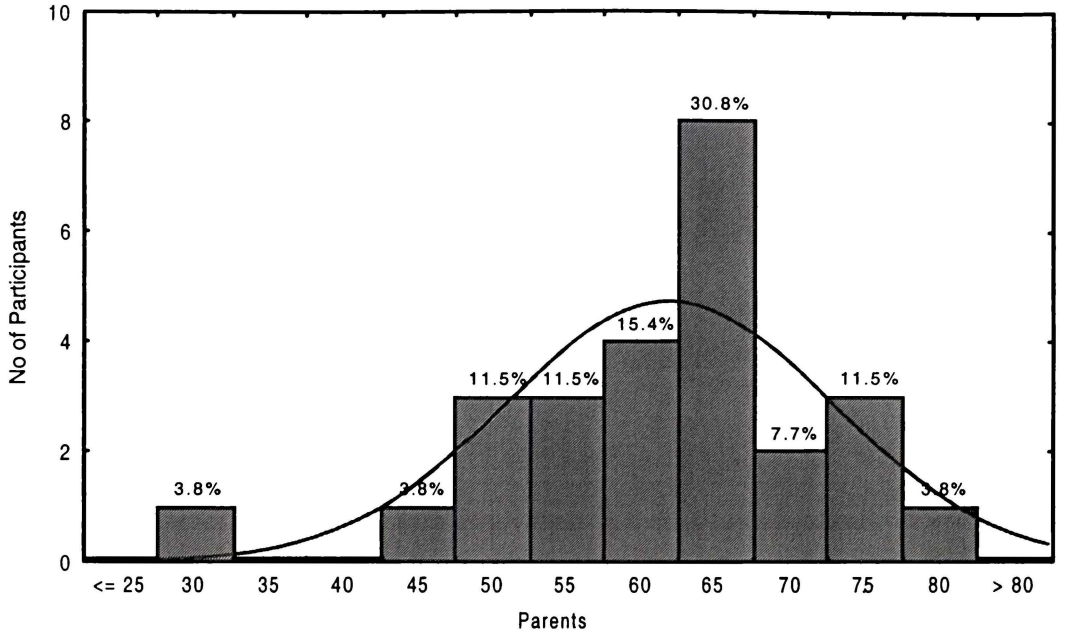


Figure L.3. Mean scores from the Relationship Questionnaire for parents and teens from the general community sample and treatment group participants at pre-treatment.



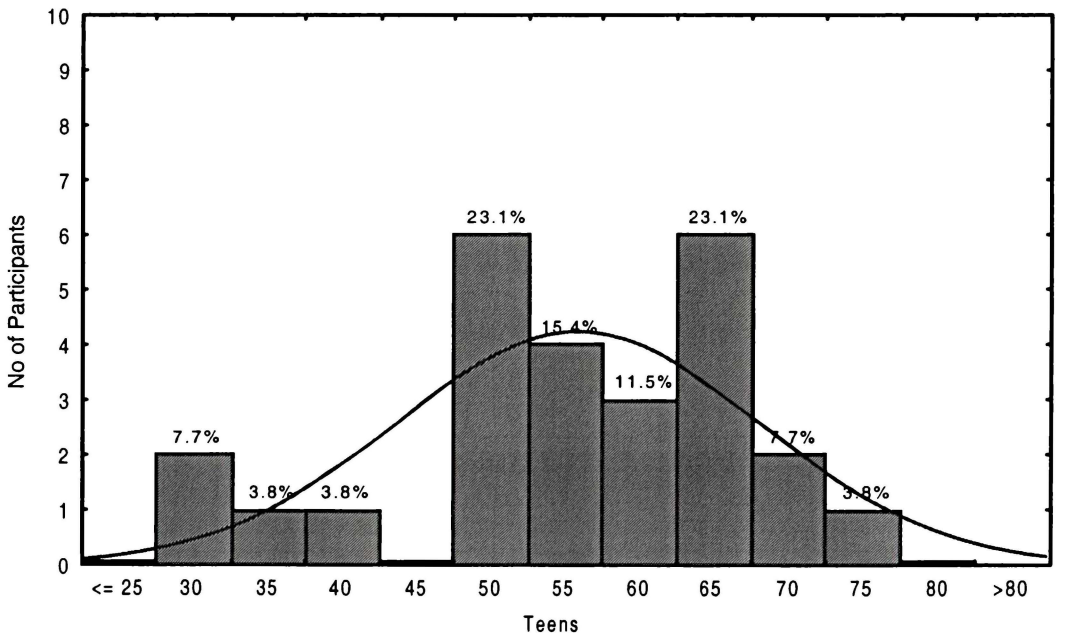


Figure L.4. Histograms of Global Severity Index Scores from the Symptom Checklist-90-R: Parents and Teens.

