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What is the impact of Parent Effectiveness Training on parental stress, parent-child interaction and children difficulties? A quantitative research study on a Greek population sample.

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Note: The Parenting Stress Index 3rd edition – Short Form is only available by purchase and therefore does not appear in the appendices for copyright reasons.

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Abstract

Background: Parent Effectiveness Training (PET) is a person-centered non-punitive parent training programme, created by Dr. Thomas Gordon in the early sixties. It emphasizes on the relationship between parent and child and teaches communication skills based on active listening and self-disclosure in the form of I-messages, as well as conflict resolution skills. The objective of this one group, pre-post design study is to examine a) the characteristics of the parents and families who become involved with the Parent Effectiveness Training (PET) programme and b) the effectiveness of the programme for the parents in regards to their stress in their role as parents, their interaction with their children, as well as their children's parent-reported difficulties. **Method:** 30 participants, parents self-referred to a PET certified facilitator and recruited from 7 different parent groups, running from January 2015 to June 2015 in a suburb of Athens, participated in this study. The parents completed a form regarding demographics, as well as the Parenting Stress Index (PSI) and the Strengths and Difficulties Questionnaire (SDQ) at the beginning and end of the parenting programme. **Results:** As expected, parents' pretest scores were non-clinical, indicating that PET served as a preventive intervention. After the end of the PET programme, parents reported significantly lower levels of Parental Stress ($p < .001$) and all its three subscales, namely Parental Distress ($p = .006$), Parent-Child Dysfunctional Interaction ($p < .001$) and Difficult Child ($p < .001$). Parents also reported a significant decrease in overall child difficulties ($p = .031$) and in their overall evaluation of their child's difficulties in emotions, concentration, behaviour or ability to get on with other people ($p = .017$), as well as in the impact of these difficulties as a burden in the child's everyday life ($p = .007$). **Conclusion:** The present study's findings indicate that the Parent Effectiveness Training programme is indeed useful as a preventive intervention in the Greek population, since, it has proved effective in reducing parents' stress in their parenting role, in promoting the parent-child relationship and in reducing children's difficulties, at least in the short term.

Key words: parent effectiveness training, parental stress, parent-child interaction, children difficulties, Greek population, one group pre-post study

1. Introduction

It seems a long time since the Children Act (1989) explicitly defined parental responsibility, emphasized the duty of parents to ensure their children's moral, physical and emotional well being, and obliged Local Authorities to promote the upbringing of children by their families by providing services required to support parents in their "parenting" task. But what exactly is this "parenting task"? In the *Handbook of Parenting,* parenting is defined thus:

'Put succinctly, parents create people. It is the entrusted and abiding task of parents to prepare their offspring for the physical, psychosocial and economic conditions in which they will eventually fare, and it is hoped, flourish…. Parents are the "final common pathway" to children's development and stature, adjustment and success.'
(Bornstein, 2002; Preface, page ix)

This is an inspiring definition, though it tells us very little about what parents actually do and what actually constitutes parenting. It is also striking that in most writing about parenting, there seems to be consensus that parenting is one of the most difficult jobs that exists. In addition, everybody, including mental health experts, blames the parents for the development of emotional problems of youth and for the problems that the latter consequently cause society as adults. But who helps the parents? Although their task is so demanding and family relationships are so important, it has been discovered that parents usually receive little preparation beyond the experience of having been parented themselves and learning "on the job", through their mistakes (Hutchings & Webster-Stratton, 2004; Sanders, Tully et al, 1999). The demands of parenting are further complicated by changes in family structure, such as divorces, unmarried families, re-partnering, centralization of population in large urban centres and women's' employment (Kanigsberg and Levant, 1988).

Ever since the 1960s, the arising need for effective parenting skills in the United States has led to the development of approaches to train parents in skills seen as necessary for a harmonious parent-child relationship and for the amelioration of a number of childhood problems (Hawkings, 1972). One of the first such parent training programmes was developed by Dr. Thomas Gordon, a clinical psychologist, student of Carl Rogers, who taught his first group of parents in 1962 in a cafeteria in Pasadena,

California. The programme was “Parent Effectiveness Training” and has served as a model for many parent-training programmes in the United States (Gordon, 2000). Ever since then, there has been an enormous growth in interventions supporting parents around the world.

The purpose of this introduction is to demonstrate that parent training is not only useful, but absolutely necessary as a prevention for various parent and children problems. And as prevention is always easier than correction, parent interventions are an extremely helpful tool for promoting healthier parental practices, serving the parents’ mental well-being and self-esteem, enriching and ameliorating the relationship with their children and preventing serious psychological or behavioural children problems, that could result in even more serious problems in adulthood. Furthermore, the essay will present the more popular and acclaimed parent training programmes around the world and clarify where Parent Effectiveness Training stands both theoretically and practically compared to them and what kind of parenting style it promotes. Finally, since the purpose of this study is to examine the effectiveness of PET, the last chapter of the literature review will be in regard to previous research made on the effectiveness of parent training programmes in general and PET in particular.

2. Literature review

As mentioned above, this review will be divided in three sections: The first section will discuss the necessity of parenting programmes regarding a) the mental well-being of parents and the reduction of their stress in their parenting role b) the quality of the parent-child interaction and c) the children’s emotional and behavioural development. The second section will present the most renowned parent-training programmes and parenting styles, will explain PET’s theoretical underpinnings and practice implementation and will elaborate where PET stands in comparison to other parenting interventions and styles. The third section will discuss previous research made concerning a) general components associated with parent-training programmes’ effectiveness and b) the effectiveness of parent-training programmes and PET in particular.

2.1 The necessity of Parent-Training as a tool for reducing parental stress, promoting the parent-child relationship and dealing with children difficulties.

The quality of family life is fundamental to the well-being of children. The important role of the family in child development as well as the quality of parent-child relationship and its effect in the child's psychological, social and cognitive development has been vastly studied (O' Connor & Scott, 2007 ; Hoghughi & Long, 2004). Safe, nurturing and positive parent-child relationships lay the foundations for the psychological, physical and social well-being of children (Collins et al, 2000), whereas harsh, punitive parenting, inadequate support and supervision, insecure attachment, family conflict and parental distress and psychopathology negatively influence children's development (Baker at al, 2005; Cummings & Davies, 1994; Patterson & Dishion, 1985). Such poor parenting has been proven to increase the risk of children developing emotional and externalizing problems such as antisocial behaviour, substance abuse and juvenile delinquency (Coie, 1996).

The improvement of the quality of parenting children receive seemed compelling. Starting in the 1960s, there was a shift in dealing with children's problematic behaviour from child therapy and adolescent institutionalization to interventions focusing on changing parents' behaviour. Parenting programmes were thus developed having as main objective the amelioration of children's behaviour problems. Parent training as a prevention intervention has started to be widely used in order to promote positive development outcomes for children and adolescents. The development and implementation of parenting programmes became a public health issue (Sanders, 2012), since the programmes that were widely and thoroughly researched (mostly the ones based on social learning and behavioural models) actually proved that they were effective in three basic categories (Moran et al, 2004): a) parent outcomes (parents emotional and mental health, parenting skills, attitudes, knowledge), b) parent – child outcomes (the parent-child relationship) and c) child outcomes (children's emotional, behavioural and educational development). Since these three areas are also examined as dependent variables in this particular research for PET effectiveness, it seems necessary to refer in detail to each of them. Let it be noted that only one aspect of the first category (parent outcomes) is examined in this study, the one that concerns parent's emotional and mental wellbeing, namely parental stress.

Parental stress is not so uncommon, since becoming a parent is undeniably a challenge. Transition to parenthood is associated with many changes and adaptation to new situations (Glade et al, 2005). Changes can be cognitive, emotional, prioritizing and behavioural. It is no wonder that scientists have named this situation “a crisis” (Demick, 2000). Practical matters, such as increased housework responsibilities and expenses for the baby, reduction of social activities due to tiredness or lack of support for leaving the child to someone else, make matters even worse (Brotherson, 2009). Transition to parenthood is experienced differently for men and women (Brotherson, 2009). For men the top transition issues include financially providing for the family, tiredness, couple disagreements about roles, decline in spouse’s sexual interest and intrusion of in-laws. For women top transition issues include lack of sleep and tiredness, increased chores and housework, changes in body figure, personal doubts about parental competence, changes in work situation. Stress factors may also include bringing up children with particular health of behaviour problems, or other areas such as marital conflict, economic difficulties, or lack of social support (Moran, Ghate et al, 2004).

Miller and Sollie (1980) have found that mothers develop high levels of stress, personal and marital, after the birth of their first child. The feeling of inadequacy is very present in mothers who feel cultural expectations pressure them to be the perfect parent, perfect wife, and to upbring perfect children (Bloomfield, Kendal et al, 2005). Juggling everyone’s needs and leaving behind their own, leaves them with a feeling of exhaustion. Indeed, many mothers arrive at support services seeking help with a wide range of issues, not just those closely related to parenting. As Forehand and Kotchick (2002) state, parents cannot fully engage in parent training unless their other basic needs have been adequately addressed.

A systematic review by Barlow and Stewart-Brown (2001), assessing the effectiveness of parenting programmes aimed at improving maternal psychosocial health, concluded that a number of different approaches have been shown to be effective in improving maternal depression, anxiety/stress, and self-esteem levels. The study reported that diverse parenting programmes were successful, which suggests that common 'process' factors in the delivery of programmes (such as length (8-12 weeks)

or intensity of intervention and the training level of the trainers) may be a more important factor influencing effectiveness than any one theoretical approach. However, as Moran, Ghate et al (2004) conclude, although there have been a number of successful interventions for parents at risk for emotional and mental health problems, more studies are required to identify the precise style of programme (in terms of content and delivery) that can most effectively reduce this risk.

Another important factor that has a pervasive influence on the well-being of children and is addressed in parenting programmes is the *parent-child interaction,* one of the most important and earliest relationships that evolve throughout the child's development (Schaefer & DiGeronimo, 2000). During infancy, this relationship focuses on the parent responding to the infant's basic needs in order to form an attachment between the parent and child. During toddlerhood, parents mostly attempt to shape their children's social behaviours, acting as teachers, nurturers, and providers of guidance and affection. Throughout childhood, children become more interested in peers. However, parents continue to influence their children as providers of social opportunities, confidants, coaches, and advisors.

What constitutes a good parent-child relationship? *Affection*, commonly referred to as warmth in literature is one of the basic components (McDonnald, 1992). It is represented by emotions such as acceptance and positive regard and behaviours such as hugging, caressing, smiling, praising and showing interest in what children do. *Responsiveness*, the ability of parents to acknowledge and appropriately respond to the cues and needs of children (Ainsworth & Bell, 1970) is also crucial, since it helps children develop a sense of security and healthily develop attachment (Bowlby, 1969). *Encouragement* also helps build strong parent-child relationships. The ability of parents to actively foster children's efforts and explorations allows children to gain a sense of self efficacy and motivation to master new tasks (Frody et al, 1985). *Parent-child play* also has the potential to build and nurture emotionally positive parent-child relationships. Play between parent and child can create an emotionally safe place for children to express some of the strong emotions such as confusion, aggression, and anger that are the roots of misbehaviour (Kuchner, 2010). When parents play with their child, they demonstrate in a language louder than words the value and importance of the child. *Physical care* must also be mentioned as fundamental for a good parent-child

relationship, which includes not only looking after the child's physical well-being in terms of housing, nutrition and clothing, but also preventing child-abuse and maltreatment (Moran et al, 2004) as a disciplinary tool or an outburst of parent anger. And last but not least, *family communication* is proven to enhance parent-child relationships, especially with older children and teenagers. Fitzpatrick & Marshall (1996) classified family communication environments as either maintaining a conformity orientation (using parental power to gain the child's agreement) or a conversation orientation (parental acceptance of communication and exchange of ideas). Research (Dixson, 1995) indicates the more conversationally oriented the family is, the more likely it is that the parent and adolescent will have a good relationship.

