Clinical Applications of Evidence-Based Family Interventions

JACQUELINE CORCORAN

OXFORD UNIVERSITY PRESS

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To Mark

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FOREWORD

I want to call the reader's attention to this excellent book, which systematically presents evidence-based practices for complex clinical disorders, while applying numerous clinical case scenarios in each chapter. The central role of evidence-based practice guidelines in facilitating family treatment has emerged during the past decade. This book is the first to bring together the interdisciplinary practice research on family treatment and apply it to complex externalizing problems and mental disorders prevalent throughout the life span. *Clinical Applications of Evidence-Based Family Interventions* has been designed to serve two purposes:

1. To examine the most effective family intervention practices based on the outcome studies and other reliable empirical evidence.
2. To provide detailed applications of the evidence-based interventions through case illustrations.

Dr. Jacqueline Corcoran, with the valuable assistance of Dr. Joseph Walsh and Dr. Patricia Gleason-Wynn, has completed a masterful and well-written text. I applaud the originality, conceptual rigor, and integration of bridging theory with evidence-based practice. I anticipate

that this critically important clinical handbook will be treasured by clinicians, researchers, and graduate students for years to come.

This volume focuses on family approaches (i.e., behavioral parent training, multisystemic family treatment, structural family therapy, and cognitive-behavioral intervention) with attention deficit/hyperactivity disorder (ADHD), oppositional defiance disorder, conduct disorder, juvenile offenders, substance abuse, adolescent pregnancy, adolescent physical abuse, and mothers of sexual abuse victims. It also examines psychoeducational groups with ADHD, parents of persons with schizophrenia, and caregivers of older adults.

In conclusion, this valuable book will increase all social workers' and counselors' understanding of evidence-based family treatment strategies and guidelines. I highly recommend this original and timely book to graduate students and to beginning and seasoned practitioners.

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CONTENTS

PATRICIA GLEASON-WYNN, LMSW-ACP, has a Ph.D. in social work from the University of Texas at Arlington. Her primary area of interest is gerontology with a particular focus on nursing home social work practice. For the past 19 years, she has worked with older people living in the community and in nursing homes. Currently, she teaches part time in the School of Social Work at UT, Arlington, and provides social work services to two nursing homes in the Fort Worth area. She was the director of the Bachelor of Social Work Program until January 2000 and was formerly an assistant professor at Southwest Texas State University in San Marcos, where she taught from 1995.

Dr. Gleason-Wynn coauthored the book *Social Work Practice in the Nursing Home Setting* (with K. Fonville, 1996). As the director of Elder Care Specialists, her consulting company, she is involved in assessing the needs of community-based frail older adults, planning care management services, presenting community seminars on aging-related topics, and providing litigation consultation in aging-related cases, including will contests and guardianship hearings.

JOSEPH WALSH, Ph.D., LCSW, is an associate professor of social work at Virginia Commonwealth University. He received his academic

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CLINICAL APPLICATIONS OF

Evidence-Based Family Interventions

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Introduction

While many excellent books cover family therapy theory, none has a unique emphasis on the evidence that supports such theories nor on how to apply these theories. And yet the emphasis on evidence-based practice is becoming increasingly important with the push of managed care to require accountability in mental health and other health care services (Gibelman, 2002). Practitioners have a responsibility to the families that seek services to intervene with the most effective theoretical methods possible, methods that have been tested and that have proven clinical utility.

But what busy practitioner has time to search through numerous databases, retrieve, and then sift through all the research to locate the studies that can inform practice? And what agency has the resources to commit to such a task? A further problem is, if such information is finally gathered, what does one do with it? How does this information translate into practice?

Clinical Applications of Evidence-Based Family Interventions was developed to answer these questions, to familiarize the practitioner with evidence-based approaches for common problems for which families seek treatment, and then to illustrate, in detail with clinical vignettes, how to apply these theories in practice.