Table L.6
Means and Standard Deviations from the Social Problem-Solving Inventory-Revised for Normative Samples and Treatment Study Participants at Pre-Treatment

	Treatment Participants				Normative Samples			
	Parents		Teens		Middle Aged Adults		High School Students	
Sub-scale	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Positive Problem Orientation[a]	14.19	3.29	11.50	3.03	13.53	3.85	11.47	3.81
Negative Problem Orientation[b]	13.96	9.04	23.62	10.31	9.46	7.02	17.68	8.43
Rational Problem Solving[c]	46.46	11.89	39.46	10.10	47.90	15.07	41.45	13.00
Impulsivity / Carelessness Style[d]	8.69	7.14	20.88	8.01	9.11	6.00	16.81	6.44
Avoidance Style[e]	7.00	6.03	14.38	6.31	6.30	5.87	12.02	5.73

Note: Maximum sub-scales scores are: [a] = 20, [b] = 40, [c] = 80, [d] = 40, [e] = 28.

Appendix M

Comparison of Parent and Teen Scores from the Domains and Development Questionnaire

Table M.1
Means and Standard Deviations from the Domains and Development Questionnaire at Pre-Treatment: Parents and Teens

Dimension	Parents		Teens	
	*M**	*SD*	*M**	*SD*
Positive Orientation	2.54	0.73	2.31	0.71
Negative Orientation	1.62	1.04	1.69	0.80
Teen Development	2.41	0.57	2.13	0.62
Roles and Responsibilities	2.04	0.61	2.16	0.52
Domains	1.95	0.70	1.56	0.77
Total Score	11.32	1.92	10.47	1.56

* *Note*: To permit comparison between dimensions, mean scores have been calculated for each group of items (range = 0 to 4). Total score range = 0 to 20.

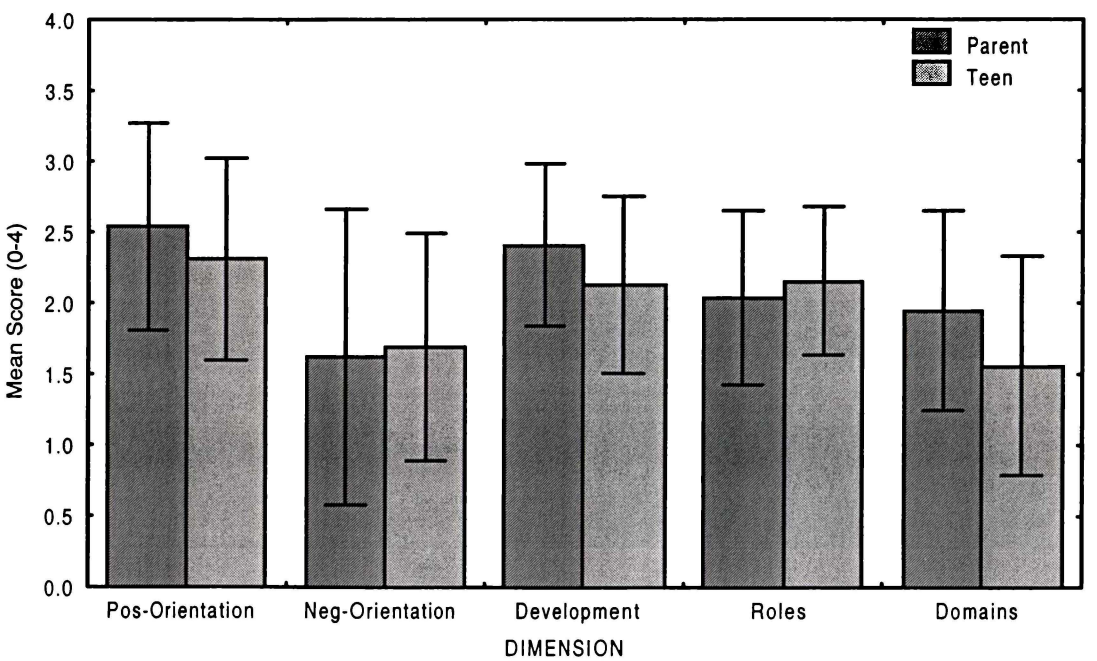


Figure M.1. Mean scores from the Domains and Development Questionnaire at pre-treatment: Parents and Teens.