The relationship between parents and children has been proven to have a significant impact on children behaviour. Parent-child relationships that lack warmth or are rejecting can have a negative impact on children behaviour (Amato & Rivera, 1999). Problematic parent-child interaction patterns, such as typically ignoring a child when behaving reasonably, but criticizing and shouting at when misbehaving, have been associated to conduct disorder, since the child, in order to get parent attention and preferring negative attention to none at all, has to behave unacceptably (Patterson, 1982). Conflict and parent-child hostility have also been correlated (though not yet proven as a cause factor) with Attention Deficit Hyperactivity Disorder in children (Thapar, Cooper et al, 2013).

From all the above, it seems obvious that the quality of the parent-child relationship is one of the main concerns in effective parenting support: without establishing good communication and warm relations between parent and child, parenting programmes fail to deliver good outcomes. Effective parenting programmes bring about changes in some aspect of family relationships, either parent-child communication and interaction or attachment patterns. Specific outcomes of effective parenting programmes include reductions in negative interaction, expressed anger, criticism and conflict as well as prevention of child abuse; increases in warmth-promoting, constructive responses such as praise and greater levels of involvement and interaction between parents and children; improvement in 'felt' qualities of the relationship such as unconditional love and acceptance of the child; and for the child, more 'secure attachment' to the parent (Moran et al, 2004).

The last category in which researched parent training programmes have proven to be necessary and effective is in reducing children difficulties. The term *children difficulties (or problems)* will be elaborated below, regarding its meaning and categorization, its symptoms, its relation to parents' behaviour, its implications for negative outcomes in adulthood and its reduction due to effective parenting programmes.

Children difficulties have been categorized in different ways. The basic categorization is between externalizing and internalizing. Externalizing problems are characterized by children's failure to control their behavior according to the expectations of parents, peers, teachers, and/or legal authorities—for example, as a result of hyperactive behavior or conduct problems, whereas internalizing problems are psychological problems that primarily affect the child's internal world—for example, excessive anxiety or sadness (Oltmanns & Emery, 2010).

Many *externalizing difficulties* have symptoms involving violations of age-appropriate social rules, including disobeying parents or teachers, violating social or peer group norms (e.g., annoying others), and perhaps violating the law. Misconduct and braking of rules is often normal and healthy for children, however when the rule violations occur at a younger age than is developmentally normal and are frequent, intense, lasting, and pervasive, they might be indicative of an externalizing disorder. Children with externalizing problems often are negative, angry, aggressive, impulsive or hyperactive.

The DSM-V (American Psychiatric Association, 2013) divides externalizing disorders into three major types: Attention-deficit/hyperactivity disorder (ADHD), Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD). ADHD is characterized by hyperactivity (difficulties remaining seated or engaging in leisure activities quietly, excessive talking), attention deficit (difficulties sustaining attention, finishing tasks, listening carefully, paying attention to details), and impulsivity (interrupting others, difficulties awaiting his/her turn). ODD is defined by a pattern of negative, hostile, and defiant behavior. The rule violations in ODD typically involve minor transgressions, such as refusing to comply with adult requests and rules, arguing,

and acting angry and vindictive. The criterion for an ODD diagnosis must of course be that the behaviour occurs more frequently than is typically observed in individuals of comparable age and developmental level and that it causes clinically significant impairment in social, academic, or occupational functioning. Conduct disorder (CD) is defined primarily by a persistent and repetitive pattern of serious rule violations, most of which are illegal as well as antisocial—for example, assault or robbery.

Internalizing difficulties include emotional disorders such as depression, anxiety and low self-esteem. Depression in children and adolescents often is comorbid both with externalizing problems and with anxiety (Oltmanns and Emery, 2010). Regarding anxiety, there are five main anxiety disorders that occur in internalizing behaviour: separation anxiety, social anxiety, general anxiety, posttraumatic stress and obsessive compulsive disorders (Chen, Lewis, & Liu, 2011). Children's internalizing symptoms include sadness, fears, feeling worthless or tense and somatic complaints. Since both depression and anxiety are difficult for children to identify, they are sometimes shown with fears, of which children are more aware (Oltmanns & Emery, 2010). Somatic complaints, such as headaches or nausea with possible vomiting or abdominal pain, are also symptoms of internalizing problems (Chen et al., 2011).

The DSM-V (American Psychiatric Association, 2013) does not list internalizing disorders as separate psychological disorders of childhood; rather, the manual notes that children may qualify for many "adult" diagnoses, such as anxiety or mood disorders. The DSM-V also contains diagnosis for other kinds of children disorders, such as learning disorders, motor skills disorder, communication disorders, feeding and eating disorders, tic disorders, enuresis, encopresis, selective mutism, separation anxiety disorder and attachment disorder.

Externalizing and internalizing problems often co-exist, although there are differences in their developmental patterns and their prevalence. According to Perle (2013) children appear to display internalizing symptoms such as anxiety and depression earlier in life, whereas externalizing behaviours are at a later time in childhood. However, the prevalence of externalizing disorders generally decreases as children grow older, but the opposite is true for internalizing disorders. Depression, for instance, increases dramatically during preadolescence and adolescence, especially

among girls (Oltmanns & Emery, 2010). Developmental research proposes that children with internalizing symptoms may also exhibit externalizing problem behaviour, with estimates as high as 80 percent for co-occuring depression and disruptive behaviours (Fanti & Henrich, 2010) and that children with internalizing or externalizing problems often have troubled peer relationships (Oltmanns & Emery, 2010).

Another way of categorizing children problems is used by Goodman (1997) in his Strengths and Difficulties Questionnaire, made both for assessment and for evaluating progress. The questionnaire screens for child emotional and behavioural problems and the scales it uses are similar to older scales, such as Rutter A & B Scales, but put a greater emphasis on strengths (Goodman, 2007). This categorization is specifically mentioned here as the SDQ is the measure used in the present study regarding the evaluation of progress in children's difficulties. Goodman divides the difficulties in conduct problems, hyperactivity, emotional problems, peer problems and has a special scale concerning the child's pro-social behavior.

Some of the children problems mentioned above are more associated with genetic factors and others with environmental factors. All biological, psychological, and social factors interact in causing externalizing disorders. For instance, the combination of a difficult temperament and family adversity may result in ODD and eventually conduct disorder, while a temperamentally "easy" child might turn out well-behaved despite growing up in difficult family circumstances (Oltmanns & Emery, 2010). ADHD, however, is more strongly related to genetic factors. Neuropsychological research suggests biological contributions to ADHD (Oltmanns & Emery, 2010), while genes contribute less to ODD and especially CD, which is why medicine (psychostimulants) are widely used for children with ADHD. Numerous double-blind, placebo-controlled studies show that psychostimulants indisputably improve children's attentiveness and decrease their hyperactivity and produce improvements in behaviour in about 75 percent of children with ADHD (Hechtman et al, 2004).

Specific problems in parenting have also been found to contribute to children's externalizing and internalizing problems. Ineffective and inconsistent parenting

contributes to child externalizing problems. More specifically, disapproval and harshness, lack of rules, use of erratic and corporal punishment and provision of positive consequences for problem behaviour are parent practices that contribute to child externalizing problems during early years (Hanisch et al, 2014). Excessive parental behavioural control (through physical punishment) and psychological control (intruding on the child's psychological and emotional development – often referred to as overparenting") – has also been associated with children's overt and relational aggression (Kuppens et al, 2009). Family conflict can contribute to externalizing issues that involve conduct problems, aggression, and antisocial behaviour, as well as internalizing problems such as depression, anxiety, withdrawal, and low self-esteem (Formoso, Gonzales, & Aiken, 2000). Extreme parental neglect deprives infants of the opportunity to form a selective attachment and can cause reactive attachment disorder. Insecure attachments predict a number of internalizing and social difficulties, including lower self-esteem, less competence in peer interaction, and increased dependency on others (Oltmanns & Emery, 2010).

Dealing with children difficulties is of crucial importance, since they are a prognostic factor for negative outcomes in adulthood. Externalizing problems that begin before adolescence are more likely to persist over the individual's life course than are problems that begin during adolescence (Oltmanns & Emery, 2010). Early life conduct problems are robustly associated with later depressive disorder (Stringaris et al, 2014). Conduct problems also place young children at high risk of later underachievement, school dropout, drug abuse, antisocial behaviour, delinquency and violence (Moffit, 1993). Numbers wise, looking forwards, 40 percent of children with conduct disorder become delinquent young adults who have ongoing behavioural problems and disrupted relationships; looking backwards, 90 percent of delinquent young adults had conduct disorder as children (Robins, 1978 and 1991; Loeber, 1991). Children who experience depression in childhood and adolescence are more likely to experience depression in adulthood (Bifulco et al, 1998). And given that depression is far more common among women than men, this means that depressed girls are at risk for becoming depressed mothers, which results in the next generation's emotional problems (Ghate & Hazel, 2002). Thus, childhood internalizing and externalizing problems are targets for early intervention.

Behavioural parent-training programmes have vastly proven their effectiveness in dealing with both internalizing and especially externalizing children problems. The Incredible Years and Triple P (see below in chapter 2.2 of the literature review) are the most researched parenting programmes that have been proven effective in reducing children difficulties (Webster Stratton and Herman, 2008; Sanders, 1999), but numerous other behavioural parenting interventions have also been proven effective in reducing specific children emotional or behavioural disorders (see below in chapter 2.3 of the literature review).

2.2 Acclaimed parenting programmes, parenting styles and Parent Effectiveness Training

Since parent education has proven its necessity as a preventive tool that has positive outcomes for both parent and children problems, parent interventions around the world have vastly proliferated and new programmes are still being developed. Most use the terms "parent-training" or "parent-education" programmes (Tully, 2009), and mainly aim at reducing risks and promoting protective factors for the children, as well as the children's social, emotional and physical well-being. Hundreds of these interventions are systematized programmes, with specific trainer manuals and workbooks that guarantee programme integrity, and even more are more informal programmes that adopt a more fluid and counselling approach with the parents. Different programmes emphasize different content (discipline or behaviour management strategies, conflict resolution skills, communication and empathy skills, knowledge of typical child development) and have different types of families participating ("high risk" families with children with identified problems – diagnosed with developmental disabilities, anxiety disorders, ODD, CD, ADHD – or self-referred families with children belonging to the general population).

The essay will now examine the most renowned parent-training programmes around the world and will present this study's intervention, Parent Effectiveness Training, in detail (its theoretical background and the skills it teaches parents) in an attempt to discuss its differences with the majority of parenting programmes. Furthermore, it will try to clarify which is the parenting style PET promotes.

Amongst numerous parent – training programmes worldwide, the most popular, well supported by research evidence and thus acclaimed are Triple-P (Positive Parenting Program), Incredible Years and PCIT (Parent-Child Interactive Therapy), with STEP (Systematic Training for Effective Parenting) following. PET (Parent Effectiveness Training) although popular in Greece, in general reviews of international evidence (Moran et al, 2004) is considered to be less and not so recently researched and is rated lower on the research evidence for its effectiveness, characterized simply as "promising" (see below in chapter 2.3 of the literature review).

Triple P was developed in Australia in the early 1980's, and has been described as a Behavioural Family Intervention. It is theoretically based on social learning theory, applied behaviour analysis, developmental models of social competence in children, and research on developmental psychopathology (Sanders, 1999). Triple P is a five-level, multi-disciplinary family intervention designed to reach families with varying types of support needs. It pays much attention to children problems, as each of its levels focuses on different degrees of their gravity: Level 1: non-problem child behaviours (e.g. toilet training, self-dressing); Level 2: specific problem behaviours (e.g. thumb-sucking, temper tantrums etc.); Level 3: less specific, more severe problem behaviours (e.g. bedtime disruptions, mealtime behaviour problems); Level 4: behavioural disorders, including oppositional defiant disorder, conduct disorder and aggressive behaviour; Level 5: severe, long-term and concurrent child and parent problems and severe conduct disorder (Sanders, 1999).

The Incredible Years programme is a set of interventions developed in the USA by Dr. Carolyn Webster-Stratton. Operant conditioning (the theory that behaviour is influenced by various stimuli and the consequences of responses to stimuli) forms its theoretical background. More specifically, the Webster-Stratton programmes are based on a key theory called 'coercion hypothesis' which suggests that negative reinforcement develops and maintains deviant child behaviours, as well as punitive, harsh or critical parent behaviours (Webster-Stratton, 2001). The 'Incredible Years BASIC parent training series' teaches parents of 2 to 7 year-old children interactive play and reinforcement skills and disciplinary techniques, over a 12-week period. The 'Incredible Years SCHOOL AGE parent training series' for parents of 5 to 12 year-old children emphasizes on parental monitoring, problem-solving with children and family problem-

solving techniques. The 'Incredible Years ADVANCE parent training series' is a supplement to the 'BASIC' programme, which focuses on family risk factors including depression, marital conflict, poor coping skills, poor anger management and inadequate support.