Definition of Evidence-Based Practice

"Evidence-based" involves a process of locating research findings through electronic searches in a particular problem area to decide the intervention that has the best available support. In order to promote confidence in one approach over another for a defined problem, priority is given to studies using experimental designs (randomization to treatment condition[s] and a control group, pretest/posttest/follow-up, data collection with standardized measures), followed by comparison-group studies with randomization to treatment conditions, then comparison group designs with non-randomization, and finally pretest/posttest designs. This book focuses on portraying the family approaches that have emerged for treating certain problems after critical evaluation of the available outcome research. In the following section, the selection process is further detailed. (For discussion on evidence-based practice, please see Chambless & Hollon, 1998; Cournoyer & Powers, 2002; Gambrill, 1999; Sackett, Robinson, Rosenberg, & Haynes, 1997; Thyer, 2002.)

Problem Areas Chosen

Clinical Applications of Evidence-Based Family Interventions is organized by problem area. For a problem to be included, sufficient research must have demonstrated that a particular family approach is helpful. The reader will note that, for child and adolescent problems, the emphasis is on *externalizing* disorders, such as attention deficit/hyperactivity disorder (ADHD), oppositional defiant disorder, conduct disorder, and substance abuse, rather than *internalizing* problems, such as depression and eating disorders. This reflects the current state of the research, which may be explained by several different factors. First, externalizing problems tend to create more problems for others than they do for clients themselves, requiring the involvement of family members. Second, conduct problems are the foremost reason for child referrals to treatment (American Psychiatric Association [APA], 2000; Kazdin, 1995). In comparison to the enormous body of work conducted on family approaches to externalizing disorders, the family treatment of internalizing disorders is very small. For instance, only one study was located on a family systems approach to adolescent depression, and this study found that individual cognitive-behavioral treatment was

more effective than either family systems treatment or individual supportive therapy (Brent et al., 1997).

In the area of eating disorders, the family treatment studies are characterized by methodological limitations (see Corcoran, 2000). In addition, studies were conducted in the 1980s with little recent research on family approaches. Taken as a whole, the research fails to provide the practitioner with clear direction on the theoretical approach to take and the role that family treatment plays, although family and marital components are seen as important aspects of treatment (see Foreyt, Poston, Winebarger, & McGavin, 1998). For these reasons, the treatment of eating disorders is excluded from this volume.

Bipolar disorder is another disorder for which a psychoeducational family component to treatment has been recommended (e.g., Miklowitz & Goldstein, 1997). Little research has been published on its efficacy up to this point with the exception of Glick, Clarkin, Haas, Spencer, and Chen (1991) and Miklowitz et al. (2000). Studies indicate much promise for family treatment in terms of delaying relapse. However, until more research has been published on the studies currently under way (e.g., George, Friedman, & Miklowitz, 2000), the decision was made to exclude the treatment from this volume.

Finally, an area of controversy in the family therapy literature involves the couples treatment of domestic violence. Foremost are concerns for victim safety and the responsibility that is implicitly placed on the victim in couples treatment (see Corcoran, 2000, for a review). In examining the research on couples treatment with family violence, studies tend to be marked by methodological limitations. A relatively recent and rigorous study reported that men who were court mandated to attend treatment performed better in the couples groups when alcohol was being treated with Antabuse (Brannen & Rubin, 1996). This program maintained many safeguards for the protection of women, however, which seemed to demand resources that many agencies would be unable to supply. Given the controversies and the lack of strong and consistent support for the efficacy of a couples approach, this volume offers the prevailing practice conclusion that couples treatment of family violence should follow individual or group treatment of the violent partner. For this reason, the couples treatment of family violence is not included in this volume.

Given the criteria for selection, the problems chosen for focus here include attention deficit/hyperactivity disorder, oppositional defiant disorder, physical abuse, sexual abuse, adolescent conduct disorder, ad-

olescent substance abuse, juvenile offending, adolescent pregnancy prevention, adult substance abuse, depression, schizophrenia, and caregiving for older persons.