Appendix N

Histograms Showing Distribution of Scores for Evaluation of Treatment

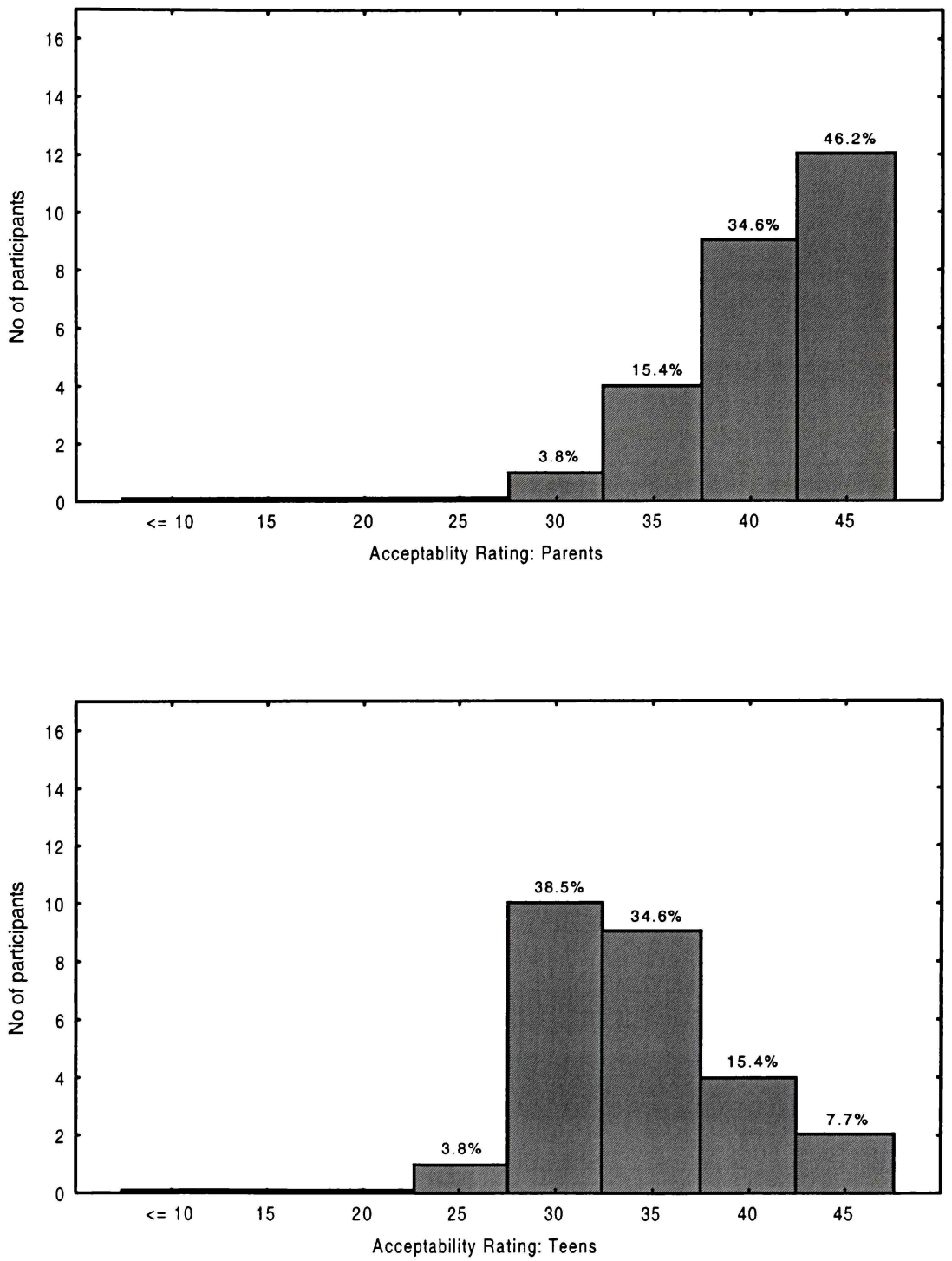


Figure N.1. Histograms of participant evaluation scores for acceptability of treatment; top = parents, bottom = teens.