Parent-Child Interaction Therapy (PCIT) was developed in the USA by Sheila Eyberg. It is a programme for disruptive behaviour disordered children aged 2-7. Disruptive Behaviour Disorders include ODD, CD and ADHD. It is also a Behavioural Theory based programme that teaches parents specific skills to establish a secure relationship with their child, to increase the child's prosocial behaviour and decrease negative behaviour. The programme focuses on two basic interactions: Child Directed Interaction (CDI), which resembles play therapy in that parents engage their child in a play situation with the goal of strengthening the parent-child relationship and Parent Directed Interaction (PDI), which resembles clinical behaviour therapy in that parents learn to use specific behaviour management techniques as they play with their child (Eyberg & Bussing, 2010).

STEP is a parent education programme developed during the 1970's and based on Adlerian concepts and communication skills training (Burnett, 1988). Alfred Adler was the founder of 'individual psychology', which emphasises the centrality of self and the importance of social contexts. The programme consists of eight training sessions, focusing on the following topic areas: understanding children's behaviour and misbehaviour (including attention, power, revenge, display of inadequacy); understanding more about children and being a parent (including emotions, family values, sex roles); encouragement (building children self-esteem); communication (including how to listen to children and express feelings and ideas to them); understanding and applying natural and logical consequences, including discipline strategies; family meetings; and developing confidence and using potential (Burnett, 1988).

Parent Effectiveness Training (PET), the current study's researched intervention, is the best known person–centered parental enhancement programme (Levant, 1983). It was created by a clinical psychologist, Dr. Thomas Gordon, a student and colleague of Carl Rogers, the founder of humanistic, person-centered therapy, who

in 1962 tried to incorporate the person-centered theory and principles in a structured parenting programme. Since Carl Rogers' theory of personality and therapy is at the heart of PET, it seems necessary to refer briefly to the Rogerian theory and philosophy.

Rogers' Person-Centered theory is underlined by the philosophy of "Humanistic Psychology". It is based on the actualizing tendency, an inherent tendency of the organism to develop all its capacities in order to maintain and enhance the organism (Rogers, 1959). It is a development towards differentiation, expansion and autonomy. In order for the actualizing tendency to naturally express itself, a certain psychological climate has to be present, primarily in the early relationship between parent and child, or correctively, later on in therapy, between therapist and client. That psychological climate, which enhances the organismic, internal valuing process (evaluating experiences in light of whether they facilitate or impede the actualizing tendency), is created with the presence of three core facilitating and therapeutic conditions: positive unconditional regard, empathy and congruence (Rogers, 1989). According to Rogers' theory, if parents experience unconditional positive regard (are loving and acceptant of the child), are empathic (can accurately perceive the child's frame of reference) and congruent (authentic and genuine in expressing their own feelings, positive or negative) towards their children, then children are expected to be psychologically adjusted and well functioning.

PET emphasizes in active listening (empathic listening), communicating acceptance, communicating congruence by confronting children using I-messages and resolving conflicts of needs using democratic conflict–resolution skills. Its aim is to alter ineffective communication patterns that rely on negative emotions such as blame and guilt and to nurture an equal relationship between parents and children, instead of using parental power (Gordon, 2000). The aforementioned skills taught in PET are basically a natural extension of an internal state governed by the philosophical principles of the Person–Centered Approach. Its philosophy is oriented towards establishing "an effective total relationship with the child, in any and all circumstances" (Gordon, 2000, p.5), respecting others' needs, entering discussions and problems without fixed solutions and being open to changing. The quality of the parent- child relationship is in first priority and all the communication skills mentioned above have

the purpose to deal with the problems and difficulties, in a way that foremost places interest in not jeopardizing the quality of that relationship.

So how exactly does PET work? The PET workshop is divided into five areas of concern depending on who "owns the problem" in the family. For each area a different set of communication skills is recommended (Gordon, 2000): The first area (where the child owns the problem and is experiencing emotional tension) consists of passive and active listening skills and avoidance of parents' problematic behaviour patterns that block communication and frustrate the child (communication roadblocks). As with Person-Centered Therapy empathic listening, the three core facilitative conditions of empathy, unconditional positive regard and congruence are present in the process. The main purpose in this area of concern is for the parent to help the child realize the core of the problem and the way it is experienced, in order to come up with his/her own solution, thus enhancing autonomy and self-confidence.

The second area is called "no problem area" (where neither party faces emotional discomfort). It is the area used to promote relationship bonding through spending fun quality time with the child and using skills such as "I-messages" to express positive feelings, to prevent expected future conflicts, to share values and to express opinions and preferences. The third area (where the problem belongs to the parent because unacceptable child's behaviour prevents him/her from satisfying a need) concerns skills in the form of confronting "I-messages". Emphasis in this process is put in finding a non-judgmental but descriptive way of pointing-out of the unaccepted behaviour and in expressing transparently and genuinely the consequences and the feelings it provoked. The aim of the I-message is to appeal to the child's empathy and to initiate a behavioural change.

The fourth area is when the needs of both parent and child are in conflict. Then both sides own the problem and the skill used are "conflict resolution" ones, namely the "no-lose" method, where both parent and child can have their needs met in a win-win situation. The procedure consists of six steps – clarifying the real needs of all involved, brainstorming for solutions, evaluating the proposed solutions or slightly altering some of them in order to meet everyone's needs, deciding on a solution, discussing the details of its implementation and proceeding to it, and finally (after some time) evaluating the

effectiveness of the solution. It is a democratic procedure, carried out with a feeling of mutual respect for the needs of all involved and serving as a great model for teaching the children how to resolve their conflicts with other people later on in life. The no lose method can also be applied in setting house rules with the participation of children and serves as a parent tool for resolving sibling conflicts and fights. Finally, the fifth area concerns conflicts of values, where taught skills include modeling desired behaviors, the parent acting as a consulting agent, using I-messages to convey feelings of worry and concern and active listening to help understand the child's point of view. Working with value conflicts also includes questioning and even reevaluating one's own values before trying to influence the child to reconsider his/her own. In other words, the Gordon model promotes self-awareness, genuineness, warmth, acceptance and empathy, while at the same time demonstrates demandingness towards unacceptable child behaviour, in an assertive but respectful and non-punitive manner. Specific details on the way it is implemented on parent groups will be given on chapter 2.3 of the literature review.

The basic differentiation between PET and the behavioural highly acclaimed parent training programmes mentioned before, is its opposition to both punitive and rewarding parent behaviours, as well as to exercise of parental power. Evidently, not only corporal punishment, obviously banned by all parenting programmes, but even "lighter" and more "politically correct" forms of punishment, such as "time out" or privilege deprivation, most commonly used in behavioural parent training programmes around the world, are considered as means to build and reinforce parental power and are not acceptable in PET. The same applies to rewards and evaluative parent praise, also considered as parental power reinforcement tools.

Another basic difference concerning the philosophical stance of PET compared to the behavioural principles of the majority of parent-training programmes is that the latest focus mostly on unaccepted behaviour and how to eliminate it, whereas PET conceives the behaviour as the tip of the iceberg, as merely the expression of thoughts, needs and feelings and urges the parent to act as a "submarine", discover the unaccepted behaviour's underlining feelings, needs and thoughts and work on them instead of simply finding ways to eliminate the inappropriate behaviour itself. So instead of being a "problem-focused" parent-training intervention (such as Triple-P or

PCIT), one could say that PET is mostly a "relationship-focused" parenting programme. Gordon's views are supported by a growing number of non-punitive child raising models that offer alternative disciplinary tools, depending on the child's developmental stage (Arnall, 2007).

Another differentiation of PET with the majority of parent-training programmes is the parenting style it promotes. The term "parenting style" describes the constellation of parents' attitudes and behaviours (parenting practices) communicated to the child, that create a psychological and emotional climate in which the child develops (Darling & Steinberg, 1993). Both parenting style and parent practices result from the goals and values parents hold. Therefore, the term "parenting style" refers to the methods, emotions, values and climate of upbringing and includes the practices (behaviours) the parents use to express their parenting style.

Diana Baumrind's model of parent typology is the mostly referred to and commonly used in modern literature. According to this model (Baumrind, 1971), there are three types of parents depending on their demandingness (control over children behaviour) and responsiveness (warmth, supportiveness) towards the child: authoritative, authoritarian and permissive. Later on, Maccoby and Martin (1983) suggested a diversification to the third type, distinguishing it in two sub-types, indulgent and neglectful. A brief reference of each of these types is in need, in order to clarify where PET stands in terms of parenting styles.

The authoritative parents, according to Baumrind (1971), combine warmth and responsiveness with control and demandingness. They are affectionate, sensitive to the needs of their children, they encourage their effort with rewards, they discuss with then and provide them explanations, but at the same time they are very assertive and firm in controlling their children's behaviour and set high standards for them. Children of authoritative parents show a better cognitive, emotional and social development (Maccoby & Martin, 1983) as well as more self – confidence and higher school achievement (Steinberg et al, 1989). The authoritarian parents are very strict, have demands and expectations that do not match the child's development stage, are extremely controlling and very low in sensitivity and communication. They force their children to obey, without giving explanations, often using physical punishment, verbal

aggression, withdrawal of love and fewer rewards (Baumrind, 1971). Authoritarian parents often over – protect their children and thus detain their psychological and social maturing. The children of authoritarian parents also seem submissive, anxious, the girls are less independent and the boys have a tendency for aggressive behaviour (Ginsburg & Bronstein, 1993).

The permissive – indulgent parents are affectionate and warm towards their children. They accept them and respect their needs, however instead of setting clear boundaries and limits, they let children set their own rules, they avoid confrontation, they neither exercise any control over the behaviour of their children, nor have any demands from them (Baumrind, 1971). Their children are usually immature and aggressive (Maccoby & Martin, 1983), they show low performances in school and higher rates of school misconduct and substance abuse (Lamborn et al, 1991). The neglectful – disengaged parents are very low in both demandingness and responsiveness. They are neither warm and affectionate, nor demanding. They don't meet their children's needs, nor set limits or control their behaviour (Maccoby & Martin, 1983). In other words, they are not actually involved in their children's lives and they do not care about their children's problems or daily activities. In this case, the picture is a lot worse: their children feel neglected and unloved, they are very disadvantaged, both psychologically and behaviourally, their academic performances are very low and they are often involved in delinquent activities and substance abuse (Lamborn et al, 1991).

So where does Parent Effectiveness Training's child rearing model stand in relation to the aforementioned styles of parenting? Considering that PET is a non-punitive model of child upbringing and does not advocate any use of parental power, one has to exclude authoritarian style. Gordon believed that every time the parents force a child to do something by using their power or authority, they deny that child the chance to learn self-discipline (Gordon, 2000). One of the major concerns of PET is to promote family democratic processes and PET proves effective in curbing authoritarian attitudes (Mitchell & McManis, 1977). So is it a permissive approach to raising children? To be permissive as a parent means to put one's own needs aside in order to avoid confrontation. This would go against the principal of congruency, a dominant principal in the Gordon model. A very big part of the taught skills (namely the I-

messages) deals with how to modify unacceptable children behaviour and how to influence them to be considerate of the parents' needs (Gordon, 2000). Wood (1985) in her study for PET suggests that it is an effective answer to both authoritarian and permissive parenting.

Is PET, then, closer to the authoritative parenting style, like the majority of parent-training programmes? Although the Gordon parenting model has both responsiveness and demandingness, there are some crucial differences with the practices and behaviours Baumrind attaches to the authoritative parent. Baumrind's model of authoritative parenting is basically based on the behavioural paradigm of punishment and reinforcement. In her article "The Discipline Controversy Revisited", she even includes corporal punishment: "Authoritative parents endorse the judicious use of aversive consequences, which may include spanking" (Baumrind, 1996, p. 412). According to the Gordon model, not only corporal punishment even in its lightest form, but also punishment in any form, such as "time out", loss of privileges or imposition of unpleasant chores as consequence (all commonly used in behavioural parenting programmes) is unacceptable as a disciplinary tool, since it demonstrates lack of respect and is considered degrading for the child's personality.