Problem areas are presented in the order they may appear developmentally and are further divided into clinical disorders and social problems. Clinical disorders are defined by the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (2000) criteria (attention deficit/hyperactivity disorder, oppositional defiant disorder, substance abuse, depression, schizophrenia). Social problems are seen as those that arise out of the environmental context (physical abuse, sexual abuse, juvenile offending, teen pregnancy, caregiving for older persons). The overlap between clinical disorders and social problems, however, is recognized. For instance, the majority of adolescents who are in the law enforcement system for juvenile offending can be diagnosed with conduct disorder or oppositional defiant disorder. In addition, the *Diagnostic and Statistical Manual* has been criticized for its emphasis on individual pathology rather than viewing disorders as arising, at least in part, from an environmental context (Kutchins & Kirk, 1997). It is acknowledged that the division between clinical and social disorders is somewhat artificial, but it has been employed as a way to organize chapters around the problems with which families may present across the lifespan.

Following this framework, first the childhood clinical disorders are covered (attention deficit/hyperactivity disorder and oppositional defiant disorder). Then, social problems that often begin in childhood are discussed (physical abuse and sexual abuse). Adolescent conduct disorder and substance abuse are the clinical disorders followed by the social problems that may present in adolescence, which include juvenile offending and teen pregnancy (the overlap between clinical and social problems is represented in chapter 7, on multisystemic treatment of juvenile offending, substance abuse, and teen pregnancy). Adult clinical disorders include substance abuse, depression, and schizophrenia. A social problem involving older adulthood involves caregiving for elder persons.

Family Theories

In the early days of family therapy, theorists presumed that family therapy could cure all nature of ills, such as diabetes (e.g., Minuchin

et al., 1975), eating disorders (e.g., Minuchin, Rosman, & Baker, 1978), and schizophrenia (Bateson, Jackson, Haley, & Weakland, 1956). At present, much greater understanding of the complexity of disorders has emerged with the biopsychosocial framework. Biological and genetic vulnerabilities, a certain cognitive psychological style operating in the individual, as well as coercive interactions or escalating feedback loops in families may all play roles, among other contributing factors. In recognition of the complexity of disorders and problems, many of the models that have gained empirical support, such as multisystemic family therapy, psychoeducational approaches, and functional family therapy,[1] are integrative models, which combine different approaches.

Problem areas described in each chapter intersect with the theories for which there is research support (psychoeducation, behavioral parent training, solution-focused therapy, cognitive-behavioral treatment, structural family therapy, and multisystemic treatment). The main emphasis is the application of the theory, illustrating how the techniques and the particular perspective can be employed with a case study family.

Some definitions of *evidence-based* have included empirical examination of individual families' progress in treatment, as well as knowledge of the research in a particular problem area (see Cournoyer & Powers, 2002, for a review). Discussion of measurement instruments and their use with case study families is not an emphasis here because of space considerations. However, the interested reader is referred to Corcoran (2000) for recommended measurement instruments for use with the different problem areas.

The limitations of applying the criteria of evidence-based practice must also be acknowledged. A certain selection process occurs as theories are chosen for empirical study. The reader will notice, for example, that many chapters discuss behavioral and cognitive-behavioral approaches. This content reflects the state of the research. Cognitive-behavioral approaches arose out of a research paradigm and, to some degree, are easier to test than other models since they rely on educational materials, skills training, and observable phenomena. To illustrate the bias in the research, in 1990, Kazdin, Bass, Ayers, and Rodgers

1. While functional family therapy (Alexander & Parsons, 1982) is empirically supported for the treatment of juvenile offending, a chapter on this model is not included since adolescent conduct disorder and juvenile offending, adolescent substance abuse, and teen pregnancy are covered in other chapters.

conducted a review of two decades of the child and adolescent therapy outcome literature. They found that behavioral and cognitive-behavioral methods accounted for half of the studies. Other practice orientations and methods, including family therapy, psychodynamic therapy, relationship-centered therapy, play therapy, and art therapy, each comprised less than 5% of studies (Kazdin et al., 1990). The state of the research appears to have changed little since then although it is hoped that in response to the current environment, proponents of other theoretical approaches will add their perspective to the research.

Format

The reader will find that chapters will only briefly summarize key points of theory since, as mentioned, many other family therapy books have as their emphasis theory (see, for example, Franklin & Jordan, 1999; Goldenberg & Goldenberg, 2000; Nichols & Schwartz, 2001). Boxes delineating theory and additional resources the reader can consult will be provided in each chapter. The empirical support for the particular theory will only be briefly described; for further details of the research studies supporting each theory by problem area, the reader is referred to Corcoran (2000).