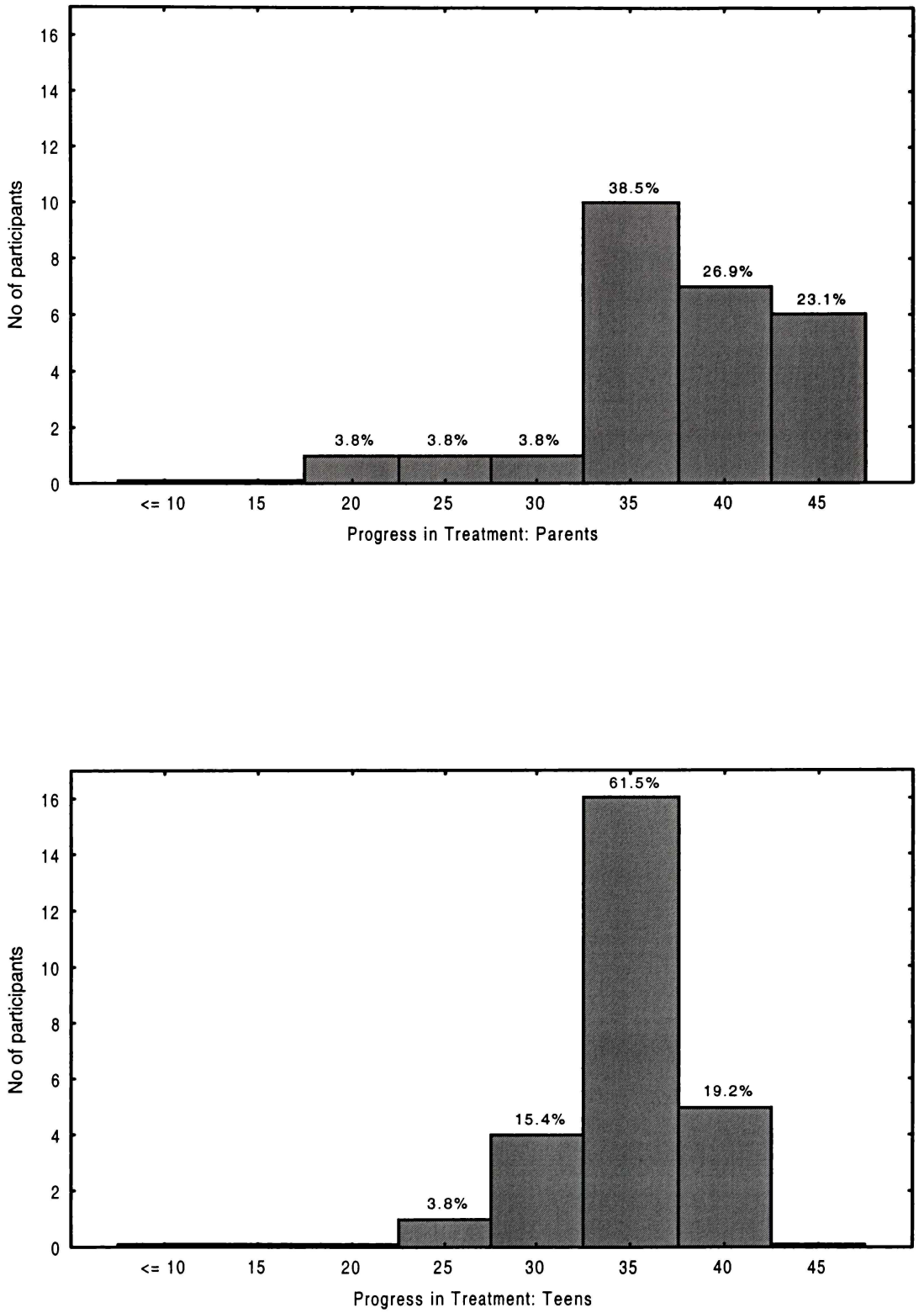


Figure N.2. Histograms of participant evaluation scores for progress in treatment; top = parents, bottom = teens.