So what parent typology fits PET's philosophy better? In her 1971 study, Baumrind observed that a very small sample of parents, whose parenting was characterized by high warmth, moderate control and high tolerance, would not fit in any of her four parenting categories, although the results obtained from this small group were very similar to the ones obtained from authoritative parenting. Baumrind described this parenting style as harmonious, but didn't deal with it any further. Perhaps, PET resembles more the harmonious style than the authoritative one, as Wood (1985) suggests.

2.3 Previous research on the effectiveness of parenting programmes and PET

This final chapter of the literature review will refer to research made prior to this study concerning the effectiveness of parenting programmes'. I will start by mentioning the general components that have been found to be associated with the effectiveness of parent-training interventions, a chapter that will also be useful later in discussion, when

I will examine these components in relation to PET and this study's sample. I will continue by presenting some of the innumerous research made on the effectiveness of behavioural parent-training programmes, concerning mainly the reduction of children problems. Finally, I will conclude with the research made on PET in particular, arguing that PET still lacks the necessary contemporary research with similar method and measures as the ones used by other therapeutic approaches' researchers, in order to prove its efficacy as clearly as many acclaimed behaviour parent-training interventions have.

A very important meta-analysis concerning *components associated with Parent-Training Programme Effectiveness* was conducted by Kaminski, Valle, Filene and Boyle in 2008. It was a review of 77 published evaluations of parent – training programmes of various approaches and delivery strategies. The review examined the components associated with effectiveness in parent-training programmes that included acquisition of skills for parents to enhance behaviour and adjustment in children aged 0-7 years. The study concluded that four components were consistently associated with *larger outcome effects* (Kaminsky et al, 2008): a) *increasing positive parent-child interactions* (by giving positive attention to proper child behaviour and spending quality time with the child in engaging in play activity where the child takes the lead), b) *increasing emotional communication skills* (with active listening and helping children recognize and deal with their emotions), c) *proper use of "time out"* disciplinary method and parenting consistency and d) *in vivo practice* of the newly taught skills with the children during the parent training sessions (with parallel support and feedback from the trainers). It is worth noticing that the three most researched behavioural parenting programmes Incredible Years, PCIT and Triple-P include most or all the above four components. Three components were found to have *smaller outcome effects*: a) teaching parents problem solving, b) teaching parents to promote children's cognitive, academic or social skills and c) providing additional auxiliary services to the parents. It was also noted (Kaminsky et al, 2008) that although some components were not found significant by themselves, they were necessary and useful when taught together with other significant components (ex. teaching parents child development stages in connection with teaching them positive interaction with their children).

In another study concerning how parents experienced parenting programs, the results showed that a very helpful factor was the *group effect* (Kane et al, 2007): In order to acquire all the provided knowledge and skills, they had to experience feelings of acceptance from other parents in the group, together with a non-judgemental climate provided by the professional trainers. That feeling of acceptance led to a reduction in feelings of guilt and social isolation and increased empathy with their children and self-confidence in coping with the difficulties.

Another factor linked with positive effects in parent training programmes is the participation of *both parents as a couple*. Father involvement in parenting programmes may result in more successful outcome for both parents and children (Lundhal et al, 2008). It has also been found that mothers who participated in parent-training programmes with their partners maintained more positive effects than mothers who attended on their own at one year follow-up (Webster-Stratton, 1985).

The *socio-economic level of parents* is another factor that has also been related to parent-training programmes effectiveness. Several studies have shown that parenting programmes are less effective for economically disadvantaged families, who are also most likely to drop out prior to completion (Lundahl et al, 2006). But because economic disadvantage is linked with other family problems, such as depression, marital conflict and lack of social support, it is likely that it is the combination of these factors that is relevant, rather than economic disadvantage in itself (Tully, 2009). Finally, the *severity of original problems* has also been found to play a part in the outcomes of parenting interventions. There are empirical findings that families with more severe problems at the beginning of the parent training interventions benefit most (Hautmann et al, 2010).

As mentioned before, in the recent years, the effectiveness of behavioural parent training programmes which are offered to “high risk” families of children with clinical problems has been vastly researched by many studies, meta-analyses and reviews. There is plenty of evidence that behavioural parenting programmes are useful in the management of a wide range of children problems. In particular, they have been proven effective in reducing internalizing problems (Webster-Stratton & Herman, 2008), developmental disabilities (Plant and Sanders, 2007), persistent feeding problems

(Adamson et al, 2013), anxiety disorders (Rapee et al, 2010). Antisocial behaviour (Serketich & Dumas, 1996 ; Scott et al, 2010), Conduct Disorder (CD) (Baruch, Vrouva et al, 2011 ; Vourdas, Triantafyllou et al, 2014), Oppositional Defiant Disorder (ODD) (Drugli, Larsson et al, 2010), Attention Deficit Hyperactivity Disorder (ADHD) (Kohut & Andrews, 2004 ; Van Den Hoofdakker et al, 2007) are also some of the DSM-V children disorders whose symptoms were found to reduce after behavioural parent training programmes.

Behavioural parent training programmes have also proved their effectiveness in ameliorating parent-child interactions. Skills taught in these programmes, such as providing positive attention and immediate reinforcement and praise to appropriate behaviour, engaging everyday in play activities selected and directed by the child, demonstrating enthusiasm and reducing parental negativity and negative communication patterns, have been proven to enhance the overall quality of the parent-child relationship (Kaminski et al, 2008). Behavioural parenting programmes have also proven effective in preventing child maltreatment (Prinz, Sanders et al, 2009) and behavioural researchers have even gone as far as discussing that differences in social learning and attachment theory are more conceptual rather than empirical (O' Connor, 2002) and proving that social learning theory parenting interventions promote attachment-based caregiving in children (O'Connor et al., 2013).

A smaller and less up to date amount of research concerns the effectiveness of programmes which are offered to parents of a general population and are more "relationship-based" than "behaviour-based", such as Parent Effectiveness Training. Research on the effectiveness of PET is mostly focused on changing parental styles, improvement in parent assertiveness, parents' active listening and conflict resolution skills and parents' stress reducing. PET has been proven effective in curbing parent authoritarian attitudes (Mitchell & McManis, 1977). Pinsker & Geoffroy (1981) made a comparison between PET and a Behavior Modification parent training workshop and the results showed that both workshops were effective but in different fields of concern: The Behavior Modification reduced deviant child behaviours and parents' perception of problem child behaviours. PET increased positive parental consequations, family cohesion and decreased family conflicts.

The most recent research of PET has been made in Australia. Starting in 1980, Rob & Norfor found that parents who had completed PET showed greater confidence in their ability as parents and more awareness of the influence of the environment on their children. Wood & Davidson (1987) showed that parents acquired new cognitive skills in active listening, confrontation and conflict resolution with their children after taking a PET course. The same group of parents was re-assessed seven years later (Wood & Davidson 1994/95) and showed that the gains achieved by the PET group remained above their initial level compared with those of the control group. Subsequent studies realized by Wood & Davidson showed that parents who completed PET improved their assertiveness and conflict resolution skills (1993, 2003c) listening and confronting skills (2000, 2003c), reduced stress on specific issues they identified themselves as their objectives at the beginning of the programme (2001, 2002a, 2003b, Wood, 2003), presented attitudinal shifts towards a collaborative parenting style regarding self-identified children problems (2002b), presented changes in communication, attitudes and behavioural responses (2003a) and observed increased family harmony levels (Wood, 2003).

The only meta-analysis on PET, which is also the biggest research made on PET, was carried in the United-States in 1990 (Cedar & Levant) and was based on 26 PET studies. The meta-analysis showed small to moderate effects of PET on parenting attitudes, parent behaviour towards children and child self-esteem and low to nil effect on parent self-esteem, child attitudes and child behaviour.

It is obvious from the above that, as Tully (2009) clearly states, while behavioural approaches have significant evidence to support their effectiveness, there is still lack of an extensive evidence base for "relationship" approaches, such as PET. Most of the studies made in PET and mentioned above (Wood and Davidson 1987, 1994-5, 2000, 2003c; Wood, 2003) used specific measures created by the researchers themselves and not widely used and established questionnaires. Furthermore, they focused on examining whether parents indeed acquire the skills taught by PET, namely active listening, confronting skills, assertiveness and conflict resolution skills (Wood and Davidson 1987, 1994-5, 2000, 2003c; Wood, 2003) or changes in parenting styles and attitudes (Mitchell & McManis, 1977; Wood and Davidson, 2002b, 2003a) instead of proving actual effectiveness in the way it is perceived in global overviews of

parenting interventions, namely the impact on parents' well-being, their relationship with their children and the children's problems (Moran et al, 2004).

Parental stress is the only one of these categories that has been researched by PET, however in a more "qualitative" way, since it was measured on specific family problems each participant-parent was asked to identify himself/herself at the beginning of the programme (Wood and Davidson, 2001, 2002a, 2003b) and not with generalized instruments that include all scientifically documented manifestations of parental stress. As far as PET's meta-analysis of 26 studies is concerned, which dealt with children's self-esteem and behaviour, methodological issues (the meta-analyzed studies varied in their methodological adequacy) prevented actual meaningful information about the effectiveness of PET (Cedar & Levant, 1990).

PET's small evidence base is probably the reason why it is simply rated as "promising" (for example in internet sites evaluating parent-training programmes, such as The California Evidence-Based Clearinghouse for Child Welfare - http://www.cebc4cw.org/), compared to other behavioural parenting programmes, especially Incredible Years, PCIT and Triple-P, the hundreds of studies on which have established them as well supported by research evidence and effective therapeutic interventions to be used in public health systems around the world. This does not mean that "relationship" approaches do not work, but that we need further evidence to support their effectiveness.

3. Research Question

All throughout my counselling studies, I learned that the Person Centered Approach has not been as well researched as other approaches, namely the Cognitive Behavioural Approach, which is one of the reasons that it is not as popular or widely used in public health systems around the world as a therapeutic intervention. In addition to that, it seems to be commonly accepted that humanistic approaches, such as the person-centered approach, cannot be easily measured with quantitative methods and questionnaires, so often used by CBT researchers, and are more compatible with qualitative research methods. However, although it might sound cynical to some, I believe we live in a world where numbers in proving effectiveness and actual reduction

of problems and dysfunctions play an important role in evaluating and trustinga therapeutic approach.

As I became engaged in parent-training and I started to be interested in research, all the above was verified: innumerous scientific researches on behavioural parent-training programmes, good results, follow-ups, meta-analyses, whereas PET had, as mentioned above, very little to show. As a parent myself, but also as a newly trained PET facilitator who has up to now worked with a few parents – whose feedback has been very good regarding how the programme has helped them significantly with their parenting task and their children – I felt intrigued to put this person-centered intervention to the test and measure its effectiveness with the methods and measures CBT researchers so successfully use. Since I wanted to generalize the question to a larger group and put to test my intuition that PET actually works, quantitative research was the best way for me to carry this study.

As clearly elaborated above, PET has not been adequately or recently researched regarding its actual effectiveness in what seems to be critical in evaluating a parent-training programme: its impact on parents' well-being, the parents' relationship with their children and the reduction of children behaviour problems. That is why the purpose of this study, which is conducted for a first time on a Greek sample, is focused on measuring, with generalized instruments, this particular person-centered intervention's effectiveness in regard to these three factors. Since PET programmes are not conducted in clinics, but in private practice and parents are self – referred instead of referred by mental health professionals and the population attending PET is expected to be mostly non-clinical, PET will be examined basically as a preventive intervention.

Based on all the aforementioned PET studies this study will investigate something new regarding the effectiveness of PET not on the actual acquisition of skills it is supposed to teach parents, but how the already proven acquisition of these skills does indeed reflect on a) reducing parents' stress in their parenting role, b) reducing difficulties in their relationship with their child and c) decreasing children behaviour difficulties. The hypothesis was that PET would be proven effective in all three variables in question: it would a) reduce parental stress, b) improve parent-child interaction and c) decrease children difficulties.