The bulk of each chapter will be devoted to the application of the theory through the case study. A visual diagram will be provided for each family so that the reader can follow the relationships involved.[2] Sessions are detailed, highlighted by dialogue, with subsequent sessions summarized for the reader. Each chapter essentially provides detailed treatment plans with step-by-step illustrations of how these perspectives can be applied. *Clinical Applications of Evidence-Based Family Interventions* serves to provide both practitioners and students with the practical knowledge to apply both theory and evidence-based practice.

One objective of the case study is to relay the complexities and realities of family treatment through the example. For instance, chapters 1 and 2 cover the same case, a child who has been diagnosed with oppositional defiant disorder and ADHD. These two diagnoses often

2. Diagrammatic notation was drawn from McGoldrick and Gerson's (1985) excellent book on genograms. However, the symbols of family dynamics and intergenerational patterns were avoided due to their theoretical association with Bowenian family therapy.

co-occur and in clinical settings might represent 90% of children who seek treatment for ADHD (Abikoff & Klein, 1992).

Discussion of how to overcome barriers and how to help families progress is a focus of the chapters with the main theme of using a collaborative approach with families. The reader will note that while some of the theoretical frameworks are skills or educationally based, services are still administered in a style that is collaborative and process-based in nature.

Cases presented are those that reflect the current practice environment. The author either personally worked with these families, they are families from cases that she supervised, or they are composites based on her practice experience (the information in all cases has been de-identified). Because the author's expertise is mainly in the areas of child, couple, and family services, two other authors, Joseph Walsh, currently associate professor at the Virginia Commonwealth University School of Social Work, and Patricia Gleason-Wynn, director of Elder Care Specialists and adjunct instructor at the University of Texas at Arlington School of Social Work, were called upon to contribute their expertise in the family treatment of schizophrenia and of caregivers of the elderly, respectively. With their contributions, *Clinical Applications of Evidence-Based Family Interventions* conveys effective family treatment approaches to problems that families may experience throughout the lifespan.

Audience

The audience for this book includes students and practitioners, who are most often interested in the question: What do you actually do with a real-life family when using a particular theory? The book also attempts to respond to the pressures that students and practitioners feel to demonstrate the validity of their approaches. Hence, *Clinical Applications of Evidence-Based Family Interventions* provides a unique, integrated perspective; here, problem area, theory, research, and application of techniques come together.

The audience for this book is not limited to any particular mental health or helping professions field even though the author's background is social work. Therefore, potential audiences include individuals from the social work, counseling, clinical psychology, marriage and family therapy, nursing, and psychiatric fields. The reason for this

breadth is that the various helping professions are all operating under the same pressures and environmental demands for evidence for their services. In addition, agencies that serve particular populations or problems often employ individuals who have been trained across different disciplines. It is the author's hope that, no matter the background of the reader, *Clinical Applications of Evidence-Based Family Interventions* will help the reader understand the application of both theory and evidence-based practice to families that seek help for their suffering.

PART I

Childhood

CLINICAL DISORDERS

SOCIAL PROBLEMS

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1 Psychoeducation with Attention Deficit/Hyperactivity Disorder

Presenting Problem

Mrs. Patsy Abell, a Caucasian woman, age 32, brought her son, Andy Stevens, an 8-year-old third-grader, who was school-referred, to an outpatient mental health clinic. Mrs. Abell complained that Andy's problems were not confined to the school; they also happened at home. For example, when she asked him to do his chores or his homework, he argued or flat-out refused. Similarly, her requests that he *not* do something (blowing a whistle, banging a stick in the house) met with his continued persistence in doing the activity, almost as if he derived pleasure from annoying family members.

His teacher reported the same behaviors (arguing about teacher commands, refusing to do schoolwork) and that he blamed others (e.g., the student sitting next to him) for his disruptive behavior. Andy's conduct grades, ever since kindergarten, were poor. He barely eked by each grade, and his math and science grades were currently at failing levels.