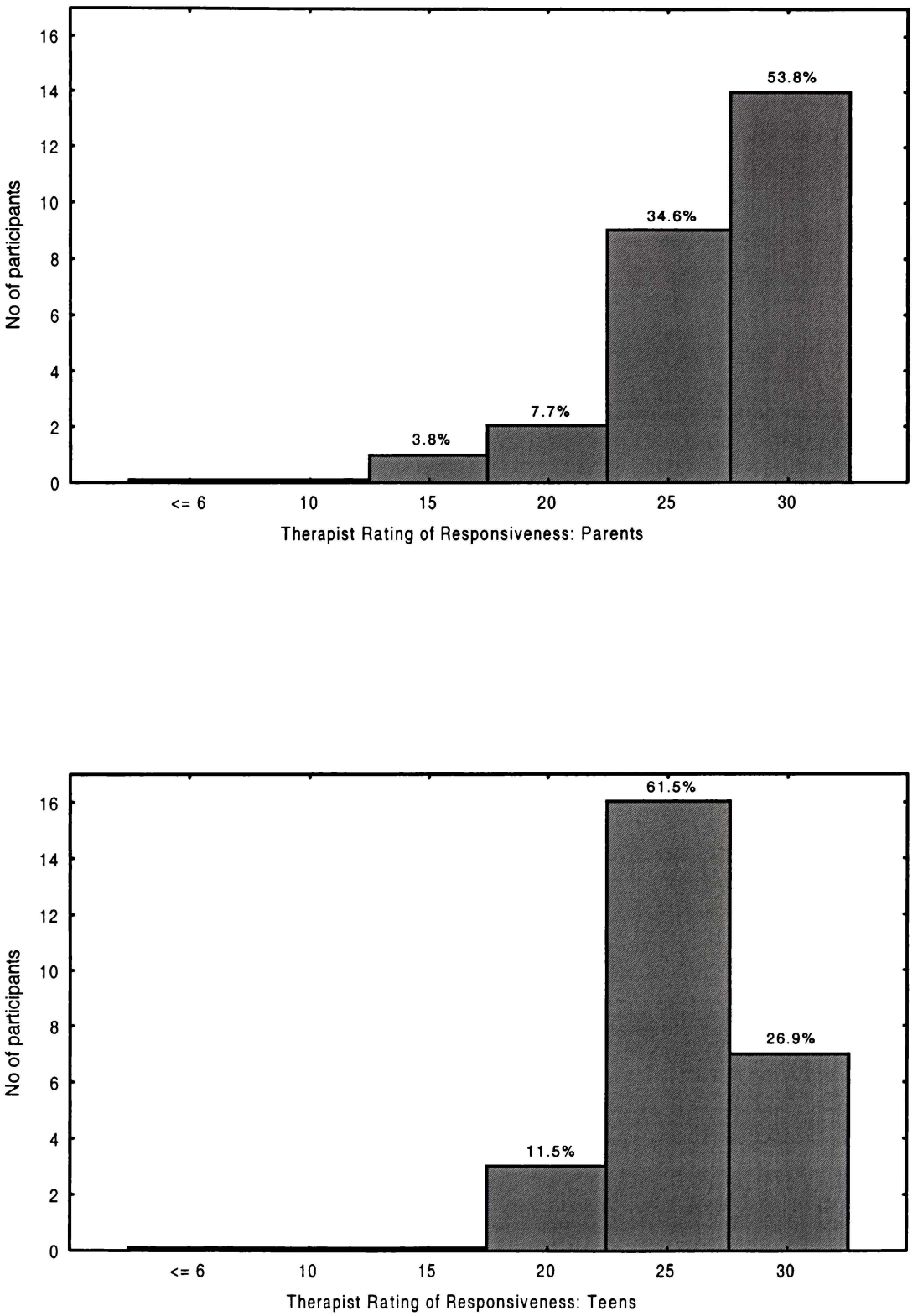
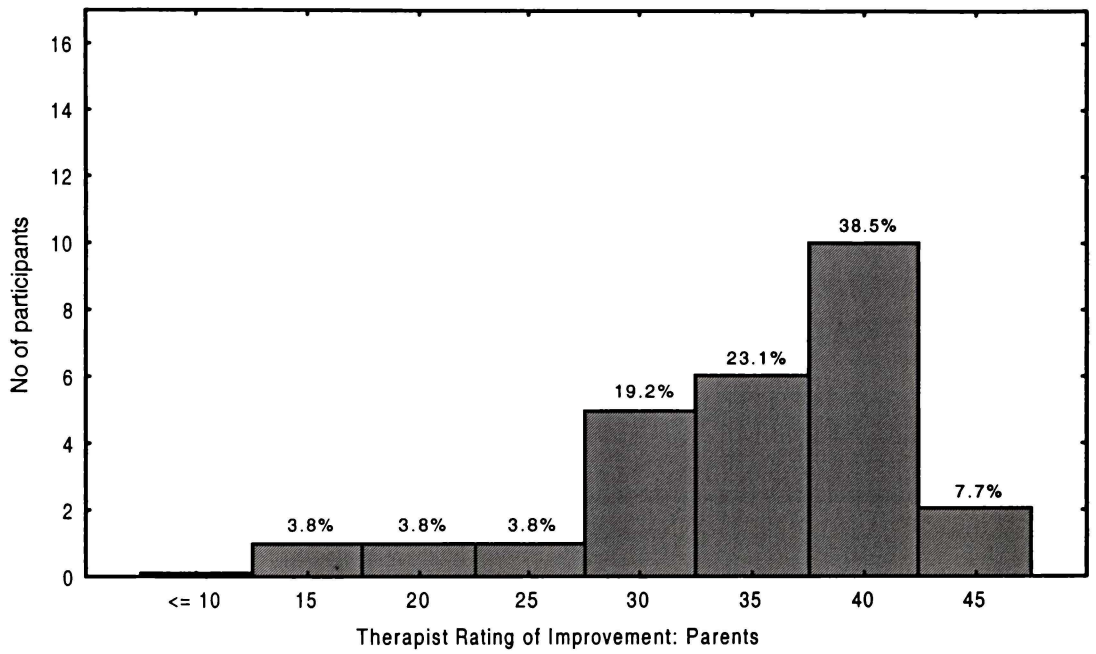