4. Method

4.1 Design

Data from the study was analyzed in two phases. In the first phase, descriptive statistics was used to examine participants' characteristics and demographics, which are presented with means and standard deviations of continuous variables. In the second phase, analyses were conducted to examine changes that occurred from pre-test to post-test. Paired-samples t-test analyses using SPSS 20 was conducted to examine the statistical significance of pre – post changes in parents during the course of the programme. This analysis was chosen because in this study there are two experimental conditions (one being the pre-treatment condition and the other one the post-treatment condition) and the same participants took part in both conditions of the experiment (Field, 2009). The independent variable of the study was the therapeutic intervention (the PET programme) and the dependent variables were parental stress, the parent-child interaction and children difficulties.

4.2 Intervention

As mentioned before, Parent Effectiveness Training is a person–centered non-punitive parent training programme that is based on the three core facilitating conditions of the person–centered theory of therapy (empathy, unconditional positive regard and genuineness) that provide the necessary climate for the child's actualizing tendency to take place (Rogers, 1989). PET's taught skills are mentioned in detail in chapter 2.2 of the literature review. The PET programme is usually taught in ten 3-hour weekly sessions, therefore lasts approximately 2,5 months, during which parents work with a PET facilitator in a group of maximum 12 participants. Classes use theory teaching, role plays and exercises from the workbook accompanying the programme. In addition, between class sessions, parents are assigned readings from the Thomas Gordons' book "Parent Effectiveness Training", homework from the aforementioned workbook in order to become more familiar with the newly taught skills, as well as practice of the skills with their children under true conditions at home. At the beginning of each session, feedback is given by the parents on what difficulties they encountered in trying to use the taught skills at home, what worked and what didn't. In addition, throughout the workshop, participants share feelings, thoughts, experiences and realizations, to

which the facilitator responds empathically and non-judgementally, which, at times, may resemble encounter groups.

4.3 Setting and Participants

The participants of this research were parents that took part in seven PET group workshops that ran through January 2015 to June 2015. The workshops were delivered by Gordon Hellas, the official representative of Gordon Training International in Greece, and they were conducted in a private setting in Kifisia, a suburb of Athens. Parents were self-referred. They sought out the programme on their own on a voluntary basis and had been informed either by advertisement or from parents who had already received the parent-training programme. There were some pre-requisites for eligibility for participating in the study. To participate, parents had to: a) have children from 4 to 17 years of age, b) complete the programme, having attended all or at least nine out of ten group sessions c) not have previously participated in a PET programme and not be participating in another parent training programme during the time of the PET workshop, d) speak adequate Greek. *Parents* were taken to include all those who provide significant care for children in a family context, including biological parents, step-parents and adoptive parents. Another criterion was related to the experience of the workshop facilitator, this is why all participants were members of groups held by the same facilitator who had conducted over 50 PET workshops, in order to ensure a high level of competence.

4.4 Procedure

The participants were recruited from seven PET workshop groups that ran from January 2015 to June 2015, with a total of 59 parents. Out of 59 parents, 14 were excluded, because their children were either younger than 4 or older than 17 years of age. One was excluded because she had participated in a previous PET workshop a year ago. The remaining 44 parents fulfilling the inclusion criteria were informed of the research by their facilitator, who handed out the information sheet, the consent form, the demographics form and the questionnaires to those who volunteered to participate. The pre-intervention (time one) questionnaires were handed out and completed during the 20 minute intermission of the first group session. In case they had more than one

children, they were given the instruction to complete the questionnaires having in mind the child with the upbringing of which they were facing the most problems.

From the total of 44 parents that fulfilled the criteria for participating, 39 completed the pre-intervention questionnaires. The post-intervention questionnaires (time two) were given to the participants who had completed the questionnaires at the beginning of the programme, at their last session, in order to complete at home and return to the facilitator at the follow-up meeting scheduled for two weeks later, or send to me by e-mail. Only 30 of the 39 parents that had completed the time-one questionnaires completed the post-intervention (time two) questionnaires, all of which had successfully completed the programme, having attended at least 9 of the 10 meetings. The reason not all 39 parents returned the post-intervention questionnaires is that some parents missed the follow-up meeting or forgot to complete the time two questionnaires in time and as some time went by, I chose not to ask by e-mail for the delayed questionnaires, since there would be a discrepancy in methodology.

Since this is a routine outcome monitoring study, there was no control group for comparison with the group receiving the treatment. Because PET is a programme run in the private sector, it had proven impossible to find parents who are in waiting lists for the treatment with the same pre-test characteristics as parents beginning the programme. Lack of control group is of course an important limitation of this study.

4.5 Measures/scales

4.5.1. Demographics form

A parent-report form of nine questions (see appendix 1) specifically designed for this study obtained information about the parent and his/her child regarding demographics (parent gender, parent age, child age, child gender, family status, number of children in the family, birth rank of the mentioned child, child's place of residence and parent's education level).

4.5.2 Parenting Stress Index (PSI) 3rd Edition – Short Form

The PSI-SF (Abidin, 1995) was developed to assess an adult's level of stress in association with parenting. This parent-report measure was selected because it had been used by previous research to show improvements in levels of parent stress following

parent participation in parent training programmes (Vourdas et al, 2014; Ralph & Sanders, 2003). All three subscales of the PSI were used for this study: a) The Parental Distress scale (questions 1-12), b) the Parent-Child Dysfunctional Interaction scale (questions 13-24) and c) the Difficult Child scale (questions 25-36). Each of these subscales is comprised of 12 questions that are rated using a 5-point scale, ranging from 1 (strongly disagree) to 5 (strongly agree). Research on the PSI – SF has shown adequate psychometric properties. Specifically, test-retest reliabilities ranged from .68 to .85 and convergent validity with the full version of the PSI ranged from .87 to .95 (Abidin, 1995). For this study the alpha coefficient was .91.

4.5.3 Strengths and Difficulties Questionnaire (SDQ) - extended version

The Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997) is a parent-completed questionnaire for children aged from 4 to 17 years of age. It asks about 25 attributes, some positive and others negative. These 25 items are divided between five scales: four problem scales (emotional symptoms, conduct problems, hyperactivity/inattention problems and peer relationship problems) and one prosocial scale, all with three answering categories (0=not true, 1=true, 2=very true). A total difficulties score is computed from the addition of the scores of the four problem scales. The extended version of the SDQ used in this study (Goodman, 1999) has an impact supplement on the back page, asking whether the respondent thinks the child has a problem, and if so, enquiring further about chronicity, distress, social impairment, and burden to child and others.

The SDQ has been vastly used in researches concerning parent training effectiveness (Vourdas et al, 2014 ; Leijten et al, 2012) and was preferred for this study from the even more commonly used Child Behavior Checklist (CBCL) because it is much shorter but equally good at detecting problems (Goodman & Scott, 1999) and is also proven to be better for mothers of low-risk children (Goodman & Scott, 1999). It has been translated and standardized in a Greek population and its validity and reliability have been adequately referred (Giannakopoulos et al, 2013). For this study the alpha coefficient was .79.

4.6 Ethical issues

Prior to the study, ethical approval was obtained by the Research Ethics Committee of the Counselling Department of the College ICPS (see appendix 2). On the issue of

confidentiality, utmost care was taken to preserve the anonymity of the participants. After the collection of both the demographic data and the questionnaires, each participant was given a number as a code and the data from both the demographics form and the questionnaires completed by him/her were carefully transferred into an SPSS database file in my PC, after which point all the questionnaires were stored in a locked drawer located in my office whose key is only in my possession. Therefore total anonymity was offered, since it is impossible for anyone who has access to the SPSS file to identify any of the participants and their individual scores. If the results of this study become published or disseminated in other forms, only the data will be reported and not any participants names or personal details.

A volunteer counselor was available for a one hour session meeting, in the unlikely case a participants' distress level arose during the completion of the questionnaires, however no participant parent showed any distress. On the issue of informed consent, the participants were informed of the rationale of the study through an information sheet attached to the questionnaires (see appendix 3), along with a consent form (see appendix 4) that was read and signed by all those who decided to participate in this research project. Their right to withdraw from the research project at any time without consequences was clearly stated. If the participants needed any clarifications about the research project or the questionnaires, my contact details were available to them for contacting me, though it proved unnecessary.

5. Results

5.1 Descriptive statistics

In order to obtain information about the parents who participated in the PET programme and this research, descriptive statistics were conducted. Results are presented in Tables 1 and 2. Overall, the sample mainly consisted of mothers (93.3%), mostly married (86.7%), with a high (University) education level (80%) and residing in the suburbs of Athens (66.7%) (The workshop groups ran in Kifisia, a northern and relatively upper-class suburb of Athens). The vast majority of questionnaires, and hence difficulties, regarded the firstborn child (83.3%), with no important differences in the child's gender. The mean parent age was 40,5 years. Even though the criteria for participating in the study included parents with children 4-17 years of age, 26 out of 30

participants were referring to children aged 4-9 years old and only 4 were referring to children aged 10-17 years of age, making the mean children age for the study 6,5 years.

Table 1

Parent and Child Demographics

	N	(%)
Parent Gender		
Mother	28	(93.3)
Father	2	(6.7)
Child Gender		
Boy	17	(56.7)
Girl	13	(43.3)
Parent Marital Status		
Married	26	(86.7)
Partners living together	2	(6.7)
Seperated/Divorced	1	(3.3)
Single parent	1	(3.3)
Widow/Widower	0	(0.0)
Number of children in family		
One	11	(36.7)
Two	16	(53.3)
Three	2	(6.7)
Four	1	(3.3)
Birth rank of the mentioned child		
First	25	(83.3)
Second	4	(13.3)
Third	1	(3.3)
Fourth	0	(0.0)
Child's residence		
Big city	10	(33.3)
Big city's suburbs	20	(66.7)
Small town	0	(0.0)
Village	0	(0.0)
Parent Education		
Never attended school	0	(0.0)
Primary school	0	(0.0)
Junior High School	0	(0.0)
High School	0	(0.0)
College	6	(20.0)
University	24	(80.0)

Table 2

Parent and Child Demographics

Mentioned Child Age			
Mean	Median	Minimum	Maximum
6.5 years	6 years	4 years	14.5 years
Parent Age			
Mean	Median	Minimum	Maximum
40.5 years	40.5 years	32 years	57 years

5.2 Original difficulties and changes from pre-test to post-test

The sample's mean pre-test total score for the Parenting Stress Index was 85,8, while only parents who have a total stress score above 90 are considered to experience clinically significant parenting stress. As far as the Strengths and Difficulties pre-test scores are concerned, the sample's mean total score was 11, whereas, as standardized in a Greek population (Giannakopoulos et al, 2013), a score of 15 or more refers to clinical problems. The same applies to all 5 SDQ subscales. The mean pre-test scores for the hyperactivity, emotional, conduct, peer and prosocial scales were 3.7, 2.5, 3.1, 1.8 and 7 respectively, whereas mean scores of above 6, 5, 5, 4 and below 6 respectively indicate clinical problems.