When asked about Andy's ability to attend to tasks, Mrs. Abell

reported his distractibility (looking out the window at home or at school when he's supposed to do his work). She added, "He doesn't listen at all when you tell him something," but Mrs. Abell attributed this tendency to pure spite. "And he's always losing things. I tell him he'd lose his head if it wasn't attached to his neck." He misplaced his math book; he forgot to bring his homework home. "Pretty convenient, huh?" Mrs. Abell said, implying that he does these things to get out of work. When asked about activities he enjoyed, she said Andy loves helping out at the fish and tackle shop (the business she helps her husband run). Her husband said Andy seems like a different kid there.

Mrs. Abell reported that she was married to her former husband for 9 years, and he was physically abusive to her but not to their children, Nikki (now age 10) and Andy. Mrs. Abell's ex-husband hung around with a motorcycle gang and used to have a problem with drugs (speed) during their early marriage, but now only drank heavily. He left her 2 years ago to be with his current girlfriend. Mrs. Abell relayed that the children have regular visitation with their father. The children said they like his girlfriend and that he is not drunk when they are over there, although he sometimes drinks beer.

One measure Mrs. Abell had taken to protect the children against her ex-husband's drinking was to drop the children off and pick them up from visitation so there was less risk when he drinks. She informed the children to call her if he had been drinking to the point where they felt uncomfortable. Mrs. Abell feared no further violence now that she was remarried.

"What's Andy's behavior like when he's at his father's?" the practitioner asked.

"His daddy can yell pretty good. Andy always did obey him more than me."

Mrs. Abell was able to see that Andy might have felt threatened by his father's violence, which included shoving, pushing, and restraining Mrs. Abell if she tried to leave. Mrs. Abell said this occurred on average once a month when her husband drank whiskey instead of his usual beer. The police were never involved.

After assessing the level and frequency of the violence, the practitioner asked Mrs. Abell how the children reacted during these episodes. She said that Andy and his sister would usually hide in the closet and cry. (See figure 1.1 for the genogram of this family.)

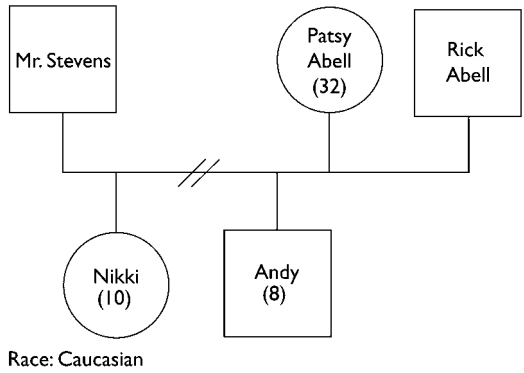

Figure 1.1. Psychoeducation Case Study: Andy Stevens's Family

Diagnostic Information

The school initiated testing due to Andy's school failure and poor conduct grades. As part of testing, Mrs. Abell and his teacher were interviewed, and each completed standardized behavior rating scales. Andy also completed intelligence and achievement tests. Mrs. Abell produced the results of these tests, which revealed no cognitive deficit or learning disability as the source of his poor school performance. However, he did meet American Psychiatric Association (2000) criteria for attention deficit/hyperactivity disorder (ADHD) (more specifically predominantly inattentive type) and oppositional defiant disorder (ODD). The school psychologist recommended that Mrs. Abell take the school testing information to a medical doctor for evaluation. Meanwhile, Andy was referred to a self-control skills training group at the school due to his symptoms.

Differential Diagnosis

Although the school recognized Andy's symptoms of ADHD and ODD, Andy's history must also be taken into account. Andy witnessed ongoing violence for years, which could result in posttraumatic stress disorder (PTSD) symptoms. Some of the symptoms of PTSD, such as "acting or feeling as if the traumatic event were recurring," "problems

concentrating," and "avoiding stimuli associated with trauma," can be confused with symptoms of inattention (Weinstein, Staffelbach, & Biaggio, 2000, p. 368). Other symptoms of trauma might include "inability to appropriately inhibit response due to hypervigilance" and "physiological reactivity when exposed to cues symbolizing an aspect of the trauma," which resemble symptoms of hyperactivity or impulsivity (Weinstein et al., 2000, p. 368). As a result, it was possible that his symptoms were derived from PTSD rather than ADHD. A careful assessment, relying on multiple sources of data (child interview, parent interview, standardized measures), was made to determine whether PTSD plays a role in Andy's symptoms.