Figure N.3. Histograms of therapist evaluation scores for responsiveness during sessions; top = parents, bottom = teens.



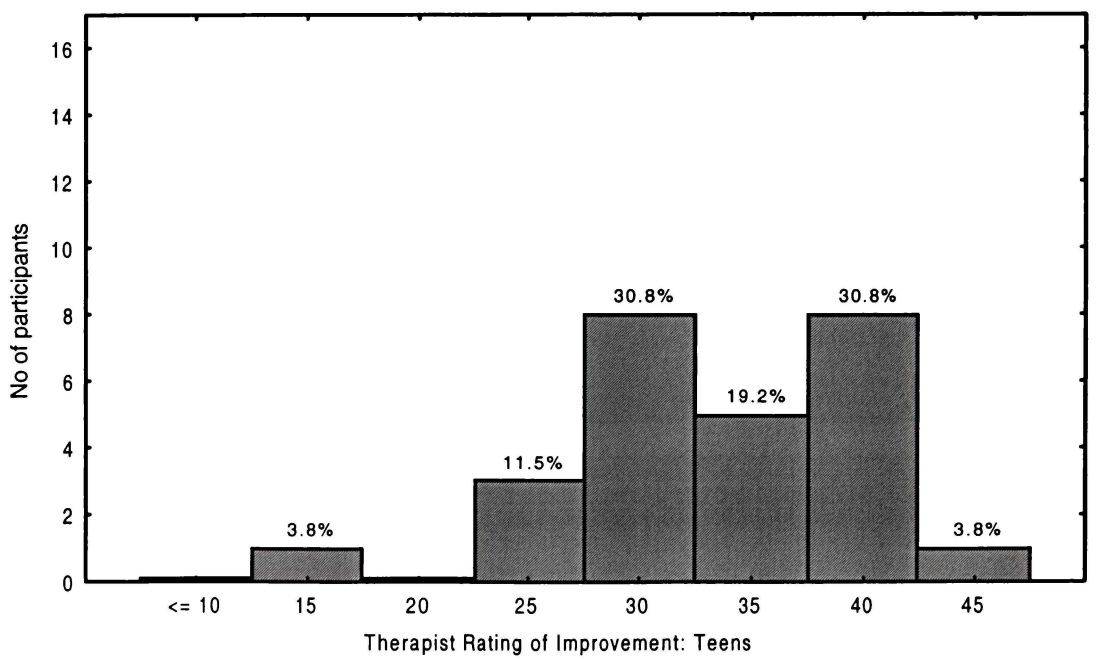


Figure N.4. Histograms of therapist evaluation scores for improvement during treatment; top = parents, bottom = teens.