Paired samples t-tests were conducted to examine the changes in parental stress and parent-child interaction and children difficulties (PSI-SF scores) before and after the intervention. Results are presented in Table 3. After the end of the PET programme, parents reported statistically significant decrease in total levels of parental stress (t (29)= 6.505, $p< .001$). Moreover, there was a statistically significant decrease in levels of all three subscales of the PSI-SF: Parental Distress (t (29)= 7.265, $p=.006$), Parent-Child Dysfunctional Interaction (t (29)= 2.935, $p< .001$) and Difficult Child (t (29)= 5.237, $p< .001$)

Table 3

Means and standard deviation in Parental Stress Index–Short Form Pretest and Posttest

	Pretest	Posttest	
PSI-SF	Mean (SD)	Mean (SD)	Significance
Total PSI scores	85.8 (18.2)	71.9 (15.4)	$p < .001$
Parental Distress	30.9 (7.3)	24.3 (5.7)	$p < .01$
Parent-child Dysfunctional Interaction	23.5 (6.9)	20.9 (5.6)	$p < .001$
Difficult Child	31.4 (7.4)	26.7 (7.3)	$p < .001$

Paired t-test analyses were conducted to examine the changes in children difficulties (SDQ-Extended Version) from pretest to posttest. Results are presented in Tables 4 and 5. There was a statistically significant decrease in the total SDQ-Extended Version difficulties scores (t (29)= 2.272, p=.031). For its five subscales, there was a statistically significant increase in prosocial skills (t (29)= -.2986, p=.006) and decrease in conduct problems (t (29)= 2.249, p=.032), however the analysis did not reveal a statistically significant decrease in hyperactivity (t (29)= .571, p= .573), emotional (t (29)= 1.484, p= .149) and peer problems (t (29)= .757, p= .455), (Table 4). There was also a statistically significant decrease from pretest to posttest in the overall parents' evaluation of their child's difficulties in emotions, concentration, behaviour or ability to get on with other people (t (29)= 2.536, p=.017), as well as in the overall impact of the difficulties as a burden in the child's everyday life (t (21)= 2.994, p=.007) (Table 5)

Table 4

Means and standard deviation in Strengths and Difficulties Questionnaire (SDQ) Pretest and Posttest

	Pretest	Posttest	
SDQ	Mean (SD)	Mean (SD)	Significance
Total Difficulties	11.0 (5.9)	9.8 (4.9)	$p < .05$
Hyperactivity/Inattention problems	3.7 (3.2)	3.6 (2.7)	$p = .573$
Emotional symptoms	2.5 (1.8)	2.1 (1.6)	$p = .149$
Conduct problems	3.1 (1.8)	2.6 (1.3)	$p < .05$
Peer relationship problems	1.8 (1.8)	1.6 (1.7)	$p = .455$
Prosocial Skills	7.0 (2.1)	7.8 (1.6)	$p < .01$

Table 5

Means and standard deviation in SDQ impact factor Pretest and Posttest

SDQ – Impact factor	Pretest Mean (SD)	Posttest Mean (SD)	Significance
Total Difficulties	1.1 (0.5)	0.9 (0.6)	$p < .05$
Impact in child's everyday life	2.0 (2.2)	1.0 (1.4)	$p < .01$

6. Discussion

Parent Effectiveness Training has not been adequately or recently researched regarding its actual effectiveness in the elements that seem critical in evaluating a parent-training programme's impact: parents' well-being, parent-child relationship and children problems. This study was therefore conducted to address the need for research on this person-centered parenting intervention and measure its effectiveness in regard to these three factors with quantitative methods and generalized instruments used this far mostly for research on behavioural parent-training programmes.

The specific purpose of the study was to determine a) the characteristics of the parents and children who sought out and were involved in the Parent Effectiveness Training programme and b) the changes that occurred after the participation in the programme, namely the programme's effectiveness in reducing parental stress, in improving parent-child interaction and in reducing children problems. Based on the results reported in the previous section, firstly, parents' demographic characteristics will be discussed; this will be followed by a discussion on the findings concerning the study's three aforementioned hypotheses, as well as the implications of these findings on practice. Finally, the discussion of the study's limitations will designate recommendations for future research on Parent Effectiveness Training.

6.1 Discussion regarding demographics

The descriptive statistics results concerning the demographic information of the sample indicate that the participants had a specific demographic profile. The sample was of middle to high socio-economic level and high educational level. As found in previous studies, these parents are less likely to dropout (Lundahl et al, 2006), more likely to be motivated, to have space and time to think about and implement the programme. The mean parents' age of 40,5 years and their family status (mostly married) indicate that the sample was once again one with high predictors of commitment to the programme. Previous research has shown demographic predictors of higher dropout rates were younger mothers and lone-parent families (Kazdin & Mazurick, 1994). As far as the participants' gender is concerned (the sample mainly consisted of mothers), it has to be mentioned that although there is an increasing recognition in the literature that parents come in two varieties (male and female), it is also still the case that most parenting interventions predominantly serve women. Since most evaluation samples contain insufficient numbers of men, as is the case with the current study, we have to be very careful in drawing definitive conclusions about what works for fathers, since this might be different from what works for mothers.

The mean mentioned child age of 6.5 years makes it safer to assume that the results refer mostly to young children than preadolescents and adolescents. Concerning the children gender, the fact that boys only slightly outnumbered girls is probably consistent with the non-clinical population the study involved. In most parent-training programme studies and meta-analyses (Thomas & Zimmer-Gembeck, 2007) the number of boys is much higher to that of girls, namely because most behavioural parenting programmes address clinical problems such as ADHD and Conduct Disorder, found most commonly in boys. Finally, the fact that most of the children mentioned in the questionnaires were the families' firstborns indicates that parents encounter more difficulties with their firstborns than with the rest of their children.

As far as the sample's original difficulties are concerned, from the pre-test scores, it can be seen that, as expected, the sample was not one of clinical population, which indicates that PET served mostly as a *preventive* intervention. In regard to this and considering the fact that research has shown that families with more severe problems at the beginning of the parent training interventions benefit most (Hautmann et al,

2010), which leads to the assumption that the higher the pre-treatment scores, the bigger the improvement in post-treatment scores, the results of this study seem of even greatest significance. Unfortunately, up to now PET has not been used in public clinics with referred parents of children with more severe problems, so a comparison in its effectiveness in clinical and non-clinical populations is impossible.

6.2 Discussion on changes from pre-test to post-test

Consistent with all three hypotheses, across all measures there were significant improvements. Specifically, as far as *parental stress* is concerned, there was a statistically significant reduction in total levels of parental stress, as well as in the PSI parental distress subscale. As far as the *parent-child relationship* is concerned, the study revealed a statistically significant decrease in the parent-child dysfunctional interaction. Finally, as far as *children difficulties* are concerned, the results showed statistically significant decrease in both the PSI Difficult Child subscale and the Total SDQ scores, as well as on the impact the children difficulties have on the child's and the family's everyday life.

In regard to parental stress, the study's findings are consistent with other PET studies (Wood & Davidson, 2001; 2002a; 2003; 2003b). As mentioned in detail in the literature review, PET hadn't been researched concerning its efficacy on reducing parent – child dysfunctional interaction and children behaviour problems. The study's results concerning children problems are different to the ones found in the PET meta-analysis in the United-States in 1990 (Cedar & Levant), that showed low to nil effects on parent self-esteem, child attitudes and child behaviour, a meta-analysis that had several methodological problems, preventing actually meaningful information about the effectiveness of PET.

In regard to the five SDQ subscales, there was a significant improvement in some and a not statistically significant improvement in others. Specifically, children conduct problems were significantly reduced, and their prosocial skills were significantly improved, whereas regarding hyperactivity/inattention problems, emotional problems and peer problems there was an improvement, yet not significant. However, because of the fact that the pre-test scores were low and below clinical range,

the reduction in each subscale, whether statistically significant or not, can be interpreted more as a trend than as a finding of clinical significance. What seems more important clinically in the findings is the significant reduction in the total SDQ score, and especially the significant reduction of the SDQ's impact factor, the pretest score of which was in the borderline of clinical significance. The latter indicates that the reduction of children problems had an important positive impact on the children and family's everyday life.

This study's findings are in line with the 2008 meta-analysis (Kaminski et al), concerning some of the components associated with parent-training effectiveness, namely the increase in positive parent-child interaction and in emotional communication skills, both of which are vastly worked in PET. However, PET proved effective in reducing children problems, although it does not use a very important component stated in the above meta-analysis: the disciplinary method of "time-out".

It therefore seems interesting that this study's findings concerning children behaviour problems are in line with studies made on behavioural parenting programmes, which are mostly problem-focused and pay much attention to discipline measures such as loss of privileges and "time-out". It seems that PET – although it is a non punitive model of parent-training that disagrees with and excludes such disciplinary methods, as well as a programme of holistic perspective, mostly focusing on establishing an effective *total* relationship with the child – can be just as effective in reducing children behaviour problems. Could it be that punishment is not as necessary as some believe? Could it be that, as Carl Rogers (1951) so long ago noticed in his therapeutic practice, the quality of the relationship itself is sufficient enough to fix problems and promote behavioural change? This study's findings could be interpreted in line of this view.

Or could it be – however daring and provocative this conclusion might seem – that theoretical approaches, although very different from each other (person-centered, psychoanalytical or behaviourist) do not play such an important role in effectiveness as the delivery of a well-structured intervention provided by well-trained and experienced therapists? It is a conclusion other research assessing the effectiveness of parenting programmes in improving maternal psychosocial health has come to, concluding that

diverse parenting programme approaches proved equally successful and suggesting that other factors (length, intensity of the intervention and training level of the trainers) may be more important than theoretical approaches themselves (Barlow & Stewart-Brown, 2001). The more I work as a therapist, the more this thought tends to occupy my mind and I find it very interesting that it arose again in discussing the results of this study.

6.3 Implications of the current findings for theory and practice

This study has succeeded in adding a small contribution to establishing the person-centered theory as something worth embracing, not only because it feels right, but because it works. The theoretical and philosophical background of PET, its aims at increasing levels of self-awareness, respect towards self and important others, empathy, acceptance, congruence and self-disclosure as well as at showing the parents an alternative parenting philosophy that has no need for excessive parental power with the use of punishments and rewards, usually impress parents as soon as they are mentioned in the first session. Although they appear new to most of them, parents identify with them and embrace them with a sense of relief, as if they are strangely very close to their inner, organismic valuing process.

The evidence that these democratic and humane principals, are not only welcome by parents on a visceral and theoretical level, but also actually effective in the real everyday problems that they encounter and that lead them to participate in a parent-training programme, can be of great importance. It can motivate them and assist them in their effort to change old established habits and re-establish new ones in the up-bringing of their children; an effort that can be very difficult at times, as “old habits die hard” and can often sabotage the path to change, despite the parents’ good intentions.

6.4 Limitations

The present findings need to be interpreted in light of the study’s potential limitations. First, since this was a routine outcome monitor study, there was no control group for comparison with the group that received the PET programme. Therefore, it is not possible to determine definitely whether the improvement in parents and children occurred because of the intervention. Factors such as regression to the mean or

confounding variables (e.g. interactions with the facilitator or other parents in the group, time out of the home, expectations about the programme) may have contributed to the outcomes. For example, previous studies (Kane et al, 2007) have found that the group effect, namely the feelings of acceptance from other members of the group, does indeed lead to reduction in feelings of guilt and increase in feelings of self-confidence.

Second, the study solely relies on the parental perspective for measuring the parent-child interaction and the child problems, since the measures used were all parent self-report measures. Although Baydar et al (2003) found that self-report measures of parenting and child behaviour were highly correlated with staff observations, other studies (Wickstrom et al, 1998) have questioned the validity of self-report measures. Third, the participants of this study were of a relatively high social and educational level. As such, they – and their children – may differ on important characteristics from parents in other areas of Greece and these differences may affect the generalization of the current results to parents and children in other geographic areas and the programme's benefits in regard to a wider population.

Fourth, the findings of the current study are based on the 30 parents who not only met the requirements for participating, but also volunteered to complete the data collection process. Although previous research did not show any demographic differences between parenting programmes completers versus non-completers (Werba et al, 2006), it is not possible to determine how parents who chose to participate in the study may have differed from those who did not, what reasons there were for not participating or what the programme's outcome were for the parents that did not chose to participate or failed to return the post-intervention questionnaires. For example, Baruch et al (2011) found that the group of parents who participated in their pre-post study had significantly higher overall level of functioning and significantly lower scores on severity of psychosocial stressors than those parents who did not provide data post-treatment. Finally, since the post-intervention questionnaires were given only once, shortly after the completion of the group parent training programme and there is no follow-up at a later time, one cannot determine if the changes achieved by the intervention are long-lasting.

6.5 Suggestions for further research

Based on the previously mentioned limitations of this study, future research on the effectiveness of PET is required. First, an important by-product of the emphasis that most researches give on more easily measured parent outcomes described earlier is the striking lack of research focusing on the views of children. As the ultimate recipients of enhanced parenting support, there is an undeniable need to embody assessments of children's views and perspectives about the impact of parenting changes, and to explore what makes a difference to *their* experience of being parented. Therefore, in future research regarding the effectiveness of PET, measures from multiple perspectives are recommended, such as children self-report forms or teachers report forms. Second, since this study only investigated changes that had occurred at the end of the parent training programme, thus focusing on short-terms effects, conducting follow-up assessments will shed light on the stability of the effects and will allow us to determine whether or not the programme achieves long-lasting change.