The practitioner asked his mother if Andy showed symptoms, such as nightmares, hypervigilance, or repetitive play themes of violence. Mrs. Abell denied that her children showed any of these effects or that they had been physically or sexually abused.

The practitioner conducted an individual assessment of Andy to see if posttraumatic stress were playing a role in his symptoms. In the first part of the individual assessment of Andy, he didn't talk at all, not even making eye contact. He looked around the office, ignoring the practitioner as various attempts were made to establish rapport, and would not even draw or play with the office toys.

The second time Andy came in, he had been prompted by his mother to cooperate with the practitioner. He started by drawing a picture of his family. While he drew, he answered some questions, saying his father hit his mother but "it didn't really hurt."

By his account, Andy seemed to enjoy visits with his father and liked his father's girlfriend. His father drank beer "but not that much." Andy also liked Rick, his stepfather of one year, although he "yells a lot." Andy denied any nightmares. He was able to complete the Trauma Symptom Checklist for Children (Briere, 1996) by the practitioner reading the questions. Scoring did not reveal posttraumatic stress.

Therefore, the symptoms of ADHD and ODD still seemed to account for Andy's presentation. The comorbid diagnoses of both ADHD and ODD are exceedingly common in clinical settings and may be as high as 90% (Abikoff & Klein, 1992). Indeed, between 30 and 50% of children with ADHD develop conduct or oppositional defiant disorder by the ages of 8 to 12. The psychoeducational model described in this chapter will target ADHD and its concomitant disorders.

Overview of Psychoeducation

Psychoeducational approaches began with the treatment of schizophrenia (see chapter 10 for discussion of this literature) after research revealed the association between *expressed emotion* in the family (hostility, criticism, and overinvolvement) and higher relapse rates in the individual with schizophrenia (Brown, Monck, Carstairs, & Wing, 1962). In contrast to family systems models (e.g., Bateson, Jackson, Haley, & Weakland, 1956), psychoeducational models do not see the family as the source of the illness; rather, illness is largely determined by genetic vulnerabilities. From the psychoeducational perspective, the family's role is to create an atmosphere conducive to continued remission and adequate functioning at considerably less stress to family members. This approach contrasts with the early family systems view that altering family interaction patterns could result in cure of the identified patient (Anderson, Reiss, & Hogarty, 1986). (See also box 1.1 for a brief summary of the psychoeducational framework and resources for the reader.)

Box 1.1

Key Points of Psychoeducational Framework and Additional Resources

Key Points

- Psychoeducational approaches began in the field of schizophrenia (see Anderson, Reiss, & Hogarty, 1986) and have been extended to the family treatment of other disorders viewed as largely genetically determined, such as ADHD.
- Through psychoeducation, the family's role is to create an atmosphere conducive to adequate functioning of the individual with the disorder at considerably less stress to family members.
- Parents are educated about the disorder and available treatment. They are also taught strategies for managing their children with ADHD and coping strategies for themselves to help manage the stress involved.
- Psychoeducation allows for cognitive-behavioral interventions integrated within the model, as a shared assumption is that information and knowledge mediates distress.

Additional Resources

C. M. Anderson, D. J. Reiss, & G. E. Hogarty. (1986). *Schizophrenia and the family: A practitioner's guide to psychoeducation and management*. New York: Guilford.

R. A. Barkley. (2000). *Taking charge of ADHD* (Revised ed.). New York: Guilford.

Psychoeducation and ADHD

Psychoeducation is appropriate to ADHD because it is believed to have a biological and, specifically, a genetic basis (Barkley, 1998). Second, the diagnosis of ADHD in a child brings significant challenges to family functioning in terms of increased parenting stress, conflict with siblings, depression in mothers, abuse of substances, marital conflict, and an increased likelihood of separation and divorce of the parents (Barkley, 1998; Pelham, Wheeler, & Chronis, 1998). A psychoeducational approach may reduce the level of strain on family members through education of parents on helpful strategies for managing a child with the disorder. The focus on education rather than therapy reflects the psychoeducational assumption that families are healthy and functional and as such may contribute to the management of a member's disorder (Franklin & Jordan, 1999).