In regard to the limitations resulting from the current study's sample, since it consisted of participants of a relatively high social and educational level, in order to be able to generalize the outcomes, additional research is needed on more diverse and nationally representative samples. It would also be very interesting to conduct the same research with fathers being the majority of participants instead of mothers, since what works for mothers might differ from what works for fathers. Furthermore, the sample concerned children of a mean age of 6,5 years. There are undeniable developmental differences between children aged 4-9 years and preadolescent or adolescent children and it has been found that parenting programmes that are effective for parents of younger children will not necessarily be developmentally appropriate or effective for parents of older children (Tully, 2006). Although PET is based on communication skills and a guess would be that it would be just as – or even more – appropriate for older children with more developed communication abilities, further research focusing on older children and adolescents is recommended. Especially since adolescents – mainly difficult ones – are generally found to do less well in parenting programmes (Bank et al, 1991).

Last but not least, qualitative research might enhance in depth this study's findings. For example, it would be interesting to research the internal procedures that helped parents feel less stressed, more fulfilled and better about themselves in their role as parents, or how these changes, along with the ameliorated relationship they started building with their children perhaps influenced or even altered their felt sense of their children's behaviour problems.

6.6 Conclusion

Nowadays, increasing emphasis is being placed on the use of well-researched and evidence based parenting programmes in child and family care. The present study showed that Parent Effectiveness Training's person centered theoretical underpinnings, its holistic and humanistic perspective, its focus on the parents' relationship with their children, as well as its non punitive parenting model do indeed work. PET has proved an effective mean to make parents feel better and less stressed about themselves in their parenting role, to grow a stronger, less dysfunctional and more loving relationship with their children, as well as to reduce the children's difficulties and the impact they have in the child's and family's everyday life. Although a thorough analysis of follow-up effects would be needed to examine long-term changes, the present findings do indicate that PET is indeed helpful as a prevention intervention for families of a subclinical community Greek population.

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APPENDICES

Appendix 1

Demographics form (in Greek and the English translation)

Το ερωτηματολόγιο συμπληρώνεται από: Οτη μητέρα Οτον πατέρα
(The questionnaires are completed by: Othe mother Othe father)

Ημερομηνία γέννησης παιδιού στο οποίο αναφέρεστε συμπληρώνοντας τα ερωτηματολόγια: …….....
(Date of birth of the child you are referring to while completing the questionnaires: ……..)

Φύλο παιδιού: ΟΑγόρι Ο Κορίτσι
(Child gender: Ο Boy Ο Girl)

Οικογενειακή κατάσταση: ΟΓονείς παντρεμένοι
ΟΓονείς συζούν
ΟΓονείς σε διάσταση/διαζευγμένοι
ΟΜονογονεϊκή οικογένεια
ΟΧηρεία
(Family status: OParents married OParents living together OParents separated/divorced OSingle parent OParent widow/widower)

Αριθμός παιδιών στην οικογένεια (συμπεριλαμβανομένου και του παιδιού στο οποίο αναφέρεστε συμπληρώνοντας τα ερωτηματολόγια): ……
(Number of children in the family – including the child you are referring to while completing the questionnaires:……..)

Σειρά γέννησης του παραπάνω παιδιού:……...
(Birth rank of the mentioned child: ……)

Που ζει το παιδί;

O σε μεγάλη πόλη
O στα προάστια ή στην περιφέρεια μιας μεγάλης πόλης
O σε κωμόπολη ή σε μικρή πόλη
O σε χωριό

Where does the child live? Oin a big city Oin the suburbs of a big city Oin a small town Oin a village)

Ηλικία γονιού που συμπληρώνει τα ερωτηματολόγια :……
(Parent's completing the questionnaires age: ……)

Εκπαιδευτικό επίπεδο του γονιού που συμπληρώνει τα ερωτηματολόγια:
(Παρακαλώ σημειώστε τον **υψηλότερο** εκπαιδευτικό τίτλο που αποκτήσατε)

O Δεν έχω πάει σχολείο ή έχω παρακολουθήσει κάποιες τάξεις δημοτικού
O Απολυτήριο δημοτικού
O Απολυτήριο Γυμνασίου
O Απολυτήριο Λυκείου
O Ανώτερη Εκπαίδευση ή ισότιμος τίτλος/ΙΕΚ/Ιδιωτικό κολλέγιο/ΤΕΙ
O Ανώτατη Εκπαίδευση (ΑΕΙ) ή ισότιμος τίτλος πανεπιστημίου του εξωτερικού

(Educational level of the parent completing the questionnaires – please note the **higher** degree you have obtained:) ONever attended school OPrimary school OJunior High school OHigh School OCollege OUniversity)

Appendix 2

Institute of Counselling & Psychological Studies
Department of Counselling

Ethics Committee: submission of project for approval

- **This form should be word processed – no handwritten forms can be considered**
- **ALL sections of this form must be completed**
- **No project may commence without authorisation from the appropriate Ethics Committee(s)**

Title of Project:	Outcome findings from a Parent Effectiveness Training Programme for Greek parents of children and adolescents: What is the impact of a Parent Effectiveness Training program on parental stress, parent–child interaction and children difficulties?
Name of Supervisor:	Eirini Zacharostylianaki
Name of Investigator:	Spyridoula Veikou
Date Ethical Approval Given:	
Level of Research: (U/G, P/G, MSc, Staff)	Master of Science in Person-centered counseling. Institution: ICPS-Greece. Accredited by the University of Strathclyde, Glascow.
Qualifications/Expertise of the investigator relevant to the submission:	1)Law: Kapodistrian University of Athens 2)PgD in Person-Centered Counselling: University of Strathclyde

Target Group: Please indicate the population of participants/nature of the subject group and how they will be recruited.	The participants (at least 30) will be constituted by parents taking part in Parent Effectiveness Training programmes on a voluntary basis. To participate in this study, parents have to: a) have children from 4 to 17 years of age, b) complete the programme, c) have not previously participated in a PET programme and not currently be participating in another parent

	training programme, d) speak adequate Greek. The recruitment of the participants will be performed through PET certified facilitators that will run PET programmes in the next six months, who will complete a consent form stating they agree to use their clients for this study. The participants/parents will be given an information sheet explaining the rationale of the study and a consent form which they must read and sign, along with the questionnaires they will be asked to complete. If they are reluctant to participate in this research project they can simply return the consent form and the questionnaires uncompleted.

Please attach the following and tick the box as appropriate:

Outline Summary: Rationale and expected benefits from the study; state clearly what you propose to do and how	Research on the effectiveness of Parent Effectiveness Training is mostly focused on changing parental styles, improvement in parent assertiveness, parents' active listening skills and conflict resolution skills and parents stress reducing. However, PET hasn't been vastly researched concerning its efficacy on reducing parent–child dysfunctional interaction and children behaviour problems. The biggest research on PET, a meta-analysis of 26 studies carried in the United-States in 1990 (Cedar & Levant), showed support for the use of PET as a preventive intervention, small to moderate effects of PET on parenting attitudes, parent behavior towards children and child self-esteem and low to nil effect on parent self-esteem, child attitudes and child behavior. However, the meta-analyzed studies varied in their methodological adequacy, thus

	preventing actually meaningfull information about the effectiveness of PET. This study will investigate something new regarding the effectiveness of Parent Effectiveness Training not on the acquisition of skills it is supposed to teach parents, but how the already proven acquisition of these skills does indeed reflect on what I believe is the main reason a parent seeks help in a parent training programme: difficulties in their role as parent, difficulties in their relationship with their child and children behaviour difficulties. This study intends to measure this person – centered counseling intervention's effectiveness, providing generalized evidence and drawing conclusions relevant to larger groups. Furthermore, this kind of study will be conducted for the first time in a Greek population.
Explanation of Method	Quantitative research was selected for this study because it allows me to challenge the person–centered approach in providing generalized evidence of effectiveness and draw conclusions that would be relevant to larger groups. The parents fulfilling the aforementioned criteria for participating in the study will be handed the information sheet and the consent form as well as the demographics form and the questionnaires at their first session. Those who chose to participate in the study will return the completed demographic form and questionnaires. After completion of the programme (usually 2,5 to 3 months after the first class) the parents who completed the demographics form and the questionnaires the first time will be asked to complete the questionnaires for a second time. Those who chose to do so will return the completed questionnaires. Demographic forms and questionnaires completed both at pre and post-intervention will be used as the basis of the subsequent data

	analysis. Data from this study will be analyzed in two phases. In the first phase, descriptive statistics will provide a summary of the characteristics of parents who participated in the programme (demographic data, pre – intervention difficulties). In the second phase, analyses will be conducted to examine changes that will occur from pre-test to post-test. Paired-samples T-test (or dependent-means t-test) analyses using SPSS will be conducted to examine the statistical significance of pre – post changes in parents during the course of the programme. This analyses was chosen because in this study there are two experimental conditions (one being the pre-treatment condition and the other one the post-treatment condition) and the same participants took part in both conditions of the experiment.
Information Sheet for Participants	
Informed Consent Form	
Details of how information will be held	All of the participants' demographic data as well as the printed and completed questionnaires will be stored in a locked drawer located in my office whose key will be only in my possession. During the analyses process each participant will be given a number as a code and the data from the demographics form and the questionnaires completed by him/her will be carefully transferred into an SPSS file in my PC, after which point it will be impossible for anyone who has access to the SPSS file to identify any of the participants and their individual scores. If the results of this study become published or disseminated in other forms, only the data will be reported and not any participants names or personal details.
Details of how results will be fed back to participants	I intend to send by e mail my final dissertation to all the participants in the study who are interested in its results.

Letter of consent from any Collaborating Institutes	n/a
Letter of consent from Head Teacher, if participants under the age of 16 years of age	n/a
Is any other External Ethical Approval required? NO If yes, which Committee?	

Appendix 3

Information Sheet to participate in the research

This research project is conducted by Veikou Leda Spyridoula, a person-centered counsellor, as part of her requirement for her degree of MSc in Counselling. Her research project is under the direction of the Institute of Counselling and Psychological Studies (ICPS), located in Athens, Greece, and under the supervision of Eirini Zacharostylianaki.

This research project aims to discover the impact of the Parent Effectiveness Training program on parental distress, parent – child interaction and children difficulties. According to the person-centered theory, a warm and intimate parent – child relationship is based on the communication of the parents' empathy and unconditional positive regard towards the child as well as the parents' self-awareness and congruence. Under these conditions, the child's actualizing tendency towards being a fully functional, responsible and self-disciplined person will not be obstructed. This kind of relationship is important not only for the well-being of children but also for the well-being of parents in their very difficult role, as well as for establishing an effective total relationship with the child.

If you agree to take part in this research project, you will be given a demographics form to complete, as well as two questionnaires to complete twice: at the beginning of your parent training program and after you've completed it. Completing the two questionnaires will require approximately 15 minutes. The questionnaires will be anonymous and stored in full confidentiality. Your answers will be used for scientific purposes only. They will be transferred in my PC for further process and held securely in password protected folders. If the results of the study become published or disseminated in other forms, confidentiality will be maintained and you will not be identifiable. You will be asked to sign a consent form agreeing to these terms.

Although I don't think there will be a risk from participating in this study, in case some of the questions raise issues you may like to talk about, I will refer you to a counsellor who will help you find some answers in a session meeting of approximately 1 hour.

I would like you to consent to participate in this study as I believe that you can make an important contribution to the research. However, your participation in this

research project is completely voluntary and it will in no way affect your current or future relations with your Parent Effectiveness Training facilitator. If you decide to participate, you may refuse to answer certain questions. You may also withdraw from the research project at any time and will be under no obligation to continue in the study.

If you have any questions or concerns regarding the research project, you can ask them by contacting me at the telephone number or e-mail address listed below.

Thank you for your time.

Appendix 4

Letter of consent

Title of Project:

What is the impact of a Parent Effectiveness Training program on parental stress, parent–child interaction and children difficulties? – A quantitative research study on a greek population sample conducted by Veikou Spyridoula.

Consent Form

I confirm that I have read and understood the information sheet for the above project and the researcher has answered any queries to my satisfaction.

I consent to being a participant in the project.

I understand that my participation is voluntary and that I am free to withdraw from the project at any time, without having to give a reason and without any consequences.

I understand that I can withdraw my data from the study at any time.

I understand that information that I provide might be used in a conference or other kind of research publication but I will remain anonymous.

I understand than any information provided in the investigation will remain confidential and no information that identifies me will be publicly made available.

Participant (name)

_____

Participant (signature)

_____

Date:_____

Appendix 5

Strenghts and Difficulties Questionnaire (in English and in Greek)

Strengths and Difficulties Questionnaire P 4-17

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child's behavior over the last six months.

Child's Name: ……. Male ☐ Female ☐
Date of birth:…….

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings			
Restless, overactive, cannot stay still for long			
Often complains of headaches, stomach-aches, or sickness			
Shares readily with other (treats, toys, pencils etc)			
Often has temper tantrums or hot tempers			
Rather solitary, tends to play alone			
Generally obedient, usually does what adults request			
Many worries, often seems worried			
Helpful if someone is hurt, upset or feeling ill			
Constantly fidgeting or squirming			
Has at least one good friend			
Often fights with other children or bullies them			
Often unhappy, down-hearted or tearful			
Generally liked by other children			
Easily distracted, concentration wanders			
Nervous of clingy in new situations, easily loses confidence			
Kind to younger children			
Often lies or cheats			
Picked on or bullied by other children			
Often volunteers to help others (parents, teachers, other children)			
Thinks things out before acting			
Steals from home, school, or elsewhere			
Gets on better with adults than with other children			
Many fears, easily scared			
Sees tasks through to the end, good attention span			

Do you have any other comments or concerns;…….

Please turn over - there are few more questions on the other side

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behavior, or being able to get on with other people?

No	Yes, Minor Difficulties	Yes- Definite Difficulties	Yes- Severe Difficulties
☐	☐	☐	☐

If you have answered **YES** please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
☐	☐	☐	☐

- Do the difficulties upset or distress your child?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

- Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
CLASROOM LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

- Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

Signature ……..
Date…….

Father /Mother/Other (please specify)……

Thank you very much for your help

Ερωτηματολόγιο Δυνατοτήτων και Δυσκολιών (SDQ-Hel) Γ 4-16

Για κάθε θέμα, σημειώστε αν Δεν Ισχύει, Ισχύει Κάπως ή Ισχύει Σίγουρα. Θα μας βοηθούσε αν απαντούσατε σε όλα τα θέματα όσο καλύτερα μπορείτε ακόμα και αν δεν είστε απόλυτα σίγουρος/η ή το θέμα φαίνεται αστείο! Παρακαλούμε να απαντήσετε βασιζόμενοι στη συμπεριφορά του παιδιού κατά τους τελευταίους έξι μήνες ή στη διάρκεια αυτής της σχολικής χρονιάς.

Όνομα του παιδιού: ..... Αγόρι/Κορίτσι

Ημερομηνία Γέννησης .....

	Δεν ισχύει	Ισχύει κάπως	Ισχύει σίγουρα
Λαμβάνει υπόψη τα συναισθήματα των άλλων	☐	☐	☐
Ανήσυχος/η και υπερδραστήριος/α, δεν μπορεί να παραμείνει ήρεμος/η, ακίνητος/η για πολύ ώρα.	☐	☐	☐
Παραπονείται συχνά για πονοκεφάλους, πόνους στο στομάχι ή αδιαθεσία	☐	☐	☐
Μοιράζεται εύκολα με τα άλλα παιδιά (κεράσματα, παιχνίδια, μολύβια κτλ)	☐	☐	☐
Συχνά έχει ξεσπάσματα νεύρων ή είναι ευέξαπτος	☐	☐	☐
Μάλλον μοναχικός/η, τείνει να παίζει μόνος/η	☐	☐	☐
Γενικά είναι υπάκουος/η, ή συνήθως κάνει ότι του/της ζητούν οι ενήλικες	☐	☐	☐
Τον/την απασχολεί το παραμικρό, συχνά φαίνεται ανήσυχος/η	☐	☐	☐
Είναι πρόθυμος/η να βοηθήσει κάποιον που είναι πληγωμένος, αναστατωμένος, στεναχωρημένος, άρρωστος	☐	☐	☐
Συνεχώς στριφογυρίζει νευρικά ή δεν στέκεται ήσυχος/η, έχει νευρικότητα	☐	☐	☐
Έχει τουλάχιστον ένα φίλο	☐	☐	☐
Συχνά μαλώνει με τα άλλα παιδιά ή τα κοροϊδεύει, τα φοβερίζει, τα κτυπά	☐	☐	☐
Συχνά είναι δυστυχισμένος/η, αποκαρδιωμένος/η ή κλαίει	☐	☐	☐
Γενικά είναι συμπαθής στα άλλα παιδιά	☐	☐	☐
Η προσοχή του/της διασπάται εύκολα, δυσκολεύεται να συγκεντρωθεί	☐	☐	☐
Σε καινούριες καταστάσεις είναι νευρικός/η ή δείχνει συμπεριφορά προσκόλλησης, εύκολα χάνει την αυτοπεποίθησή του/της	☐	☐	☐
Είναι καλός/ή με τα μικρότερα παιδιά	☐	☐	☐
Συχνά λέει ψέμματα ή εξαπατά	☐	☐	☐
Τα άλλα παιδιά τον/την έχουν στο μάτι ή τον/την κοροϊδεύουν, τον/την φοβερίζουν, τον/την χτυπούν	☐	☐	☐
Προθυμοποιείται συχνά να βοηθήσει τους άλλους (γονείς, καθηγητές, άλλα παιδιά)	☐	☐	☐
Πριν κάνει κάτι το μελετάει προσεκτικά	☐	☐	☐
Κλέβει από το σπίτι, το σχολείο ή αλλού	☐	☐	☐
Τα πηγαίνει καλύτερα με τους ενήλικες παρά με τα παιδιά	☐	☐	☐
Έχει πολλούς φόβους, τρομάζει εύκολα	☐	☐	☐
Φέρνει σε πέρας μία εργασία, έχει καλή προσοχή	☐	☐	☐

Έχετε άλλα σχόλια ή ανησυχίες;

Παρακαλούμε γυρίστε σελίδα-υπάρχουν μερικές ερωτήσεις ακόμη

Συνολικά, νομίζετε ότι το παιδί σας έχει δυσκολίες σε μία ή περισσότερες από τις παρακάτω περιοχές: συναισθήματα, συγκέντρωση, συμπεριφορά ή δυνατότητα να τα πηγαίνετε καλά με τους άλλους ανθρώπους;

Όχι	Ναι-κάποιες δυσκολίες	Ναι-αρκετές δυσκολίες	Ναι-σοβαρές δυσκολίες
☐	☐	☐	☐

Εάν έχετε απαντήσει «Ναι», παρακαλούμε να απαντήσετε στις ακόλουθες ερωτήσεις σχετικά με αυτές τις δυσκολίες:

- Από πότε υπάρχουν αυτές οι δυσκολίες;

Λιγότερο από μήνα	1-5 μήνες	6-12 μήνες	Περισσότερο από χρόνο
☐	☐	☐	☐

- Αυτές οι δυσκολίες ανησυχούν ή αναστατώνουν το παιδί σας;

Καθόλου	Μόνο λίγο	Αρκετά	Πάρα πολύ
☐	☐	☐	☐

- Οι δυσκολίες αποτελούν εμπόδιο στη καθημερινή ζωή του παιδιού σας στις παρακάτω περιοχές;

	Καθόλου	Μόνο λίγο	Αρκετά	Πάρα πολύ
ΖΩΗ ΣΤΟ ΣΠΙΤΙ	☐	☐	☐	☐
ΦΙΛΙΕΣ	☐	☐	☐	☐
ΣΧΟΛΙΚΗ ΜΑΘΗΣΗ	☐	☐	☐	☐
ΨΥΧΑΓΩΓΙΑ	☐	☐	☐	☐

- · Οι δυσκολίες είναι βάρος για σας ή γενικά για την οικογένεια;

Καθόλου	Μόνο λίγο	Αρκετά	Πάρα πολύ
☐	☐	☐	☐

Υπογραφή..... Ημερομηνία .....

Πατέρας / Μητέρα / Άλλος (διευκρινείστε):

Ευχαριστούμε πολύ για τη βοήθεια

Appendix 6

Parenting Stress Index – Short Form (Greek Translation) – excerpt

ΚΛΙΜΑΚΑ ΑΓΧΟΥΣ ΓΟΝΙΩΝ ΛΟΓΩ ΤΟΥ ΓΟΝΕΪΚΟΥ ΡΟΛΟΥ

(σύντομη μορφή)
Richard F: Abidin of Virginia

Οδηγίες:
Όταν απαντάτε τις ακόλουθες απαντήσεις, σας παρακαλούμε να έχετε το νου σας το παιδί που σας ανησυχεί περισσότερο.

Οι ερωτήσεις στις επόμενες σελίδες σας ζητάνε να σημειώσετε εκείνη που περιγράφει καλύτερα τα συναισθήματά σας. Μπορεί να μην βρείτε μια απάντηση που δηλώνει ακριβώς τα συναισθήματά σας, οπότε σας παρακαλούμε να σημειώσετε την απάντηση που πλησιάζει περισσότερο στο να περιγράψει πως αισθάνεστε.

Η ΑΠΑΝΤΗΣΗ ΣΑΣ ΘΑ ΠΡΕΠΕΙ ΝΑ ΕΙΝΑΙ Η ΠΡΩΤΗ ΣΑΣ ΑΝΤΙΔΡΑΣΗ ΣΕ ΚΑΘΕ ΕΡΩΤΗΣΗ

Σας παρακαλούμε να σημειώσετε το βαθμό στον οποίο συμφωνείτε ή διαφωνείτε με τις ακόλουθες διατυπώσεις βάζοντας σε κύκλο τον αριθμό που ταιριάζει καλύτερα με το πώς αισθάνεστε. Αν δεν είστε σίγουρος, κυκλώστε παρακαλούμε τον αρ. 3

1	2	3	4	5
Συμφωνώ πολύ	Συμφωνώ	Δεν είμαι σίγουρος	Διαφωνώ	Διαφωνώ πολύ

Παράδειγμα:
Μου αρέσει να πηγαίνω στον κινηματογράφο (Αν σας αρέσει μερικές φορές να πηγαίνετε στον κινηματογράφο θα κυκλώσετε τον αρ. 2

1 (2) 3 4 5

1	2	3	4	5
Συμφωνώ πολύ	Συμφωνώ	Δεν είμαι σίγουρος	Διαφωνώ	Διαφωνώ πολύ

1.	Συχνά νοιώθω ότι δεν μπορώ να χειριστώ τα πράγματα	1	2	3	4	5
2.	Βλέπω ότι δεν μπορώ να χειριστώ τα πράγματα	1	2	3	4	5
3.	Νοιώθω παγιδευμένος από τις ευθύνες μου ως γονιός	1	2	3	4	5

4.	Από τότε που έκανα αυτό το παιδί δεν κατάφερα να κάνω καινούργια πράγματα	1	2	3	4	5
5.	Από τότε που έκανα αυτό το παιδί δεν μπορώ να κάνω πράγματα που μου αρέσουν	1	2	3	4	5
6.	Δεν νοιώθω ευχαριστημένος/η με τα ρούχα που ψώνισα την τελευταία φορά για μένα	1	2	3	4	5
7.	Υπάρχουν αρκετά πράγματα όσον αφορά τη ζωή μου που με ενοχλούν	1	2	3	4	5
8.	Το ότι αποκτήσαμε παιδί προκάλεσε περισσότερα προβλήματα από όσα περίμενα στη σχέση μου με το/η σύζυγό μου (ή το/η φίλο/η μου)	1	2	3	4	5
9.	Νοιώθω μόνος/η και χωρίς φίλους	1	2	3	4	5

Note: The PSI-3rd Edition – Short Form is only available by purchase, and for copyright reasons only an excerpt appears in the appendices. It is in Greek, as the English version has not been purchased.