In the ADHD treatment field, the psychoeducational approach has dominated as a way to work with families, although it is generally not named as such in the literature, with the exception of Shelton, et al. (2000). However, the combination of strategies—sharing information about the disorder and medication treatment, teaching parents behavioral management strategies with their children, and using cognitive strategies to manage parental frustrations—essentially translates into a psychoeducational approach.

Most studies on family treatment of ADHD are instead theoretically associated with behavioral or cognitive-behavioral schools (e.g., Anastopoulos, Shelton, DuPaul, & Guevremont, 1993; Basu & Aniruddha, 1996; Frankel, Myatt, Cantwell, & Feinberg, 1997). The cognitive-behavioral orientation is compatible with a psychoeducational approach they share an assumption that providing information can mediate distress (Nichols & Schwartz, 2001). Indeed, theories that help family members manage the disorder, such as training them in behavioral management strategies, can be integrated within the psychoeducaitonal approach. (See chapter 2 for an application of behavioral parent training for the treatment of Andy's oppositional and defiant symptoms.)

The treatment needs of children with ADHD and their families are complex and intense, with multimodal approaches, including medication, psychosocial interventions for both child and parent, and school-based approaches, necessary to produce adequate outcome (MTA Co-

operative Group, 1999; Satterfield, Satterfield, & Schell, 1987). Psychoeducation can help parents organize the many and varied treatment needs of their children. Education about the disorder helps family members revise their often too-high expectations for the child and replace these with clear and reasonable goals. Education also aids the family in creating the type of environment that is most conducive for optimal functioning.

Case Application

In this chapter, the case application will be used to illustrate the main components of a psychoeducational approach. The application will first involve *joining* with Mrs. Abell to help her recognize her stress and cope with it. Education about ADHD follows, which involves a description of the disorder, its prevalence, and a discussion of its causes. A rationale for the importance of including all caregivers is provided, as well as methods to encourage their participation. Education about medication and interfacing with the medical system is followed by information on risk factors for the disorder and strategies to ameliorate risk. Methods to reinforce children's social skills are taught to parents, as are strategies for interfacing with the school system. Finally, education about ODD is provided. Chapter 2 will continue with the psychoeducational approach for Andy with a focus on strategies for behavioral management of his ODD symptoms.

Joining

When parents bring their child into a clinic setting for disruptive disorders, they tend to expect the practitioner to work alone with the child (Morrissey-Kane & Prinz, 1999). For example, Mrs. Abell began by saying, "I just want you to talk to Andy, find out why he's doing those things." However, McMahon (1994) suggests that only when children succeed at externally controlled programs should parent training and classroom management programs segue into those that are more internally based, such as cognitive-behavioral programs.

The practitioner started by explaining that she first wanted to work

with Mrs. Abell rather than dividing the session between parent and child. Once there was some environmental structure for Andy, the practitioner could work with Andy on controlling his behaviors and communicating appropriately. She could also process with him his reactions to the family violence, his parents' divorce, and his mother's recent marriage.

The practitioner offered several other reasons to convince Mrs. Abell to act as the initial focus of the intervention. "First, you are the most important person to your child, more than I ever will be. If I work with you on some things, you can be much more effective than I could ever hope to be in my hour a week." Like most parents, Mrs. Abell was pleased to admit that she played a dominant role in her child's life. A second reason involved the lack of feasibility associated with seeing both parent and child during the same session as that left Andy and his sister alone in the waiting room for some time. The office manager had already complained about their unruly behavior. A third reason involved children's cognitive limitations. "Young children have a difficult time learning a new behavior in one place, such as my office, and then generalizing that skill to another context. For example, if I teach your son some techniques for the classroom, it will be hard for him to remember when he is actually in the classroom. That's why it's good that he's in the social skills training group at school, so it's right there in the environment with the other kids he sees. And if you can learn what I will be teaching him, you can prompt him for these behaviors at home and then reinforce him for doing them."

Mrs. Abell was interested to hear that working with the parent to change the child's environment was a way to make treatment move along more quickly. "Work with children tends to go slowly. Even with a child who is able to listen and follow directions, attention can only be focused on one subject, especially if it is uncomfortable or unfamiliar, for only so long. You describe Andy as having some difficulties with paying attention and complying, so that would make the work even more challenging."

A final way to engage Mrs. Abell was to describe the benefits to her. The next session would cover the stress to parents of having a child diagnosed with ADHD, as one of the goals of a psychoeducational approach is to reduce the burden associated with caregiving.

Dealing with Maternal Stress

The stress experienced by a parent with a child with ADHD is at least as severe as that experienced by parents of children with autism, a developmental disorder that is far more serious and pervasive. "The excessive, demanding, intrusive, and generally high-intensity behavior of children with ADHD as well as their clear impairment in self-control, naturally elicit greater efforts at direction, help, supervision, and monitoring by parents" (Barkley, 2000, p. 113). The impact on parents includes low self-esteem, depression, self-blame, and social isolation (Barkley, 2000).

Mrs. Abell identified with this information and shared some of her caregiving difficulties, which began, she said, as soon as Andy was born. "He was different from Nikki from the start. He cried a lot, fussed, wouldn't get on schedule." The practitioner normalized Mrs. Abell's experience. Many children who have ADHD are irritable, hard to soothe, and have difficulty with regulation from birth (Barkley, 2000).

After empathizing with some of Mrs. Abell's parenting challenges, the practitioner discussed with Mrs. Abell the coping strategies she used. Mrs. Abell said the situation was much better since she married her husband. When she was a single parent, she worked at a convenience store and didn't have as much time to spend with the children. The family's finances improved dramatically with the addition of Mr. Abell's income, and she now had his help with parenting. They also enjoyed time together as a couple: "His brother and wife will take the kids every once in a while, so we can get something to eat, or go see a movie." Clearly, Mrs. Abell's relationship with her new husband was important to her.

The practitioner then inquired about sources of social support other than Mrs. Abell's husband since social support has been consistently associated with reduced stress (e.g., Cohen & Wills, 1985; Lincoln, 2000). "Well, now I have Rick's family. Before that, I didn't really have anyone."

"How about friends with children or extended family?"

"My sister and I don't talk much. She thought I was an idiot to stay with my ex-husband. I know she meant well, but he was my husband, so I didn't feel much support from her. Now we're just out of the habit of talking. The kids see my mother occasionally, but it's a

2-hour drive to get there, and my mom's too old to be driving down here. My dad died about 15 years ago now."

"Any other relatives?"

"Just my brother, but he's in the army, always being stationed somewhere else, divorced."

When the practitioner mentioned friends, Mrs. Abell gave an ironic laugh. "My ex-husband was so jealous, he always thought I was with some guy, so it just became easier to stay home. And then he's the one who ran off with someone else."

Since Mrs. Abell did not seem linked to many informal supports, the practitioner suggested a support group for mothers with children with ADHD.

Mrs. Abell looked dubious. "I don't know. It was hard enough to come here. This is okay, but I can't imagine talking about this stuff in front of a room full of strangers." Despite the practitioner's attempt at reassurance ("They would all be going through the same kind of experiences you are"), Mrs. Abell was still not convinced.

To further assist in the alleviation of stress, the practitioner inquired about what Mrs. Abell did for herself that was pleasurable. She identified watching TV and reading women's magazines and further said that she enjoyed these activities daily. After joining with Mrs. Abell and attending to aspects of her stress, the practitioner moved into providing education on ADHD.

Education on ADHD

Information on ADHD included its description, prevalence, and the etiology of the disorder.[1] Further, risk factors for the disorder were discussed. All information was imparted *collaboratively*, which means that efforts were made to personalize material to the family's situation and to allow time for processing reactions and experiences to the educational material (Webster-Stratton & Herbert, 1993). Part of a collaborative approach also means bringing to light concerns parents have about new material (Webster-Stratton & Herbert, 1993). In this way,

1. As a source for further information, the practitioner recommended R. A. Barkley's revised edition (2000) of *Taking Charge of ADHD: The Complete, Authoritative Guide for Parents*, which also lists many other helpful resources (organizations, books, and videotapes).